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
December 1, 2003

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  
1900 Kanawha Blvd., E.  
Charleston, WV  25305

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

Jane L. Cline, Commissioner
Office of the Insurance Commissioner

Steven Summer, President
West Virginia Hospital Association

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, 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.

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

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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:
  - 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

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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

\(^5\) 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.” [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:

- 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;

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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.  

**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 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. The 25% rule only applied to the defendants in the medical liability action at time of verdict. 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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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.
defense. 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.

House Bill 2122 generally abolishes joint liability in medical professional liability civil actions. 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. 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.

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.

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.\textsuperscript{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.\textsuperscript{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).\textsuperscript{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.

\textsuperscript{21} W. Va. Code § 55-7B-9(b).
\textsuperscript{22} W. Va. Code § 55-7B-9(g).
\textsuperscript{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. . . .

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.”

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.” The trauma care limit also applies to:

- Health care services rendered by a licensed EMS agency or employee of an EMS agency;

- 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.

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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

\(^{29}\) 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.\textsuperscript{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.\textsuperscript{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.

\textbf{Funding Options for the Patient Injury Compensation Fund}

\textbf{Actuarial Funding Determinations}

The West Virginia PICF is required to be “actuarially sound” and “fully-funded.”\textsuperscript{35} BRIM retained the services of AON Risk Consultants, Inc. (“ARC”) to review the effects of

\textsuperscript{33} W. Va. Code § 55-7B-9c(k).
\textsuperscript{34} 64 C.S.R., Series 27 \textit{Statewide Trauma / Emergency Care System (filed as an emergency rule)}.
\textsuperscript{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:

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

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:

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

- 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

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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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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.”
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.\footnote{W. Va. Code § 29-12C-1(c)(3); } 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.”\footnote{W. Va. Code § 55-7B-2(k).} 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
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, 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

\[^{42}\text{W. Va. Code § 55-7B-8(a).}\]
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.\(^4\) 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.\(^4\) BRIM is governed by a five-member board.\(^5\) The BRIM Board has general supervision and control over the insurance of all state property, activities and responsibilities.\(^6\) In addition, to managing the state insurance program, BRIM currently administers the mine subsidence fund, the Senate Bill 3

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\(^4\) W. Va. Code §§ 33-26-1 et seq.
\(^4\) W. Va. Code § 29-12C-(c) (1).
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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\(^{48}\) 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” 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

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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, 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 protect 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

\(^{51}\) 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.\textsuperscript{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

\textsuperscript{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

\(^{53}\) 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.”

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

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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.

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### Exhibit 1: Patient Compensation Fund State Comparison

<table>
<thead>
<tr>
<th>State</th>
<th>Florida Birth-Related Neurological Injury Compensation Association</th>
<th>Florida Patient Compensation Fund</th>
<th>Indiana Patient Compensation Fund</th>
<th>Kansas Health Care Stabilization Fund</th>
<th>Louisiana Patient Compensation Fund</th>
<th>Nebraska Excess Liability Fund</th>
<th>New Mexico Patient Compensation Fund</th>
<th>Medical Care Availability and Reduction of Error (Mcare) (PA)</th>
<th>South Carolina Patients Compensation Fund</th>
<th>Virginia Birth-Related Injury Compensation Fund</th>
<th>Wisconsin Patient Compensation Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal of PCF</strong></td>
<td>To provide an exclusive no-fault remedy for birth-related neurological injury claims</td>
<td>&quot;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&quot;</td>
<td>To provide a system of excess insurance for health care providers</td>
<td>&quot;to provide excess professional liability coverage for defined health care providers&quot;</td>
<td>&quot;to guarantee that affordable medical malpractice coverage was available to all private providers&quot;</td>
<td>&quot;an alternate way to determine medical malpractice claims and to ensure that malpractice insurance coverage in Nebraska is available at reasonable rates.&quot;</td>
<td>&quot;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&quot;</td>
<td>&quot;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&quot;</td>
<td>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</td>
<td>The exclusive remedy for birth-related neurological injuries in Virginia</td>
<td>&quot;(T)o provide excess medical malpractice coverage for health care providers.&quot;</td>
</tr>
<tr>
<td><strong>Governance</strong></td>
<td>5 Member Board of Directors</td>
<td>11 Member Board of Governors</td>
<td>Commissioner of Department of Insurance</td>
<td>10 Member Board of Governors</td>
<td>PCF Oversight Board</td>
<td>Director of Department of Insurance</td>
<td>Director of Department of Insurance</td>
<td>DOI Administers the Fund</td>
<td>13 Member Board of Governors</td>
<td>7 Member Board of Directors</td>
<td>13 Member Board of Governors</td>
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<tr>
<td><strong>Participation</strong></td>
<td>Voluntary</td>
<td>Mandatory, Physicians</td>
<td>Voluntary</td>
<td>Mandatory</td>
<td>Voluntary</td>
<td>Mandatory</td>
<td>Voluntary</td>
<td>Mandatory</td>
<td>Voluntary</td>
<td>Voluntary</td>
<td>Mandatory, with exemptions</td>
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<tr>
<td>Eligibility</td>
<td>Florida Birth-Related Neurological Injury Compensation Association</td>
<td>Florida Patient Compensation Fund</td>
<td>Indiana Patient Compensation Fund</td>
<td>Kansas Health Care Stabilization Fund</td>
<td>Louisiana Patient Compensation Fund</td>
<td>Nebraska Excess Liability Fund</td>
<td>New Mexico Patient Compensation Fund</td>
<td>Medical Care Availability and Reduction of Error (Mcare) (PA)</td>
<td>South Carolina Patients Compensation Fund</td>
<td>Virginia Birth-Related Injury Compensation Fund</td>
<td>Wisconsin Patient Compensation Fund</td>
</tr>
<tr>
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<tr>
<td>Required Primary Coverage (000)</td>
<td>Physicians, Hospitals</td>
<td>Physicians, Hospitals</td>
<td>Physicians, Osteopaths, Chiropractors, Podiatrists, RNAs, Medical Care Facilities, Mental Health Clinics, Dentists, health Care LLCs Corps, etc.</td>
<td>Physicians, Hospitals</td>
<td>Physicians, Hospitals</td>
<td>Physicians, Hospitals</td>
<td>Physicians, Hospitals</td>
<td>Physicians, Hospitals</td>
<td>Physicians, Registered Nurses, Midwives, Hospitals</td>
<td>Physicians, Osteopaths, RNs, Nursing Homes, Hospitals, Ambulatory Surgery Centers, Cooperative sickness care associations</td>
<td></td>
</tr>
<tr>
<td>Private Insurance or qualified Self-insurance (for Hospitals), of JUA</td>
<td>$250/claim or $500/occurrence</td>
<td>$250/$750, Hospitals $250/$5,000, etc.</td>
<td>$200/$600</td>
<td>$100/$300</td>
<td>$200/$600</td>
<td>Physicians $500/1.5M, Hospitals $500/$2.5M</td>
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</tr>
<tr>
<td>Private Insurance Options</td>
<td>Private Insurance or qualified Self-insurance for Hospitals</td>
<td>Private Insurance or qualified Self-insurance</td>
<td>Private Insurance or qualified Self-insurance</td>
<td>Private Insurance or qualified Self-insurance</td>
<td>Private Insurance or qualified Self-insurance</td>
<td>Private Insurance or qualified Self-insurance</td>
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<tr>
<td>PCF Coverage Limits</td>
<td>Unlimited</td>
<td>Physicians either $1M/3M or $2M/3M (including entry limits), Hospitals $2.5M per claim (no agg.)</td>
<td>$1.0M per occurrence in excess coverage</td>
<td>$500K plus future medical expenses less primary coverage</td>
<td>$1.05M per occurrence in excess coverage</td>
<td>$1.05M per occurrence in excess coverage</td>
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<tr>
<td></td>
<td></td>
<td>1) 100/300, 2) 300/900, 3) 800/2.4M options available</td>
<td>$600K non-economic, unlimited medical</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>LIMITS</td>
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</table>

