

THE STORY OF TORT REFORM IN *West Virginia*



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West Virginia recently survived a historic medical malpractice insurance crisis, and the state appears to have emerged from this trying period with significant tort reform legislation. This law and the process by which we crafted it potentially could serve as a template for other states facing similar situations.

West Virginia is a rural state with a population of 1.8 million, and no single city has more than 100,000 inhabitants. Most areas of the state have a thin layer of health care resources, largely due to West Virginia's rural nature. There are currently two Level I state-designated trauma centers and one Level II center. The state suffers from chronic unemployment and, as a result, many patients have either government-funded health care coverage or no insurance at all. Medicaid pays for 50 percent of all births. The state population recently became the "oldest" in the nation, leading to a large Medicare population, as well. Unfortunately, the people of West Virginia are the most obese, use smokeless tobacco with the greatest frequency, and have the highest rate of per capita pediatric and geriatric all-terrain vehicle mortality. The combined strain of all these factors nearly precipitated the collapse of West Virginia's fragile health care system.

MALPRACTICE CRISIS EPICENTER

The northern panhandle of West Virginia, located between the adjoining states of Ohio and Pennsylvania, found itself in a less than enviable position as the epicenter for medical malpractice lawsuits. A circuit court favorable to the plaintiff, and backed up by even more favorable state supreme courts, provided fertile ground for the plaintiffs' attorneys. Additionally, there was an influx of suits from out-of-state attorneys seeking the same hospitable climate. Spurred by the publicity of seven-figure settlements, the juries began to award ever-increasing sums, trying to outdo newspaper reports of previous trials.

In the meantime, reimbursement steadily fell as HMOs and indemnity insurance plans began paying at rates lower than Medicare's, ignoring an already flawed payment system. The northern panhandle physicians, already earning less than their counterparts in the rest of the state, also began to bear higher malpractice premiums than their colleagues.

The three neurosurgeons in the region steadily retreated from practice under the relentless assault of highly skilled plaintiffs' attorneys. The first neurosurgeon left, taking early retirement; the second fled due to a lack of insurance availability; and the

third finally moved to another state to find affordable liability insurance and a more friendly climate.

FIGHTING BACK

At this point, physicians began fighting back. The circuit court judge, who was much sought after by the plaintiffs' attorneys, came up for reelection. A record marred by questions regarding his personal life, his behavior in the courtroom, and an obvious vendetta for physicians was enough to convince the local press to join efforts with the medical community. Many physicians actually changed their voter's registration in order to cast a ballot in the primary. The incumbent was unseated in the primary. This nearly unprecedented event sent ripples throughout the rest of the state.

Nonetheless, liability insurance premiums continued to soar. Small business, homeowners, and auto insurance policies followed suit. The public slowly began to take notice.

The PHICO insurance company in Pennsylvania in the summer of 2001 suffered a barrage of eight- and nine-figure loss verdicts in Philadelphia and was taken into receivership by the state of Pennsylvania. Many physicians insured in West Virginia were affected. The largest group of reconstructive plastic surgeons in the state closed their doors for a week until they could locate a stable company to replace PHICO.

The pressure of declining reimbursement and the mounting overhead for insurance continued to erode the already thin supply of physicians in the rest of the state.

Physicians began exerting greater pressure on state legislators to intervene in the mounting crisis in obtaining affordable and available medical liability insurance as carriers began to abandon the state. Notices of intent to "not reinsure" were mailed to high-risk specialists. The migration of specialists out of the state increased and recruitment became impossible.

In the winter session of the 2002 state legislature, the state moved to correct the availability problem by expanding the state risk insurance pool to include physicians who otherwise could not obtain insurance. The affordability problem, however, remained uncorrected as premiums were set 10 percent above commercial rates.

As the year progressed, the reduction in availability of specialty care and the threat of liability

exposure combined to increase the transfer of patients to the university centers. In the already overburdened Level I trauma center in the state capital of Charleston, the orthopaedic surgeons finally rebelled, faced with an avalanche of patients being transferred to their institution around the clock from outlying communities that found themselves without orthopaedic coverage or the courage to assume the risk of liability. The surgeons announced the decision to stop taking trauma call. Immediately thereafter, the hospital was downgraded to a Level III trauma center. The public perception based on the media coverage was that the hospital was essentially closed for all critical patients. The state capital was in an uproar as the legislature was about to convene for the 2003 session.

