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CHAPTER 79

Medical Malpractice Insurance

ARTICLE 1

General Provisions

**SECTION 38‑79‑20.** Medical malpractice judgments, settlements, agreements and awards to be filed by insurers with appropriate licensing board.

 All medical malpractice insurance carriers shall file with the appropriate professional or occupational licensing board all final judgments, settlements, agreements, and awards against any licensee of that board. All information relative to parties involved is and shall remain confidential.

HISTORY: 1988 Act No. 427; 1993 Act No. 181, Section 830.

**SECTION 38‑79‑30.** Volunteer health care provider not liable for civil damages; exception.

 No licensed health care provider, as defined in Section 38‑79‑410, who renders medical services voluntarily and without compensation or the expectation or promise of compensation and seeks no reimbursement from charitable and governmental sources is liable for any civil damages for any act or omission resulting from the rendering of the services unless the act or omission was the result of the licensed health care provider’s gross negligence or wilful misconduct. The agreement to provide a voluntary, noncompensated service must be made before rendering service in the case of a nonemergency and may be evidenced by the provider’s giving notice to the patient or to the person responsible for the patient’s care and acting for the patient that the service being rendered is voluntary and without compensation.

HISTORY: 1994 Act No. 461, Section 2; 2010 Act No. 153, Section 1, eff May 11, 2010.

**SECTION 38‑79‑40.** Employment and compensation restrictions on members of Board of Joint Underwriting Association and Board of Governors of Patients’ Compensation Fund; exception.

 (A) A person who serves on the Board of the Joint Underwriting Association or the Board of Governors of the Patients’ Compensation Fund is prohibited from being employed in any manner or compensated by the Joint Underwriting Association or the Patients’ Compensation Fund, and this prohibition continues for one year after the person ceases to be a member of the board.

 (B) No provision of this section may be construed to prohibit an insurance agent from selling insurance products from the association or from receiving commissions as a result of selling insurance products from the association.

HISTORY: 2005 Act No. 32, Section 6, eff July 1, 2005, for causes of action arising after that date.

ARTICLE 3

South Carolina Medical Malpractice Liability Joint Underwriting Association

**SECTION 38‑79‑110.** Definitions.

 As used in this article:

 (1) “Association” means any joint underwriting association established pursuant to the provisions of this article.

 (2) “Licensed health care providers” means physicians and surgeons, nurses, oral surgeons, dentists, pharmacists, chiropractors, podiatrists, hospitals, nursing homes, or any similar major category of licensed health care providers. The term “licensed health care provider” also includes blood centers which collect, process, and distribute blood to hospitals and physicians for the care of patients if these blood centers as of July 1, 1997, were insured with the Joint Underwriting Association.

 (3) “Medical malpractice insurance” means medical professional liability insurance or insurance protection against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering or failing to render professional service by any licensed physician, licensed health care provider, or hospital.

 (4) “Net direct premiums” means gross direct premiums written on bodily injury liability insurance, other than automobile liability insurance, homeowners liability insurance, and farmowners liability insurance, including the liability component of multiple peril package policies, as computed by the director or his designee, less return premiums or the unused or unabsorbed portions of premium deposits.

HISTORY: 1987 Act No. 155, Section 1; 1988 Act No. 306, Section 1; 1993 Act No. 181, Section 830; 1997 Act No. 62, Section 2.

**SECTION 38‑79‑120.** Association created; membership as a condition of authority to transact insurance; purpose; calling Association into operation.

 (1) A joint underwriting association (association) is created, consisting of all insurers authorized to write within this State, on a direct basis, bodily injury liability insurance, other than automobile bodily injury liability insurance, homeowners liability insurance, and farmowners liability insurance, including insurers covering such peril in multiple peril package policies. Every such insurer is and must remain a member of the association as a condition of its authority to continue to transact such kind of insurance in this State.

 (2) The purpose of the association is to provide medical malpractice insurance on a self‑supporting basis to the fullest extent possible.

 (3) The association must be called into operation at any time that the department finds and declares the existence of an emergency because of the unavailability of medical malpractice liability insurance, or the unavailability of medical malpractice liability insurance on a reasonable basis through normal channels, in respect to all or any one or more of the major categories of licensed health care providers listed in item (2) of Section 38‑79‑110.