**Note:** The limits provided are subject to change and should be verified with the respective compensation fund.
<table>
<thead>
<tr>
<th>Funding Approach &amp; Revenues</th>
<th>Hospitals ($50 per live birth) and physicians ($5K annually) are assessed by the Association</th>
<th>Assessments “on the same basis as premiums”</th>
<th>Assessments “on the same basis as premiums”</th>
<th>Assessments “on the same basis as premiums”</th>
<th>Assessments “on the same basis as premiums”</th>
<th>Pay-As-You-Go Funding</th>
<th>Administrative costs, operating costs, and claim payments are funded through assessments on participating health care providers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding Collection</td>
<td>Paid to Fund</td>
<td>Collected by primary insurer as “pass-through”</td>
<td>Collected by primary insurer as “pass-through”</td>
<td>Collected by primary insurer as “pass-through”</td>
<td>Collected by primary insurer as “pass-through”</td>
<td>Annual payments to the Fund</td>
<td>Health Care providers are billed annually with lump sum or quarterly payments</td>
</tr>
<tr>
<td>Claims Administration</td>
<td>Administrative law judge determines coverage, Association staff administers</td>
<td>DOI Staff monitors all Med Mal claims and suits in the state</td>
<td>Executive Director, Office of Risk Management</td>
<td>Director Administrativ E Services</td>
<td>DOI Staff</td>
<td>Outsourced</td>
<td>Agency Staff</td>
</tr>
<tr>
<td>Medical Review Board/Pretrial Screenings</td>
<td>Each Insurance company has a 90 day period to do an internal pretrial screening</td>
<td>Mandatory for Claims&gt;$15K</td>
<td>Mandatory</td>
<td>Mandatory, unless waived</td>
<td>Mandatory</td>
<td>None</td>
<td>Review Panel set by Medical School Deans to determine Fund coverage</td>
</tr>
<tr>
<td>Damage Caps</td>
<td>Florida Birth-Related Neurological Injury Compensation Association</td>
<td>Florida Patient Compensation Fund</td>
<td>Indiana Patient Compensation Fund</td>
<td>Kansas Health Care Stabilization Fund</td>
<td>Louisiana Patient Compensation Fund</td>
<td>Nebraska Excess Liability Fund</td>
<td>New Mexico Patient Compensation Fund</td>
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<tr>
<td>Punitive</td>
<td>Punitive are limited to three times compensatory damages</td>
<td>Punitive are limited to three times compensatory damages</td>
<td>$250,000 per provider, $1.25M for all qualified providers and the Fund</td>
<td>$250K for non-economic, punitive limits to $5M or highest income in last 5 years</td>
<td>$500K plus future medical expenses</td>
<td>$1.25M per occurrence</td>
<td>$600K non-economic, unlimited medical</td>
</tr>
<tr>
<td>Limits on non-economic damages</td>
<td>None</td>
<td>None</td>
<td>$500K plus future medical expenses</td>
<td>$1.25M per occurrence</td>
<td>$600K non-economic, unlimited medical</td>
<td>Punitive cannot exceed 200% of compensatory but cannot be &lt;$100K</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attorneys’ Fees</th>
<th>Sliding scale depending on recovery amount and type of judicial processes required</th>
<th>Sliding scale depending on recovery amount and type of judicial processes required</th>
<th>15% of PCF awards</th>
<th>Fees require judicial approval</th>
<th>None</th>
<th>No limits, fees are reviewable by judge</th>
<th>None</th>
<th>Unconstitutional</th>
<th>None</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sliding scale</td>
<td>Sliding scale depending on recovery amount and type of judicial processes required</td>
<td>Sliding scale depending on recovery amount and type of judicial processes required</td>
<td>15% of PCF awards</td>
<td>Fees require judicial approval</td>
<td>None</td>
<td>No limits, fees are reviewable by judge</td>
<td>None</td>
<td>Unconstitutional</td>
<td>None</td>
<td>None</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Structured Settlements</th>
<th>Any party may request for future economic damages in excess of $250K</th>
<th>Any party may request for future economic damages in excess of $250K</th>
<th>Allowed, but not required</th>
<th>Not mandatory, but judges are authorized to require</th>
<th>PCF payments “paid as incurred”</th>
<th>Not required</th>
<th>Medical Payments must be paid as they are incurred</th>
<th>Allowed, but not Mandated</th>
<th>Allowed, but not Mandated</th>
<th>Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Settlements</td>
<td>Any party may request for future economic damages in excess of $250K</td>
<td>Any party may request for future economic damages in excess of $250K</td>
<td>Allowed, but not required</td>
<td>Not mandatory, but judges are authorized to require</td>
<td>PCF payments “paid as incurred”</td>
<td>Not required</td>
<td>Medical Payments must be paid as they are incurred</td>
<td>Allowed, but not Mandated</td>
<td>Allowed, but not Mandated</td>
<td>Allowed</td>
</tr>
</tbody>
</table>

