

The scope, purpose, and reasoning behind Senate Bill 602

The 2016 Regular Session of the West Virginia Legislature focused almost entirely on a budget crisis which had been looming since the collapse of the coal industry and the coal severance tax on which the budget relied. Victims of the projected budget shortfall occupied media attention throughout the session. Among many programs on the chopping block was the Patient Injury Compensation Fund (“PICF”) – a fund created in 2004 to provide an alternative source of recovery for medical malpractice plaintiffs who were unable to recover full economic damage awards due to caps imposed by the Medical Professional Liability Act (“MPLA”). As a result of the budgetary crisis, the legislative leadership and the administration made it clear that the unfunded PICF fund was going to be eliminated during the 2016 legislative session. However, the Legislature and administration sought to provide an alternative to the PICF in order to maintain the viability of the tort reform contained in the MPLA. Senate Bill 602 reflects a compromise measure which provides temporary alternative funding of unsatisfied PICF claims, closes the PICF to future claims, and affects emergency medicine practitioners’ exposure to certain types of damages in order to maintain the viability of the trauma cap.

A brief history of medical malpractice tort reform in West Virginia

In the early-2000s West Virginia experienced a health care crisis due to the rapid exodus of medical malpractice insurance companies and physicians from the State. Those physicians who remained faced increasing premiums, particularly for practitioners in certain high risk specialties. The dire climate was largely driven by high jury verdicts in medical malpractice cases. The Legislature addressed the crisis with the 2003 amendments to the MPLA.

The central tort reform feature of the 2003 amendments is a series of “caps” on damages in medical malpractice cases. Specifically, the 2003 amendments imposed a cap on the recoverable non-economic damages (such as pain, suffering, and loss of enjoyment of life) of \$500,000 in cases involving wrongful death, permanent and substantial physical deformity, loss of use of a limb or a bodily organ system, or permanent physical or mental injury which permanently prevents the patient from independently caring for himself or herself. In other cases, the cap is \$250,000.¹ In non-trauma cases, the MPLA did not cap recovery for economic damages such as medical bills, lost wages, future lost earning capacity, funeral bills, and the like.

In cases involving patients who present to a WV OEMS designated trauma center with an emergency

condition,² the 2003 MPLA capped all damages at \$500,000 with no inflation adjustment.³ As a compromise for the limits on recovery and to protect against challenges by attorneys that the limit was unconstitutional, the Legislature authorized creation of the PICF to pay claims of up to \$1,000,000 to patients who were unable to recover the full amount of economic damages awarded by jury verdicts due to the caps. The first three fiscal years of the PICF (2005, 2006, and 2007) were to be capitalized with annual appropriations of \$2.2 million from the Tobacco Settlement Medical Trust Fund; however, the actual Legislative appropriations into the PICF over those three years totaled only \$4,914,000 (which was \$1,686,000 short of the statutory obligation). In addition, the PICF had no dedicated, continuous stream of funding beyond 2007. By 2015, the fund did not have enough money to pay most of the existing claims. With the 2016 budget crisis on the horizon, the PICF could not remain solvent. Plaintiff personal injury lawyers advocated for repealing the trauma cap and treating trauma cases in the same manner as other medical malpractice claims, which would have resulted in much greater exposure to health care providers treating emergency conditions. Further, without an alternative source of recovery such as the PICF, the trauma cap and the

elimination of joint liability would be ripe for a constitutional challenge.

The effect of SB602 on the MPLA

As a result of SB 602, the PICF will be closed to any additional claims. In lieu of the ability to recover from the PICF, plaintiffs will now be able to recover up to \$1,000,000 in economic damages from the defendant health care provider.

Even though SB 602 creates an additional exposure⁴ to health care providers of up to \$1,000,000, it still provides a greater limitation on potential verdicts in trauma cases than the non-trauma caps initially adopted in 2003. While the non-trauma caps apply only to non-economic damages, the new higher trauma cap under SB 602 still applies to both economic *and* non-economic damages.

For example, consider a non-trauma case where a 22 year old plaintiff suffers a brain injury

as a result of an elective surgery and incurs \$3,000,000 in lost future income and future medical expenses. In such a case, the maximum damages recoverable by that plaintiff from a physician under the non-trauma caps would be \$3,652,815.22 (the inflation adjusted non-economic damages cap plus 100% of economic damages). However, if the same plaintiff suffered the same injury as a result of surgery necessitated by an emergency condition, the trauma cap under SB 602 limits the maximum damages recoverable to \$1,506,790.65 (the inflation adjusted trauma cap plus an additional \$1,000,000 in economic damages), which is over \$2 million less than the non-trauma cap.⁵

The trauma cap is also still preferable in most cases without significant economic damages: For example, if a 66 year old retiree dies as a result of a physician's

negligence but incurred \$42,000 in medical bills and \$10,000 in funeral bills, the maximum allowable potential verdict under the non-trauma cap would be \$704,815.22 (the inflation-adjusted non-economic damages cap plus 100% of economic damages). However, under the trauma cap, the maximum allowable potential verdict would be \$506,790.65 (the inflation-adjusted trauma cap), which is over \$200,000 less than is allowable under the non-trauma cap.