HISTORY: 1987 Act No. 155, Section 1; 1988 Act No. 306, Section 2; 1993 Act No. 181, Section 830.

Editor’s Note

2005 Act No. 32, Section 15, provides as follows:

“As a majority of the health care community is insured through the South Carolina Medical Malpractice Joint Underwriting Association and the Patients’ Compensation Fund and as it is essential for the General Assembly to understand the effects of changes to tort laws, the South Carolina Department of Insurance is given authority to request data regarding changes in claims practices from the South Carolina Medical Malpractice Joint Underwriting Association and the Patients’ Compensation Fund. Such data may include paid claims, paid loss adjustment expense, case reserves, bulk reserves, and claim counts by quarter for the previous five years. The department may make such a request of the South Carolina Medical Malpractice Joint Underwriting Association and the Patients’ Compensation Fund and such information must be provided within thirty days.

“The Department of Insurance shall report annually to the Speaker of the House of Representatives, the President Pro Tempore of the Senate, and the Governor as to whether this and other related enactments have resulted in reductions in premiums and as to any other trends of significance which might impact premium cost.”

2005 Act No. 32, Section 21(B), provides as follows:

“Upon approval by the Governor, this act takes effect July 1, 2005, for causes of action arising after July 1, 2005, except that as of this act’s effective date, the State Treasurer shall relinquish the management of funds in the Patients’ Compensation Fund, created pursuant to Section 38‑79‑420, to the Board of Governors of the fund, and premiums paid on or after this act’s effective date must be deposited with the Board of Governors of the fund. The fund must be fully transferred to the Board of Governors, and the State Treasurer may not hold any deposits of the fund as of ninety days after this act’s effective date.”

**SECTION 38‑79‑130.** Powers of association; policy limits.

 The association, pursuant to the provisions of this article and the approved plan of operation in respect to medical malpractice insurance, has the power on behalf of its members to:

 (1) issue, or cause to be issued, policies of insurance to applicants including incidental coverages including, but not limited to, premises or operations liability coverage on the premises where services are rendered, all subject to limits of liability as specified in the plan of operation but not to exceed two hundred thousand dollars for each claim under one policy and six hundred thousand dollars for all claims under one policy in any one year; provided, however, that the association may offer policies up to one million dollars for each claim under one policy and three million dollars for all claims under one policy in any one year only upon approval of the board of the association and with the written concurrence of the Board of Governors of the South Carolina Patients’ Compensation Fund;

 (2) underwrite medical malpractice insurance and to adjust and pay losses with respect to it or to appoint service companies to perform those functions;

 (3) cede and assume reinsurance.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830; 2000 Act No. 313, Section 1; 2008 Act No. 348, Section 7, eff June 16, 2008.

**SECTION 38‑79‑140.** Plan of operation.

 (1) The association must operate pursuant to a plan of operation which shall provide for economic, fair, and nondiscriminatory administration and for the prompt and efficient provision of medical malpractice insurance and may contain other provisions including, but not limited to, preliminary assessment of all members for initial expenses necessary to commence operations, establishment of necessary facilities, management of the association, assessment of the members to defray losses and expenses, commissions arrangements, reasonable and objective underwriting standards, acceptance and cession of reinsurance, appointment of servicing carriers, and procedures for determining amounts of insurance to be provided by the association.

 (2) The plan of operation shall provide that any profit achieved by the association must be added to the reserves of the association or returned to the policyholders as a dividend.

 (3) The plan of operation becomes effective and operative no later than thirty days after the declaration of any emergency by the department.

 (4) Amendments to the plan of operation may be made by the directors of the association with the approval of the director or his designee or must be made at the direction of the director or his designee after due notice and public hearing.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830.

**SECTION 38‑79‑150.** Application for coverage.

 Any licensed health care provider in a category in which the department has declared an emergency exists is entitled to apply to the association for coverage. The application may be made on behalf of the applicant by a licensed agent or broker authorized in writing by the applicant. If the association determines that the applicant meets the underwriting standards of the association as set forth in the approved plan of operation and there is no unpaid, uncontested premium due from the applicant for any prior insurance of the same kind, the association, upon receipt of the premium, or a portion thereof as prescribed by the plan of operation, shall cause to be issued a policy of medical malpractice liability insurance for a term of one year.

