COMMITTEE ON HEALTH, HOSPITALS AND HUMAN SERVICES

BILL NO. 36-0048

Thirty-Sixth Legislature of the Virgin Islands

March 28, 2025

An Act amending title 22, Virgin Islands Code, chapter 3 relating to annual rate changes for medical malpractice liability insurance and amending title 27, Virgin Islands Code, chapter 1 by increasing the limitation on recovery in medical malpractice actions from $250,000 to $400,000; designating the records and testimony gathered by quality improvement committees as confidential; and establishing additional requirements for filing medical malpractice claims

PROPOSED BY: Senator Novelle E. Francis, Jr.

Be it enacted by the Legislature of the Virgin Islands:

SECTION 1. Title 22 Virgin Islands Code, chapter 3 is amended by adding the following section 53b:

"§53b. Annual rate change for medical malpractice liability insurance

(a) The Commissioner shall prescribe, by regulation, a designated range of annual rate change for medical malpractice liability insurance, which must be an increase or decrease of between not less than 5% and not more than 15%, and within which any rate, supplementary rate information, or change or amendment thereof, filed by an insurer or rating organization, becomes effective not less than 30 days after the filing.

(1) The Commissioner may determine, pursuant to regulation, the categories, subcategories, specialties, and subspecialties of the health care provider to which the application of the designated range will apply.

(2) Only one filing by an insurer or rating organization of a proposed

rate change within the designated range may take effect within any 12-month period without the express approval of the Commissioner, as set forth in subsection (c).

(b) In prescribing the designated range of annual rate change, the Commissioner may consider the availability and affordability of medical malpractice liability insurance for different categories, subcategories, specialties, and subspecialties of the healthcare provider in relation to the capitalization and reserve requirements necessary to ensure the solvency of the insurers. The Commissioner may also consider current data relating to the frequency and severity of medical malpractice claims and trends in the cost of investigating, defending and settling claims.

(c) (1) Any filing by an insurer or rating organization proposing a rate change that exceeds the designated range established pursuant to subsection (a) or proposing anadditional rate change within this range during any 12-month period, is subject to approval by the Commissioner.

(2) If the Commissioner determines that there is not sufficient evidence to justify a new rate, the Commissioner may disallow the rate increase. The reason for the rejection must be in writing. An aggrieved carrier may demand a hearing pursuant to chapter 7 of this title to reconsider the ruling and may appeal from the Commissioner's order refusing a hearing or an order on hearing to the Superior Court of the Virgin Islands. The appeal must be taken within 30 days.

SECTION 2. Title 27 Virgin Islands Code, chapter 1 is amended as follows:

(a) Add subchapter IId to read:

"Subchapter IId. Quality Improvement Committees

§58. Policy

It is the policy of this Territory to encourage the improvement of patient safety,

the quality of patient care and the evaluation of the quality, safety, cost, processes and necessity of healthcare services by hospitals, healthcare facilities and healthcare providers. This Territory further recognizes that certain protections must be available to these entities to ensure that they are able to effectively pursue these measures.

§59. Definitions

As used in this section:

(a) "Healthcare organization" means any:

(1) Healthcare facility licensed or regulated by the Territory;

(2) Hospital under the Virgin Islands Government Hospitals andHealth Facilities Corporation or any other hospital regulated by this Territory;

(3) Entity owning, owned by, affiliated with or providing ancillary or allied health services to, or on behalf of, a hospital or healthcare facility licensed or regulated by this Territory;

(4) Entity that contracts with a healthcare organization to perform any of the functions of a quality improvement committee;

(5) Entity that maintains a patient safety evaluation system in compliance with the Patient Safety and Quality Improvement Act of 2005, P.L. 109-41 for reporting to a patient safety organization listed as such by the federal secretary of health and human services pursuant to § 924 of the Patient Safety and Quality Improvement Act of 2005;

(6) Professional assistance program providing, or attempting to provide, intervention, counseling, referral or other assistance to any healthcare provider or family of a healthcare provider directly related to and including the alcohol or drugimpairment of a healthcare provider;

(7) Professional healthcare foundation;

(8) Health maintenance organization, preferred provider organization, hospital and medical service corporation, or accountable care organization as defined by§ 3022 of the federal Patient Protection and Affordable Care Act, P.L. 111-148;

(9) Entity that operates or manages hospitals or related facilities in the Virgin Islands, including specifically the Virgin Islands Government Hospitals and Health Facilities Corporation;

(10) Accredited medical programs in the Territory; or

(11) Community behavioral health center as defined by 19 V.I.C. § 4101.