<p>| 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 &gt;$15K | Arbitration Option available | Allowed, but optional | Medical Review Panel is a non-binding option | Allowed, but mandatory | Unconstitutional | None |
|-------------------------------------------------|---------------------------------|---------------------------------|-----------------|---------------------------------|-----------------|---------------------------------|-----------------|---------------------------------|-----------------|---------------------------------|
| 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 &gt;$15K | Arbitration Option available | Allowed, but optional | Medical Review Panel is a non-binding option | Allowed, but mandatory | Unconstitutional | None | Mediation System | None | None |</p>
<table>
<thead>
<tr>
<th>HOSPITAL</th>
<th>ADDRESS</th>
<th>LEVEL</th>
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<tbody>
<tr>
<td>CAMC-General Division</td>
<td>PO Box 1547</td>
<td>I</td>
</tr>
<tr>
<td></td>
<td>Charleston, WV 25326</td>
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</tr>
<tr>
<td>WVU Hospitals, Inc.</td>
<td>Medical Center Drive</td>
<td>I</td>
</tr>
<tr>
<td></td>
<td>Morgantown, WV 26506</td>
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</tr>
<tr>
<td>Tri-State Trauma Center -</td>
<td>1340 Hal Greer Boulevard</td>
<td>II</td>
</tr>
<tr>
<td>Cabell-Huntington Hospital</td>
<td>Huntington, WV 25701</td>
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<tr>
<td>Tri-State Trauma Center -</td>
<td>2900 1st Avenue</td>
<td>II</td>
</tr>
<tr>
<td>St. Mary’s Hospital</td>
<td>Huntington, WV 25702</td>
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<tr>
<td>Weirton Medical Center</td>
<td>601 Colliers Way</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>Weirton, WV 26062</td>
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<tr>
<td>Wetzel County Hospital</td>
<td>3 E. Benjamin Drive</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>New Martinsville, WV 26155</td>
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<tr>
<td>Reynolds Memorial Hospital</td>
<td>800 Wheeling Drive</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>Glen Dale, WV 26038</td>
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<tr>
<td>Grant Memorial Hospital</td>
<td>PO Box 1019</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>Petersburg, WV 26847</td>
<td></td>
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<tr>
<td>Jefferson Memorial Hospital</td>
<td>300 S. Preston Drive</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>Ranson, WV 25438</td>
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<tr>
<td>Stonewall Jackson Memorial Hospital</td>
<td>230 Hospital Plaza</td>
<td>III</td>
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<tr>
<td></td>
<td>Weston, WV 26452</td>
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<tr>
<td>Logan Regional Medical Center</td>
<td>20 Hospital Drive</td>
<td>III</td>
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<tr>
<td></td>
<td>Logan, WV 25601</td>
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<tr>
<td>St. Joseph’s Hospital</td>
<td>Amalia Drive</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>Buckhannon, WV 26201</td>
<td></td>
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<tr>
<td>Raleigh General Hospital</td>
<td>1710 Harper Road</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>Beckley, WV 25801</td>
<td></td>
</tr>
</tbody>
</table>
EMS Providers

Ed Jones
Action Delivery Service
2431 Greenup Ave
Ashland, KY 41101
606-324-3286

Gerald Kyle
Alderson Volunteer Fire Department Inc.
PO Box 647
Alderson, WV 24910
304-445-7420

Paul Eddie Hardman
Anmoore EMS
P. O. Box 187
Anmoore, WV 26323
304-622-0274

Carl Wade
Anthony Creek Rescue Squad
HC 70 Box N-10
Neola, WV 24986
304-536-1636

Bill Ball
Appalachian First Response
180 Hospital Drive Box 1 E
South Williamson, KY 41503
606-237-5100

Deborah Harding
Augusta Volunteer Rescue Squad
P. O. Box 105
Augusta, WV 26704
304-496-8223

Robert Jones
Barbour County Emergency Squad Inc.
P. O. Box 55
Philippi, WV 26416
304-457-2037

Janet Ghigo
Bartow-Frank-Durbin Fire And Rescue
P. O. Box 267
Durbin, WV 26264
304-456-4999