Furthermore, it is also important to note that the maintaining of the same economic and non-economic cap amounts by the Legislature was designed to prevent future constitutional challenges in catastrophic injury or death cases. Personal injury attorneys have successfully challenged caps in other states by arguing such caps deprive plaintiffs of the right to trial by jury, constitute an



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invasion by the legislative branch into the judicial branch, or violate constitutional equal protection guarantees by unfairly punishing patients with significant injuries but lower economic damages.⁶ The Legislature's reasoning for creating an alternative funding source for trauma patients in exchange for an inflation adjustable cap of \$500,000 on both economic *and* non-economic damages was to avoid just such constitutional challenges. When the PICF collapsed, the Legislature, by passing SB 602, retained the potential for plaintiffs to recover additional economic losses in excess of the \$500,000 economic and non-economic trauma cap in order to try to avoid creating grounds for a constitutional challenge to the trauma cap.

The temporary funding of legacy claims of the Patient Injury Compensation Fund

Under SB 602, responsibility for PICF legacy claims – i.e. claims made before July 1, 2016 – will be shared by plaintiffs, healthcare providers, and health insurers. In order to fund these outstanding liabilities, SB 602 imposes a series of assessments on patients, plaintiffs, and health care providers alike:

1. Medical malpractice case filing fees have been increased to \$400 of which \$285 is deposited to the PICF;
2. Trauma centers are charged a \$25 assessment per trauma patient as reported to the WV Trauma Registry through June 30, 2020;
3. Physicians are charged a biennial fee of \$125 by their licensing boards with some limited exceptions (through the 2019 renewal period);
4. A 1% assessment is imposed on settlements and verdicts in medical malpractice cases –

payable by the plaintiff if the case is settled pre-suit or by the defendant if the case is settled after suit or a jury verdict for the plaintiff is returned through June 30, 2020;

SB 602 provides that the assessments on trauma centers, physicians, and settlements/verdicts shall terminate earlier than the dates noted above in the event all legacy PICF liabilities are fully funded.

Preserving the elimination of joint and several liability

SB 602 also preserved the elimination of joint and several liability in all malpractice cases by removing the PICF contingency.

The status of tort reform in West Virginia following Senate Bill 602

The PICF was closed because it was severely underfunded and there were no viable sources of permanent funding. The MPLA's elimination of joint liability in medical malpractice cases as well as the trauma cap provision itself were contingent upon the viability of the PICF as an additional source of recovery. In recent years, personal injury attorneys have filed motions arguing that courts should not enforce the trauma cap and/or enforce joint liability because the PICF was underfunded. If the Legislature had not taken action to (1) temporarily fund legacy PICF liabilities and (2) provide an alternative to the PICF in the future, a real probability existed that the MPLA's trauma cap and elimination of joint and several liability would have been struck down by the Courts.

The brunt of SB 602 will plainly be felt by emergency health care providers who find themselves faced with a malpractice suit. But when weighing the higher potential verdict exposure under SB 602 versus an unfunded PICF and the real threat

that the Supreme Court of Appeals of West Virginia would not apply the trauma cap or the MPLA's several liability provision, it is clear that the trauma cap *still* provides greater protection from high verdicts than the other non-economic caps.

While the 2016 budget crisis has impacted the MPLA and the PICF, SB 602 represents a reasonable solution among undesirable alternatives and demonstrates the Legislature's ongoing commitment to providing tort reform under the MPLA.

References

1. The caps are adjusted annually based on the consumer price index. As of 2016, the caps are \$652,815.22 and \$326,407.61.
2. Under the MPLA, "emergency condition" means any acute traumatic injury or acute medical condition which, according to standardized criteria for triage, involves a significant risk of death or the precipitation of significant complications or disabilities, impairment of bodily functions, or, with respect to a pregnant woman, a significant risk to the health of the unborn child. Under current OEMS Triage Procedures, these patients are those assigned triage Category III.
3. The 2015 amendments to the MPLA instituted an annual inflation adjustment to the \$500,000 trauma cap up to a maximum of \$750,000. In 2016, the inflation-adjusted trauma cap is \$506,790.65.
4. In practical terms, any exposure to a verdict beyond the limits of the health care provider's malpractice policy is borne by the insurer under West Virginia law so long as the plaintiff makes a demand to settle within policy limits prior to trial. See *Shamblin v. Nationwide Mut. Ins. Co.*, 183 W.Va. 585, 396 S.E.2d 766 (1990).
5. Although, cases could exist where the trauma cap would permit a greater recovery than the non-trauma caps – but this is limited to those cases with little to no economic damages which would ordinarily be subject to the \$250,000 cap. In such a case, a plaintiff with no economic damages in a typical medical malpractice case is limited to \$326,407.61 in recovery (the \$250,000 cap plus inflation). In a trauma case, the cap is \$506,790.65 (the \$500,000 cap plus inflation). However, this result would occur with or without SB 602.
6. See *Estate of McCall v. U.S.*, 134 So. 3d 894 (Fla. 2014) (striking \$1 mil. limit on medical malpractice noneconomic damages in death actions); *Watts v. Lester E. Cox Med. Ctrs.*, 376 S.W.3d 633 (Mo. 2012) (striking \$350,000 medical malpractice non-economic damages cap); *LeBron v. Gottlieb Mem. Hosp.*, 930 N.E.2d 895 (Ill. 2010) (striking \$1 mil./\$500,000 non-economic damages caps applicable to hospitals and/or physicians); *Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt*, 691 S.E.2d 218 (Ga. 2010) (striking \$350,000 medical malpractice non-economic damages cap).