 The rates, rating plans, rating rules, rating classifications, territories, and policy forms applicable to insurance written by the association and the statistical and experience data relating thereto are subject to this article and to those provisions of Chapter 73 of this title which are not inconsistent with the purposes and provisions of this article.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830.

**SECTION 38‑79‑160.** Statistical data and plan.

 The director or his designee shall obtain complete statistical data in respect to medical malpractice losses and reparation costs as well as all other costs or expenses which underlie or are related to medical malpractice liability insurance. He shall promulgate any statistical plan he considers necessary for the purpose of gathering data referable to loss and loss adjustment expense experience and other expense experience. When a statistical plan is promulgated all members of the association shall adopt and use it. The director or his designee shall also obtain statistical data in respect to the costs of compensating or rehabilitating victims of medical malpractice without respect to insurance for purposes of studying the feasibility or desirability of alternative medical malpractice compensation systems and estimating the impact of medical malpractice loss and insurance costs upon other compensation and insurance systems such as workers’ compensation and accident and health insurance. He may require from any person obtaining insurance through the association loss, claim, or expense data. This information or data is confidential and the physician‑patient privilege must be preserved.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830.

**SECTION 38‑79‑170.** Investment income considered in rates and determination of profit or loss of Association.

 In respect to the structuring of rates for medical malpractice liability insurance and the determination of the profit or loss of the association in respect to that insurance, due consideration must be given by the director or his designee to all investment income.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830.

**SECTION 38‑79‑180.** Initial filings of policy forms, rates, etc.

 Within a time that the director or his designee directs, the association shall submit, for the approval of the director or his designee, an initial filing, in proper form, of policy forms, classifications, rates, rating plans, and rating rules applicable to medical malpractice liability insurance to be written by the association. In the event the director or his designee disapproves the initial filing, in whole or in part, the association shall amend the filing, in whole or in part, in accordance with the direction of the director or his designee. If the director or his designee is unable to approve the filing or amended filing, within the time specified, he shall promulgate the policy forms, classifications, rates, rating plans, and rules to be used by the association in making rates for and writing the insurance.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830.

**SECTION 38‑79‑190.** Policy forms and rate structure; claims‑made or occurrence basis; forbidden provisions; rates charged.

 (1) The board of directors shall specify whether policy forms and the rate structure must be on a “claims‑made” or “occurrence” basis and coverage may be provided by the association only on the basis specified by the board of directors. The board of directors shall specify the “claims‑made” basis only if the contract makes provision for residual “occurrence” coverage upon the retirement, death, disability, or removal from the State of the insured. Provision may be made for a premium charge allocable to any such residual “occurrence” coverage and the premium charges for the residual coverage must be segregated and separately maintained for such purpose which may include the reinsurance of all or a part of that portion of the risk.

 (2) The policy may not contain any limitation in relation to the existing law in tort as provided by the statute of limitations of the State of South Carolina.

 (3) The policy form whether on a “claims‑made” or “occurrence” basis may not require as a condition precedent to settlement or compromise of any claim the consent or acquiescence of the insured. However, such settlement or compromise may never be held or considered to be an admission of fault or wrongdoing by the insured.

 (4) The premium rate charged for either or both “claims‑made” or “occurrence” coverage must be at rates established on an actuarially sound basis, including consideration of trends in the frequency and severity of losses, and must be calculated to be self‑supporting.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830; 1997 Act No. 19, Section 1.

**SECTION 38‑79‑200.** Rate increase or assessment authorized.

 The association is authorized to provide a rate increase or assessment which is subject to the approval of the director or his designee.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830.

**SECTION 38‑79‑210.** Deficits to be recouped.

 Any deficit sustained by the Association in any year must be recouped, pursuant to the plan of operation and the rating plan then in effect, by one or both of the following procedures:

 (1) An assessment upon the policyholders which may not exceed one additional annual premium at the then current rate.

 (2) A rate increase applicable prospectively.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830.