G. Kim Flannery
Bayer Corp.
P. O. Box 500
New Martinsville, WV 26155
304-455-4400

Steve Roberts
Bayer Cropscience
P. O. Box 1005
Institute, WV 25112
304-767-6000

Arnold Bolen
Beckley Fire Department
P. O. Box 2514
Beckley, WV 25802
304-256-1780

Terry Stuck
Beech Bottom Volunteer Fire Department
P. O. Box 333
Beech Bottom, WV 26030
304-394-5726

Nicholas Raschella
Belington Emergency Medical Squad Inc.
P. O. Box 922
Belington, WV 26250
304-823-2010

Thomas Smith
Benwood Volunteer Fire Dept. Inc.
P. O. Box 71
Benwood, WV 26031
304-232-0174
Gary Collis
Berkeley County Emergency Ambulance Authority
110 West King Street
Martinsburg, WV 25401
304-264-1921

Connie Hall
Best Transports Ambulance Service
P. O. Box 1495
Beckley, WV 25802
304-252-5522

Brian Cunningham
Bethany VFD
P. O. Box 219
Bethany, WV 26032
304-829-4504

Paul F. Walters
Bethlehem Fire Department
P. O. Box 6305
Wheeling, WV 26003
304-242-1603

William Ferguson
Blennemassett VFD
P. O. Box 33
Washington, WV 26181
304-863-3103

Leonard Lehman
Blue Ridge Mountain Volunteer Fire Company
RT 1 Box 740
Harpers Ferry, WV 25425
304-725-8118

Robert Youther
Bluefield WV Rescue & Ambulance, Inc.
P. O. Box 311
Bluefield, WV 24701
304-327-7172

Archie Hubbard
Boone County Ambulance Authority
P. O. Box 159
Racine, WV 25165
304-837-3911

Brenda S. Slaughter
Braxton Emergency Squad
505 Main Street
Sutton, WV 26601
304-765-5361

Gary L. Hatfield
Brenton Volunteer Fire & Rescue
HC 63 Box 718
Brenton, WV 24818
304-732-7165

John A. Vanlandingham
Bridgeport Fire Department
P. O. Box 1310
Bridgeport, WV 26330
304-842-8252

John Schertfeger
Brooke County Emergency Medical Service
P. O. Box 268
Wellsburg, WV 26070
304-737-1757

Peggy Slagle
Bruceton Community Ambulance Service
P. O. Box 84
Bruceton Mills, WV 26525
304-379-3792

Rolfe Kelley
BSR inc.
P. O. Box 190
Summit Point, WV 25446
304-725-6512
<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Randy Henderson</td>
<td>Burlington Volunteer Fire Department Box 97 Burlington, WV 26710</td>
<td>304-289-3032</td>
</tr>
<tr>
<td>A. Gordon Merry III</td>
<td>Cabell County EMS 846 8th Avenue Huntington, WV 25701</td>
<td>304-526-9797</td>
</tr>
<tr>
<td>William M. Favors</td>
<td>Cabell Huntington Hospital Patient Transport Service 1340 Hal Greer Blvd Huntington, WV 25701</td>
<td>304-526-2323</td>
</tr>
<tr>
<td>Randy Burgess Calhoun</td>
<td>County EMS Inc. P. O. Box 177 Grantsville, WV 26147</td>
<td>304-354-7008</td>
</tr>
<tr>
<td>Larry Stephens</td>
<td>Camden Clark Memorial Hospital Ambulance Service P.O. Box 718 Parkersburg, WV 26102</td>
<td>304-424-2373</td>
</tr>
<tr>
<td>Beth Ann Howard</td>
<td>Cameron E Squad P. O. Box 5 Cameron, WV 26033</td>
<td>304-686-3467</td>
</tr>
<tr>
<td>Karen Roksandich</td>
<td>Capon Bridge Volunteer Rescue Squad P. O. Box 265 Capon Bridge, WV 26711</td>
<td>304-856-3109</td>
</tr>
<tr>
<td>Gerald Brill</td>
<td>Capon Springs Volunteer Fire And Rescue P. O. Box 366 Capon Springs, WV 26823</td>
<td>304-874-3739</td>
</tr>
<tr>
<td>Cindy McLaughlin</td>
<td>Cass Volunteer Fire And Rescue Inc. P. O. Box 62 Cass, WV 24927</td>
<td>304-456-4118</td>
</tr>
<tr>
<td>John Smoot</td>
<td>Cedar Grove VFD P. O. Box 262 Cedar Grove, WV 25039</td>
<td>304-595-2244</td>
</tr>
<tr>
<td>Clinton Burley</td>
<td>Ceredo Volunteer Fire Department P.O. Box1119 Ceredo, WV 25507</td>
<td>304-453-4808</td>
</tr>
<tr>
<td>Gary Taylor</td>
<td>Charleston Fire Department 115 Lee Street West Charleston, WV 25302</td>
<td>304-348-8098</td>
</tr>
<tr>
<td>Paul E. Bragg</td>
<td>City of Martinsburg 200 North Railieg Street Martinsburg, WV 25401</td>
<td>304-264-2111</td>
</tr>
<tr>
<td>Kessler Cole</td>
<td>City Of Weirton Fire Department 200 Municipal Plaza Weirton, WV 26062</td>
<td>304-797-8560</td>
</tr>
</tbody>
</table>
Joe Gonzalez
Clarksburg Fire Department
465 West Main Street
Clarksburg, WV 26301
304-624-1669

Mitzie S. Adkins
Clay County Emergency Ambulance Authority
P. O. Box 624
Clay, WV 25043
304-587-2554

Michael Russell
Clearview Volunteer Fire Department, Inc
166 Clearview Ave.
Wheeling, WV 26003
304-277-1230