(b) "Healthcare provider" means any healthcare professional licensed, authorized,certified or regulated under title 27 Virgin Islands Code, including medical resident physicians, interns and fellows participating in a training program of one of the accredited medical schools or of one of such medical school's affiliated teaching hospitals in this Territory, or any other clinical staff of a healthcare organization.

(c) "Quality improvement committee" or "QIC" means a committee formed or retained by a healthcare organization, an activity of a healthcare organization, or one or more individuals employed by a healthcare organization performing the types of functions listed in paragraphs (1)-(16), the purpose of which, or one of the purposes of which is to evaluate the safety, quality, processes, costs, appropriateness or necessity of healthcare services by performing functions including:

(1) Evaluation and improvement of the quality of healthcare services rendered;

(2) Determination that health services rendered were professionally

indicated or were performed in compliance with the applicable standards of care;

(3) Determination that the cost of health care rendered was reasonable;

(4) Evaluation of the qualifications, credentials, competence and performance of healthcare providers or actions upon matters relating to the discipline of any individual healthcare provider;

(5) Reduction of morbidity or mortality;

(6) Establishment and enforcement of guidelines designed to keep the cost of health care within reasonable bounds;

(7) Research;

(8) Evaluation of whether healthcare facilities are being properly utilized;

(9) Supervision, education, discipline, admission, and the determination of privileges of healthcare providers;

(10) Review of professional qualifications or activities of healthcare providers;

(11) Evaluation of the quantity, quality and timeliness of healthcare services rendered to patients;

(12) Evaluation, review or improvement of methods, procedures or treatments being utilized;

(13) Participation in utilization review activities, including participation in review activities within the healthcare facility and activities in conjunction with an insurer or utilization review committee members or related or affiliated personnel;

(14) The evaluation of reports and any internal reports related thereto or in the course of a healthcare organization's patient safety and risk management activities;

(15) Activities to determine the healthcare organization's compliance with local or federal regulations;

(16) Participation in patient safety activities as defined at § 921 of the Patient Safety and Quality Improvement Act of 2005.

(d) "Records" means records of interviews and all reports, incident reports, statements, minutes, memoranda, charts, statistics, evaluations, critiques, test results, corrective actions, disciplinary actions, and all other documentation generated by or in connection with activities of a QIC and any patient safety work product as defined at § 921 of the Patient Safety and Quality Improvement Act of 2005.

§60. Records, confidentiality

(a) Records of a QIC and testimony or statements by a healthcare organization's officers, directors, trustees, healthcare providers, administrative staff, employees or other committee members or attendees relating to activities of the QIC are confidential and privileged and are protected from direct or indirect means of discovery, subpoena or admission into evidence in any judicial or administrative proceeding. Any person who supplies information, testifies or makes statements as part of a QIC may not be required to provide information as to the information, testimony or statements provided to or made before a QIC or opinions formed by such person as a result of committee participation.

(b) Any information, documents or records, which are not produced for use by a QIC, or which are not produced by persons acting on behalf of a QIC, and are otherwise available from original sources, may not be construed as immune from discovery or use in any judicial or administrative proceeding merely because the information, documents or records were presented during proceedings of the QIC.

(c) A QIC may share information and documents, including complaints, incident reports, and testimony and statements by any person to the QIC, with one or more other QICs as defined under this section. Information and documents disclosed

by one QIC to another QIC, and any information and documents created or maintained as a result of the sharing of such information and documents, are confidential, privileged and protected from direct or indirect means of discovery, subpoena or admission into evidence, to the same extent as provided in subsection (a). The QIC sharing such information with another QIC shall determine the manner and process by which it will share such information and documents, which process may include requiring a written agreement between QICs regarding the sharing of practitioner information. The QIC and its sponsoring healthcare organization may not be held liable and are immune from suit for any disclosure or sharing of information in compliance with this section.