GOVERNMENT RESPONDS

The governor took immediate action. He and his team put together a financial plan to divert state money through the hospital to directly offset insurance premiums for the orthopaedic surgeons. The trauma center went back to work, and in the rest of the state, physicians erupted in criticism.

The northern panhandle physicians marched back into political combat. State senators and representatives, impressed by the circuit court judge election and the influence of physicians on their constituents, began to listen. Town meetings, editorials, articles, and television interviews, steeped in both data and emotion, were pervasive and persuasive. Around-the-clock contact with politicians began as the 2003 session neared.

Frustrated by the special financial "deal" enjoyed by the orthopaedists in Charleston and sensing a lack of political commitment to even the playing field and provide affordable insurance for all of the state's physicians, a large group of northern panhandle surgical specialists stopped all their elective cases. Hospitals in the area, which were already struggling under inadequate reimbursement, began to suffer mounting losses in income. The hospital association's involvement in the lobbying effort intensified dramatically.

Simultaneously, a governor's action committee was appointed to develop recommendations to stabilize trauma and emergency care in the state and build a system for the state's future. This team's emphasis on quality patient care did not go unrec-

ognized and provided balance to the criticism of the physician walkout.

The stage was set for the 2003 legislature to convene in Charleston while national and international news teams were interviewing physicians in the northern panhandle.

The governor introduced a significant tort reform bill, as did the House of Representatives and, subsequently, the Senate. The Chair of the Senate Judiciary Committee, coincidentally, was from the northern panhandle.

MAJOR PROVISIONS

Some people consider what emerged in West Virginia to be the most significant tort reform legislation in the last decade in the U.S. Embedded in the bill is a significant protection piece for trauma and emergency cases treated in state-designated trauma centers of all levels, providing a powerful incentive for hospitals to be part of an inclusive statewide trauma system.

Critical portions of the tort reform bill include a \$250,000 cap on noneconomic damages and a \$500,000 cap on all damages for treatment of emergency conditions for patients who receive care at a designated trauma center. Joint liability has been eliminated, and each individual defendant bears liability equal to his or her percentage of fault. Collateral payments, which had not been allowed in court before, may now be presented. The “ostensible agency theory” of liability was abolished. Additionally, a committee was established to develop a patient injury compensation fund to provide for economic damages that exceed financial limits set in the bill.

The new law also requires that an expert witness maintain a current license to practice medicine and be engaged in the medical specialty in which he is testifying. The expert witness must also devote 60 percent of his annual professional time to active clinical or teaching practice in the particular specialty.

Important from the perspective of the state government was the creation of a physician mutual insurance company. The state is underwriting the start-up cost. The state is also providing a small tax credit to help offset physician insurance premiums over the next two years. Additional protection of real and personal property in the event of a bankruptcy settlement for physicians was added

to allow the physician to exempt up to \$250,000 per household in real or personal property. Importantly, the state medical board was empowered to more vigorously investigate physicians.

CLOSING THOUGHTS

What lessons did we learn over the past three years?

1. It is obvious that physicians can no longer be bystanders in local, state, or national politics where such governments affect their lives and the well-being of their families and patients. They need to become closely acquainted with their political representatives as well as newspaper publishers and reporters for print and televised media.

2. Very often the image of the physician as the high-tech miracle worker (who never fails) contributes to patients’ unrealistic expectations. Docudramas in print and on television only contribute to this perception, as they seldom portray less than dramatic or successful outcomes.

3. The general public tends to view physicians as “personally unaffected” by insurance losses and the assault by plaintiffs’ attorneys in the courtroom.

4. The public operates under the misconception that jury awards do not affect health care insurance availability and affordability or, for that matter, physician availability.

A physician needs to be a real human being and a friend in the eyes and hearts of their patients. It is only through a true alliance of the physicians, their patients, and the media that political reform can be achieved. □

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