Dwane Weekley
Columbia St Joseph's Healthcare System
P. O. Box 327
Parkersburg, WV 26101
304-424-4670

Edward Howell Crompton
Corporation
3500 South State Route 2
Friendly, WV 26146
304-652-8000

Ken Porter
Dallas VFD
General Delivery
Dallas, WV 26036
304-347-4999

Derrick Rost
Deerwalk Volunteer Fire Department
Rt. 2 Box 96
Walker, WV 26180
304-679-3925

Darrel Swisher
Doddridge County Emergency Squad
P. O. Box 115
West Union, WV 26456
304-873-2211

Sherree Hicks
Dry Fork Rescue Squad
P. O. Box 100
War, WV 24892
304-875-2230

Fred Tillis
Duff Transport
P. O. Box 1058
Poca, WV 25159
304-755-3355

Terry Likens Jr.
Dunlow Volunteer Fire Department And Rescue
Route 1 Box 41
Dunlow, WV 25511
304-385-4631

Gary Lyons
Dupont Belle Plant EMS Squad
901 West Dupont Avenue
Belle, WV 25015
304-357-1377

Robb Murphy
Eastwood Volunteer Fire Department
P. O. Box 6
Davisville, WV 26142
304-422-4410

Arthur D. Welch
Elk District Ambulance Service
P. O. Box 183
Elk Garden, WV 26717
304-446-5752
William Swoyer  
Emergency Medical Transport  
2511 Waynesburg Drive S.E.  
Canton, OH 44707  
330-484-4000

Rick Stam  
Fairmont Fire Department  
P. O. Box 1428  
Fairmont, WV 26554  
304-363-7620

Brenda A. Swiger  
Fairview Volunteer Fire Company  
P. O. Box 120  
Fairview, WV 26570  
304-449-1904

Kelly G. Marshall  
Flemington Area EMS  
P. O. Box 161  
Flemington, WV 26347  
304-739-4700

Judy Faye McLaughlin  
Fork Ridge Community Volunteer Fire Department  
Route 1 Box 203A  
Glen Easton, WV 26039  
304-845-1412

Jennifer Logsdon  
Fort Ashby Volunteer Fire Company Inc.  
P.O. Box1110  
Fort Ashby, WV 26719  
304-298-3615

Bart Salmons  
Fort Gay Volunteer Fire Department Inc.  
P.O. Box 97  
Fort Gay, WV 25514  
304-648-5325

Jeff Myers  
Fountain Volunteer Fire Company  
P. O. Box 56  
Keyser, WV 26726  
304-788-4071

Pattie M. Fraley  
Fraley Ambulance Service  
P. O. Box 89  
Moorefield, WV 26836  
304-538-2549

Michael Kidwiler  
Friendship Fire Company  
P. O. Box 126  
Harpers Ferry, WV 25425  
304-535-2211

S. Edward Ball  
G. E. Plastics  
P. O. Box 68  
Washington, WV 26181  
304-863-7284

Cart George  
G. E. Specialty Chemicals Inc.  
1000 Morgantown Industrial Park  
Morgantown, WV 26501  
304-296-2564

David Goff  
General Ambulance Inc.  
P. O. Box 1131  
Oak Hill, WV 25901  
304-465-8700

Chris Ziegler  
Ghent Area Volunteer Fire Department  
P. O. Box 99  
Ghent, WV 25843  
304-787-3196
Edward J. Messenger  
Gilmer County Ambulance Service  
P. O. Box 358  
Glenville, WV 26351  
304-462-5695

Norman Pastorius  
Glen Dale Volunteer Fire Department  
P. O. Box 25  
Glen Dale, WV 26038  
304-845-8800

Sonnee Carter  
Grant County Ambulance  
P. O. Box 1019  
Petersburg, WV 26847  
304-257-1026

Robert Riggs Jr. Grant  
Town VFD  
P. O. Box 28  
Grant Town, WV 26574  
304-278-7777

Tom Scott  
Green Sulphur District Volunteer Rescue Squad  
P.O. Box 12  
Sandstone, WV 25985  
304-466-2610

Christopher Teubert  
Greenbrier County Emergency Ambulance  
P. O. Box 5778  
Fairlea, WV 24902  
304-645-2252

Richard Rock  
Harrison County Emergency Squad  
1000 North 12th Street  
Clarksburg, WV 26301  
304-623-6611

Patti Heilman R.N.  
HealthNet I  
P. O. Box 8221  
Morgantown, WV 26506  
304-598-4173

Rebecca Oakley  
HealthNet II  
P. O. Box 1393  
Charleston, WV 25325  
304-388-6002

William Favors HealthNet III  
1340 Hal Greer Boulevard  
Huntington, WV 25701  
304-526-2332

Rebecca Oakley  
HealthNet IV  
400 Eagle Mountain Road Suite 201  
Charleston, WV 25311  
304-342-7348

Rosia Vanover  
laeger Ambulance Service  
Box 584  
laeger, WV 24844  
304-938-5677

Ray Braithwaite  
Independent Fire Company  
P. O. Box 925  
Charles Town, WV 25414  
304-725-2514

Harold Gibson  
Jackson County Emergency Medical Service  
P. O. Box 800  
Ripley, WV 25271  
304-372-2011
Paul Seamann
Jan Care Ambulance Service Inc.
P. O. Box 2414
Beckley, WV 25801
304-255-0277

Edwin Smith
Jefferson County Ambulance Authority
208 South Mildred Street
Ranson, WV 25438
304-728-3287

W. Mark Fox
Jumping Branch-Nimitz VFD
P. O. Box 15
Jumping Branch, WV 25969
304-466-5533

John David Kees
K & B Behavioral Health Services
1006 East Main Street
Oak Hill, WV 25901
304-469-2291