§60a. Immunity, information provided to QIC

(a) No healthcare organization or its officers, trustees, directors, healthcare providers, administrative staff, employees, other committee members or attendees, or any person providing information to a QIC is liable:

(1) In any action for damages or other relief arising from the provision of information to a QIC or in any judicial or administrative proceeding if the information is provided to the QIC in good faith and without malice and on the basis of facts reasonably known or reasonably believed to exist; or

(2) For damages resulting from any decisions, opinions, actions, and proceedings rendered, entered or acted upon by a QIC undertaken or performed within the scope or function of the duties of a QIC or in any judicial or administrative proceeding, if made or taken in good faith and without malice and on the basis of facts reasonably known or reasonably believed to exist.

(b) Any person providing information to a QIC is presumed to have acted

in good faith and without malice. Any person alleging lack of good faith has the burden of proving bad-faith and malice.

(c) All decisions, opinions, actions and proceedings rendered, entered or acted upon by a QIC are presumed to have been completed in good faith and without malice. Any person alleging lack of good faith has the burden of proving bad faith and malice.

§60b. Immunity, reviewers in general

Any person who serves on any peer review committee or any other committee board, commission or other entity constituted by any Virgin Islands medical association, local medical society, the Virgin Islands Government Hospitals and Health Facilities or governmental or quasi-governmental agency, for the purpose of quality improvement, evaluating or making determinations relative to alleged acts or omissions of patient care and treatment, is immune from liability with respect to any action taken by that person in good faith and without malice as a member of the committee, board, commission or other entity.

§60c. Federal laws

Nothing in this subchapter may conflict with any federal protection of records provided under the federal Health Care Quality Improvement Act, compiled in 42 U.S.C. § 11101 et. seq., or the federal Patient Safety Act."

SECTION 3. Title 27 Virgin Islands Code, chapter 1, subchapter IX is amended in the following instances:

(a) In section 166, subsection (g), strike "$250,000" and insert "$400,000";

(b) In section 166b:

(1) in subsection (a), strike "two hundred and fifty thousand dollars ($250,000)" and insert "$400,000";

(2) in subsection (c), strike "seventy-five thousand dollars ($75,000)" and insert "$120,000"; and

(3) add subsections (g) and (h) to read:

"(g) (1) Beginning July 1, 2026, and each July 1 thereafter until July 1, 2031, the Director of the Office of Management and Budget ("OMB"), with the assistance of the V.I. Bureau of Economic Research ("VIBER") shall adjust the limit for damages under subsection (a) for inflation.

(2) The amount in paragraph (1) must:

(A) be rounded to the nearest $10,000; and

(B) apply to a cause of action arising on or after the date the annual adjustment is made.

(3) By July 15 of each year until July 1, 2031, the Director of OMB, with the assistance of the VIBER, shall:

(A) certify the inflation-adjusted limit calculated under this subsection; and

(B) inform the Commissioner of Health and the Superior Court of the Virgin Islands of the certified limit.

(h) The term "inflation" as used in subsection (g) means the seasonally adjusted consumer price index for all urban consumers as published by the Bureau of Labor Statistics of the United States Department of Labor."

(c) In section 166e:

(1) in subsection (b), strike "$250,000" and insert "$400,000";

(2) in subsection (e)(3), strike "$250,000" and insert "$400,000"; and

(3) add subsection (j) to read:

"(j) The liability amounts in subsection (b) and subsection (e)(3) must be adjusted to conform with the provisions of 27 V.I.C. §166b(g)."

(d) In section 166i:

(1) in subsection (b), insert "if the complaint is accompanied by an Affidavit of Merit consistent with section 166n" after "provider in court".