Allen Hillery
KAMP Central Ambulance Service Inc.
133 Wellsley Street
Kingwood, WV 26537
304-329-1614

Joe Lynch
Kanawha County Ambulance Authority
P. O. Box 292
Charleston, WV 25321
304-345-2312

Cecil L. Henderson
Kenova Volunteer Fire Department Inc.
P. O. Box 186
Kenova, WV 25530
304-453-4153

Jason L. Umstot
Keyser Emergency Medical Service Inc.
P. O. Box 903
Keyser, WV 26726
304-788-5314

James R. Lambert
Lambert's Ambulance Service
P. O. Box 1022
Romney, WV 26757
304-822-7124

Richard Meadows
Lavalette Volunteer Fire Department
P. O. Box 540
Lavalette, WV 26535
304-525-7156

John Carroll
Lewis County Emergency Ambulance Service Authority
P. O. Box 228
Weston, WV 26452
304-269-8207

Joyce Jones
Lifeline Medical Transport
P. O. Box 1337
Huntington, WV 25715
304-523-4525

Kelly Betteridge
Lifeteam EMS Inc.
P. O. Box 362
East Liverpool, OH 43920
330-386-9284

Harry Galloway
Limestone Regional Emergency Service Inc. Rd
1 Box 217 A
Moundsville, WV 26041
304-845-4800
Trish Watson
Lincoln Emergency Medical Services
P. O. Box 495
Hamlin, WV 25523
304-824-7871

Roger Bryant
Logan Emergency Ambulance Service Authority
261/2 Main Avenue
Logan, WV 25601
304-752-0917

Lloyd R. White
Marion County Rescue Squad Inc.
400 Virginia Avenue
Fairmont, WV 26554
304-363-6246

Patrick R. Mull
Marshall County Sheriffs Ofc.
601 6th Street
Moundsville, WV 26041
304-843-1500

Daniel Luzier
Masontown Fire Rescue
Box 58
Masontown, WV 26542
304-864-2828

Tim R. McPeak
McDowell County Emergency Ambulance Authority
P. O. Box AG
Welch, WV 24801
304-436-3875

Connie Drum
Med-Assist
P. O. Box 253
Woodsfield, OH 43754
740-472-2177

Don McNeel
Little Levels Emergency Ambulance Patrol, Inc
P. O. Box 187
Hillsboro, WV 24946
304-653-4636

Joel Merrit
Lubeck Volunteer Fire Department
1346 Harris Hwy.
Parkersburg, WV 26101
304-863-8722

Richard Bartow
Marlinton Volunteer Fire Department Rescue Squad
709 Second Avenue
Marlinton, WV 24954
304-799-4211

Charles Blake
Mason County Emergency Ambulance Service Authority
P. O. Box 34
Point Pleasant, WV 25550
304-875-6134

Richard Hamilton
Mathias Baker Volunteer Emergency Squad
P. O. Box 89
Mathias, WV 26812
304-897-5000

John Eiklebeny
McMechen Volunteer Fire Department
811 Marshall Street
McMechen, WV 26040
304-232-4650

Jay Parsons
Mineral Wells VFD
P. O. Box 98
Mineral Wells, WV 26150
304-489-2340
<table>
<thead>
<tr>
<th>Name</th>
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<td>Barbara W. Lay</td>
<td>Minnie Hamilton Health Care Center RT</td>
<td>304-354-9244</td>
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<tr>
<td>1 Box 1 A</td>
<td>Grantsville, WV 26147</td>
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<tr>
<td>Mathew L. Abbott</td>
<td>Monongah Volunteer Fire Department</td>
<td>304-534-5172</td>
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<td>P. O. Box 9089</td>
<td>Monongah, WV 26555</td>
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<tr>
<td>John Corson</td>
<td>Morgan County Rescue</td>
<td>304-258-4594</td>
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<td>P. O. Box 151</td>
<td>Berkeley Springs, WV 25411</td>
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<td>Ellison A. Ponzurick</td>
<td>Monongalia Emergency Medical Services Inc.</td>
<td>304-285-2715</td>
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<td>801 J.D. Anderson Drive</td>
<td>Morgantown, WV 26505</td>
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<tr>
<td>Noel E. Clarke</td>
<td>Moundsville Fire Department</td>
<td>304-845-2050</td>
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<td>D. Rolland Jennings</td>
<td>Mountaineer Ambulance Service Inc.</td>
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<td>Duane A. Bartsch</td>
<td>Mozart Volunteer Fire Department</td>
<td>304-232-2016</td>
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<td>25 South Frazier Street</td>
<td>Wheeling, WV 26003</td>
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<td>Billy Cook Jr.</td>
<td>Mullens Fire Department</td>
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<td>P. O. Box 36</td>
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<td>Lindsay Bryan</td>
<td>New Creek Volunteer Fire Department</td>
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<td>Joseph E. Polgar</td>
<td>New Cumberland Ambulance Service Inc.</td>
<td>304-564-3979</td>
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<td>Richard A. Jones Jr.</td>
<td>New Manchester Volunteer Fire Department</td>
<td>304-564-4497</td>
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<td>P. O. Box Drawer C</td>
<td>New Manchester, WV 26056</td>
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<tr>
<td>Jay Haught</td>
<td>New Martinsville Fire Department</td>
<td>304-455-9115</td>
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<td>P. O. Box 486</td>
<td>New Martinsville, WV 26155</td>
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<td>Scott Wilson</td>
<td>Newell Volunteer Fire Department</td>
<td>304-387-0795</td>
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<td>P. O. Box 28</td>
<td>Newell, WV 26050</td>
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<td>Kim Kelly</td>
<td>Northern Greenbrier Ambulance Service Inc.</td>
<td>304-497-4334</td>
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<td>P. O. Box 74</td>
<td>Renick, WV 24966</td>
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</table>
H. Allen Sisson
NSGA Fire Dept.
N7 NSGA Fire Dept.
Sugar Grove, WV 26815
304-249-6390

Rickey E. Hicks Jr.
Oceana Volunteer Fire Department Rapid Response
P. O. Box 848
Oceana, WV 24870
304-682-5741

John Knapp
Parkersburg Fire Department
One Government Square
Parkersburg, WV 26101
304-424-8470

Justin E. Ratcliff
Patterson Creek Volunteer Fire Co. Inc.
Route 3 Box 305
Patterson Creek, WV 26753
304-738-2253

Joseph W. Smith
Paw Paw Volunteer Fire Co. Inc.
P. O. Box 15
Paw Paw, WV 25434
304-947-7644

A. John Brosseau
Peacemaker Medical Response
40 Canal Street
Lancaster, NH 03584
617-590-7943

George Armstrong
Pechiney Rolled Products
P. O. Box 68
Ravenswood, WV 26164
304-273-6230

Diana Mitchell
Pendleton County Emergency Rescue Inc.
P. O. Box 727
Franklin, WV 26807
304-358-7869

Keith Boggess
Peterstown Fire and Rescue, Inc.
P. O. Box 128
Peterstown, WV 24963
304-753-4343

Harvey H. Hatfield
Pleasants County Emergency Ambulance Authority
P. O. Box 327
St Marys, WV 26170
304-684-3811

Patricia J. Moreland
PNGI Charles Town Gaming
P. O. Box 551
Charles Town, WV 25414
304-724-4231

Anthony Rawson
Pond Creek VFD
Rt 1 Box 297
Belleville, WV 26133
304-663-5280

Sherri Fannin
Portsmouth Ambulance Service
P. O. Box 849
Portsmouth, OH 45662
740-353-7553

Theresa Davies
PPG Industries
P. O. Box 191
New Martinsville, WV 26155
304-455-2200
Amy Boone  
Prichard Volunteer Fire Department  
P. O. Box 7  
Prichard, WV 25555  
304-486-5051

Don Meadows  
Princeton Rescue Squad  
208 N. First St.  
Princeton, WV 24740  
304-425-3914

Cecil T. Kimble  
Putnam County EMS  
3389 Winfield Road  
Winfield, WV 25213  
304-586-0246

Thomas Davis  
Quinwood Emergency Ambulance Inc.  
P. O. Box 253  
Quinwood, WV 25981  
304-438-9252

Ray Chaney  
Randolph County Emergency Squad  
4 Randolph Avenue  
Elkins, WV 26241  
304-636-6593

David Cox  
Redi Care Inc.  
PO Box 1800  
Craigsville, WV 26205  
304-742-5136

Paula Detrick  
Ridgeley Volunteer Fire Department  
P. O. Box 619  
Ridgeley, WV 26753  
304-738-8888

Floyd A. Jenkins  
Ritchie County Emergency Services Inc.  
P. O. Box 322  
Harristown, WV 25362  
304-659-2120

Kathryn Ellis  
Roane County Emergency Squad  
P. O. Box 975  
Spencer, WV 25276  
304-927-3725

Carla Lease  
Romney Volunteer Rescue Squad, Inc.  
P. O. Box 543  
Romney, WV 26757  
304-822-4019

Swanee R. Masters  
Rowlesburg Volunteer Ambulance Service  
P. O. Box 428  
Rowlesburg, WV 26425  
304-454-2080

Mary J. Helmick Ryneal  
Fire Company #1  
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
Ray Crewey  
Summers County EMS Inc.  
P. O. Box 91  
Pipestem, WV 25979  
304-466-0312

Andrew Lett  
Sunoco Chemical - Neal Plant  
200 Big Sandy Road  
Kenova, WV 26530  
304-453-1371

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

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

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

Robert Kirk  
Terra Alta Volunteer Fire Dept. Inc.  
1120 East State Street  
Terra Alta, WV 26764  
800-834-3131

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

John R. Diddle Sr.  
Tri County Ambulance Service  
P. O. Box 975  
East Liverpool, OH 43920  
330-385-4903

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

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

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

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

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

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  
P. O. Box 78  
Union, WV 24983  
304-772-3383

Darren Stapleton  
Upper Laurel Ambulance Service  
P. O. Box 514  
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. O. Box 138  
Van, WV 25206 304-245-8436

Ivan Strawderman  
Wardensville 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  
304-881-0145