(2) in subsection (d), add paragraph (5) to read:

"(5) In an action subsequently brought by a claimant in court after a finding by the expert under subsection (d)(1) that the health care provider acted within the appropriate standards of medical care as charged in the proposed complaint, the claimant shall file an Affidavit of Merit, consistent with section 166n, and post a bond, consistent with section 166o, with the filing of the complaint."

(e) add sections 166n through 166q to read:

"§166n. Affidavit of Merit

(a) Except as provided in subsection (f), the claimant shall file the Affidavit of Merit required to be filed under section 166i subsections (b) and (d)(5) as to each named defendant signed by an expert witness, as defined in section 166p(b)(1), and accompanied by a current curriculum vitae of the expert witness, stating that:

(1) the expert is competent under section 166p (b) to express an opinion or opinions in the case; and

(2) there are reasonable grounds and a good faith basis to maintain an action consistent with the requirements of section166p(a) as to each named defendant.

(b) The Affidavit of Merit and curriculum vitae must be filed with the court in a sealed envelope which must state on its face:

"CONFIDENTIAL SUBJECT TO 27 V.I.C. §166n. THE CONTENTS OF THIS ENVELOPE MAY ONLY BE VIEWED BY A JUDGE OF THE SUPERIOR COURT."

(c) Notwithstanding 3 V.I.C. §881 or any law to the contrary, the Affidavit of Merit must be and must remain sealed and confidential, except as provided in subsection (g).

(d) If the Affidavit of Merit is not filed with the complaint, the court shall dismiss as provided in subsection (e) absent a showing that the failure was due to demonstrated extraordinary cause.

(e) The failure of a claimant to file an Affidavit of Merit in compliance with this section, upon motion, makes the action subject to dismissal with prejudice. The court may, upon timely motion of the claimant and for extraordinary cause shown, grant a single 60-day extension to file the Affidavit of Merit. Extraordinary cause includes the inability to obtain, despite reasonable efforts, relevant medical records for expert review. A motion to extend the time for filing an Affidavit of Merit is timely only if it is filed on or before the filing date of the complaint. The filing of a motion to extend the time for filing an Affidavit of Merit tolls the time period within which the affidavit must be filed until the court rules on the motion. In cases where a motion to extend the time for filing an Affidavit of Merit is filed, the defendant is not required to take any action with respect to the complaint until 20 days after the court rules on the motion and the claimant has filed the Affidavit of Merit.

(f) An Affidavit of Merit is not required if the complaint alleges a rebuttable inference of medical negligence, the grounds of which are set forth in subsection (h).

(g) Upon motion by the defendant, the court shall determine in camera if the Affidavit of Merit complies with subsection (a). The Affidavit of Merit is not discoverable in any malpractice action. The Affidavit of Merit itself, and the fact that an expert has

signed the Affidavit of Merit, are not discoverable or admissible, nor may the expert be questioned in any respect about the existence of the Affidavit of Merit in the underlying malpractice action or any subsequent unrelated malpractice action in which that expert serves as a witness.

(h) (1) A rebuttable inference that personal injury or death was caused by medical negligence arises where evidence is presented that the personal injury or death occurred in any one or more of the following circumstances:

(A) A foreign object was unintentionally left within the body of the patient following surgery;

(B) An explosion or fire originating in a substance used in treatment occurred in the course of treatment; or

(C) A surgical procedure was performed on the wrong patient or the wrong organ, limb or part of the patient's body.

(2) Except as otherwise provided in paragraph (1), there may be no inference or presumption of negligence on the part of a health care provider.

§166o. Requirement of a Bond

(a) The bond required to be filed under section 166i(d)(5) must be in the amount $6,000.00 in the aggregate, secured by cash or its equivalent, and filed with the clerk of the Superior Court of the Virgin Islands, payable to the defendant in the case for costs assessed, including witness and experts fees and attorney's fees if the claimant does not prevail in the final judgment. If the bond is not posted when the complaint is filed, the action shall be dismissed.

(b) Upon motion filed by the claimant, and a determination by the court that the claimant is indigent, the judge may reduce the amount of the bond but may not eliminate the requirement of a bond.

§166p. Claimant's burden in medical malpractice action, expert testimony, jury instructions

(a) In a malpractice action, the claimant has the burden of proving by expert testimony, the qualifications of which are described in subsection (b), the following:

(1) The recognized standard of acceptable professional practice in the profession and the specialty thereof, if any, that the defendant practices in the community in which the defendant practices or in a similar community at the time the alleged injury or wrongful action occurred;

(2) That the defendant acted with less than or failed to act with ordinary and reasonable care in accordance with the standard in paragraph (1); and

(3) As a proximate result of the defendant's negligent act or omission, the claimant suffered injuries which would not otherwise have occurred.

(b) (1) No person in a health care profession requiring licensure under the laws of this Territory is competent to testify in any court of law to establish the facts required to be established by subsection (a), unless the person was licensed to practice in any U.S. state or territory, a profession or specialty which would make the person's expert testimony relevant to the issues in the case, and has practiced this profession or specialty and has been engaged in the treatment of patients in a relevant field of medicine to the issues in the case in a U.S. state or territory during the year immediately preceding the date that the alleged injury or wrongful act occurred.

(2) The requirements of paragraph (1) also apply to expert witnesses testifying for the defendant as rebuttal witnesses.

(c) (1) In a malpractice action, the court shall instruct the jury that the claimant has the burden of proving, by a preponderance of the evidence, the negligence of the defendant and, that as a proximate result of the defendant's negligent act or omission, the claimant suffered an

injury or injuries which would not otherwise have occurred. The court shall further instruct the jury that injury alone does not raise a presumption of a defendant's negligence.

(2) The instructions required to be given in paragraph (1) must also be applied in the case of a bench trial.

§166q. Claimant's burden in action for failure to obtain informed consent

In a malpractice action based upon the lack of informed consent, the claimant shall prove by expert testimony, the qualifications of which are described in section 166p (b), that the defendant did not supply appropriate information to the claimant in obtaining informed consent as to the procedure out of which claimant's claim allegedly arose, in accordance with the recognized standards of acceptable professional practice in the profession and in the specialty, if any, that the defendant practices in the community in which the defendant practices and in similar communities."

BILL SUMMARY

The bill amends title 22 Virgin Islands Code, chapter 3 by adding section 53b requiring the Commissioner of the Division of Banking and Insurance to prescribe, by regulation, a designated range of annual rate change for medical malpractice liability insurance and restricting insurers offering malpractice insurance to one proposed rate change filing every 12 months. The bill also amends title 27 Virgin Islands Code, chapter 1 by: designating the records and testimony of healthcare quality improvement committees to be confidential and privileged and offering immunity to persons offering this information who act in good faith and without malice and offering immunity protection to persons serving on committees, commissions, or boards involving patient care and treatment who act in good faith and without malice; increasing the limitation on recovery in malpractice actions and increasing the amount required for malpractice liability insurance coverage, from $250,0000 to $400,000; requiring the Director of the Office of Management and Budget, with the assistance of the VI Bureau of Economic Research, to adjust for inflation, the recovery limitation amount for malpractice suits

over the next five years; requiring a claimant to file an Affidavit of Merit in cases where the Medical Malpractice Action Review Committee ("Committee") fails to receive an expert opinion within 90 days from the filing date of the complaint and requiring a patient to file an Affidavit of Merit and a bond in the amount of $6,000 in cases where the expert selected by the Committee renders an opinion that a health care provider acted within the appropriate standards of medical care and the patient proceeds to file a malpractice suit in court; establishing the requirements for an Affidavit of Merit and requiring the affidavit to be signed by an expert witness and accompanied by a current curriculum vitae of the expert witness; allowing a judge to reduce the amount of the $6,000 bond upon filing of a motion by the claimant and a determination by the court that the claimant is indigent; establishing the factors to be proven to establish a rebuttable inference that personal injury or death was caused by medical negligence and providing that an Affidavit of Merit is not required in cases where this inference exists; and establishing a claimant's burden in a malpractice action and the jury instructions to be given by the court in a jury or bench trial.

BR25-0189/March 25, 2025/GC