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

Keith Richmond  
Wayne Volunteer Fire Department P. O. Box 446  
Wayne, WV 25570 304-272-5656
<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Address</th>
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<tr>
<td>Michael L. Hart</td>
<td>Webster County Memorial Hospital</td>
<td>P.O. Box 312, Webster Springs, WV 26288</td>
<td>304-847-5682</td>
</tr>
<tr>
<td>A.G. Lucas</td>
<td>Weirton Area Ambulance And Rescue</td>
<td>1305 Pennsylvania Avenue, Weirton, WV 26082</td>
<td>304-797-1233</td>
</tr>
<tr>
<td>Michael De Hamer</td>
<td>Weirton Steel Fire Department</td>
<td>400 Three Springs Drive, Weirton, WV 26082</td>
<td>304-797-4320</td>
</tr>
<tr>
<td>Albert W. Bond</td>
<td>West Liberty Volunteer Fire Department</td>
<td>P. O. Box 49, West Liberty, WV 26074</td>
<td>304-336-7500</td>
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<tr>
<td>Carla Morris</td>
<td>Wetzel County Ambulance Authority</td>
<td>P. O. Box 515, New Martinsville, WV 26155</td>
<td>304-455-5931</td>
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<tr>
<td>Stephen Johnston</td>
<td>Wheeling Fire Department</td>
<td>2126 Market Street, Wheeling, WV 26003</td>
<td>304-234-3776</td>
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<tr>
<td>Dan Hancock</td>
<td>Wheeling Island Gaming, Inc.</td>
<td>1 South Stone St., Wheeling, WV 26003</td>
<td>304-232-5050</td>
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<tr>
<td>H. Lee Bragg</td>
<td>White Sulphur Springs Emergency Medical Service</td>
<td>P. O. Box 129, White Sulphur Springs, WV 24986</td>
<td>304-536-4122</td>
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<tr>
<td>Jim Hodges</td>
<td>Whitesville Ambulance Service</td>
<td>P. O. Box 145, Whitesville, WV 25209</td>
<td>304-854-1195</td>
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<tr>
<td>James E. Widener Jr.</td>
<td>Widener's Ambulance Service Inc.</td>
<td>P. O. Box 728, Northfork, WV 24868</td>
<td>304-862-2506</td>
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<tr>
<td>Shirley Winfrey</td>
<td>Williamsburg Volunteer Fire And Rescue Squad</td>
<td>P.O. Box 160, Williamsburg, WV 24991</td>
<td>304-647-1318</td>
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<tr>
<td>James Joseph Rut</td>
<td>Williamstown Volunteer Fire Company 411</td>
<td>West Fifth Street, Williamstown, WV 26187</td>
<td>304-375-3960</td>
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<tr>
<td>Ronnie Somerville</td>
<td>Wirt County Emergency Squad</td>
<td>P. O. Box 448, Elizabeth, WV 26143</td>
<td>304-275-4219</td>
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<tr>
<td>Terry Brown</td>
<td>Wood County Emergency Services</td>
<td>911 Core Road, Parkersburg, WV 26101</td>
<td>304-485-7811</td>
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## EXHIBIT 3
**WV BOARD OF RISK AND INSURANCE MANAGEMENT**
**LITIGATION OUTCOME* BY CALENDAR YEAR**

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

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<th>Year</th>
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<td>$3.2M, $1.3M</td>
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<td>1995</td>
<td>$1.3M, $2.7M</td>
<td>(2)</td>
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<td>1996</td>
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<td>(1)</td>
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<tr>
<td>1997</td>
<td>$3.7M</td>
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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

<table>
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<th>Year</th>
<th>Number of Dismissals*</th>
<th>% of Total</th>
<th>Judgments</th>
<th>% of Total</th>
<th>Settlements</th>
<th>% of Total</th>
<th>All</th>
<th>Total</th>
</tr>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Non Zero</td>
<td>Total</td>
<td>Non Zero</td>
<td>Total</td>
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<td>8</td>
<td>18</td>
<td>6%</td>
<td>186</td>
<td>187</td>
<td>66%</td>
</tr>
<tr>
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<td>10</td>
<td>36</td>
<td>11%</td>
<td>208</td>
<td>210</td>
<td>66%</td>
</tr>
<tr>
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<td>103</td>
<td>31%</td>
<td>14</td>
<td>38</td>
<td>11%</td>
<td>190</td>
<td>190</td>
<td>57%</td>
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<tr>
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<td>27%</td>
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<td>20</td>
<td>7%</td>
<td>194</td>
<td>197</td>
<td>66%</td>
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<tr>
<td>1997</td>
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<td>9</td>
<td>28</td>
<td>6%</td>
<td>289</td>
<td>291</td>
<td>67%</td>
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<tr>
<td>1998</td>
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<td>9</td>
<td>27</td>
<td>11%</td>
<td>156</td>
<td>156</td>
<td>66%</td>
</tr>
<tr>
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<td>99</td>
<td>30%</td>
<td>15</td>
<td>28</td>
<td>8%</td>
<td>207</td>
<td>208</td>
<td>62%</td>
</tr>
<tr>
<td>2000</td>
<td>104</td>
<td>30%</td>
<td>7</td>
<td>37</td>
<td>11%</td>
<td>204</td>
<td>205</td>
<td>59%</td>
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<tr>
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<td>9</td>
<td>37</td>
<td>10%</td>
<td>226</td>
<td>230</td>
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<tr>
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<td>7</td>
<td>25</td>
<td>8%</td>
<td>165</td>
<td>166</td>
<td>53%</td>
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<tr>
<td>Total</td>
<td>941</td>
<td>29%</td>
<td>93</td>
<td>294</td>
<td>9%</td>
<td>2,025</td>
<td>2,040</td>
<td>62%</td>
</tr>
</tbody>
</table>

Average 94 9 29 203 204 328

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

11/20/2003
## West Virginia Board of Medicine
### Size of Judgment Loss Distributions

#### Exhibit 5

<table>
<thead>
<tr>
<th></th>
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<td><strong>Total</strong></td>
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<td>$5,285,547</td>
<td>36</td>
<td>$3,946,419</td>
<td>38</td>
<td>$6,022,369</td>
<td>20</td>
<td>$3,085,837</td>
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<td>$6,636,729</td>
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<td>$5,285,547</td>
<td>10</td>
<td>$3,946,419</td>
<td>14</td>
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<td>$3,085,837</td>
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<td>$6,636,729</td>
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</table>

<table>
<thead>
<tr>
<th></th>
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<tbody>
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<td>37</td>
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<td>$4,791,290</td>
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<td>$8,093,223</td>
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11/20/2003
## West Virginia Board of Medicine

### Size of Paid Settlement Loss Distribution

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<td>$44,418,941</td>
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<table>
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<th>2000</th>
<th>2001</th>
<th>2002</th>
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<td>$33,781,267</td>
<td>203</td>
<td>$44,198,384</td>
<td>199</td>
</tr>
</tbody>
</table>

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