**SECTION 38‑79‑220.** Recoupment.

 Effective after the initial year of operation, rates, rating plans, and rating rules, and any provision for recoupment through policyholder assessment or premium rate increase, must be based upon the association’s loss and expense experience and investment income, together with any other information based upon such experience and income as the director or his designee considers appropriate. The resultant premium rates must be on an actuarially sound basis and must be calculated to be self‑supporting.

 In the event that sufficient funds are not available for the sound financial operation of the association, pending recoupment as provided in Section 38‑79‑210, all members shall, on a temporary basis, contribute to the financial requirements of the association in the manner provided for in Section 38‑79‑230. Any such contribution must be reimbursed to the members following recoupment as provided in Section 38‑79‑210.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830.

**SECTION 38‑79‑230.** Insurer participation in the Association.

 All insurers which are members of the association shall participate in its writings, expenses, profits, and losses in the proportion that the net direct premiums of each member (excluding that portion of premiums attributable to the operation of the association) written during the preceding calendar year bear to the aggregate net direct premiums written in this State by all members of the association. Each insurer’s participation in the association must be determined annually on the basis of the net direct premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the insurer with the department. The assessment of a member insurer, after hearing, may be ordered deferred in whole or in part upon application by the insurer if, in the opinion of the director or his designee, payment of the assessment may render the insurer insolvent or in danger of insolvency or otherwise may leave the insurer in a condition that further transaction of the insurer’s business may be hazardous to its policyholders, creditors, members, subscribers, stockholders, or the public. If payment of an assessment against a member insurer is deferred by order of the director or his designee in whole or in part, the amount by which the assessment is deferred must be assessed against other member insurers in the same manner as provided in this section. In the order of deferral or in subsequent orders as may be necessary, the director or his designee shall prescribe a plan by which the assessment deferred must be repaid to the association by the impaired insurer with interest at the six‑month treasury bill rate adjusted semiannually. Profits, dividends, or other funds of the association to which the insurer is otherwise entitled may not be distributed to the impaired insurer but must be applied toward repayment of any assessment until the obligation has been satisfied. The association shall distribute the repayments, including interest on them, to the other member insurers on the basis on which assessments were made.

HISTORY: 1987 Act No. 155, Section 1; 1989 Act No. 129, Section 1; 1993 Act No. 181, Section 830.

**SECTION 38‑79‑240.** Plans to be binding on members of Association.

 Every member of the Association is bound by the approved plan of operation of the Association and by any other rules the board of directors of the Association lawfully prescribes.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830.

**SECTION 38‑79‑250.** Obligations of terminated members; responsibility of State.

 (1) If the authority of an insurer to transact bodily injury liability insurance, other than automobile, homeowners, or farmowners, in this State terminates for any reason its obligations as a member of the association nevertheless continue until all its obligations have been fulfilled and the director or his designee has so found and certified to the board of directors.

 (2) If a member insurer merges into or consolidates with another insurer authorized to transact such insurance in this State or another insurer authorized to transact such insurance in this State has reinsured the insurer’s entire general liability business in this State, both the insurer and its successor or assuming reinsurer, as the case may be, are liable for the insurer’s obligations in respect to the association.

 (3) Any unsatisfied net liability of any insolvent member of the association must be assumed by and apportioned among the remaining members in the same manner in which assessments or gain and loss are apportioned and the association shall thereupon acquire and have all rights and remedies allowed by law in behalf of the remaining members against the estate or funds of the insolvent insurer for funds due the association.

 (4) The State is not responsible for any costs, expenses, liabilities, judgments, or other obligations of the association.

HISTORY: 1987 Act No. 155, Section 1; 1988 Act No. 306, Section 3; 1993 Act No. 181, Section 830; 2000 Act No. 313, Section 3.

**SECTION 38‑79‑260.** Board of directors.

 The association is governed by a board of thirteen directors, all of whom must be appointed by the Governor. The Governor shall appoint five health care providers after consultation with the South Carolina Medical Association, the South Carolina Dental Association, and the South Carolina Health Alliance; four insurance representatives after consultation with the insurance industry; one consumer representative who is unaffiliated with the insurance or health care industries or the medical or legal professions; and two licensed insurance agents or brokers. The professional associations listed and the insurance industry may nominate qualified individuals to the Governor for his consideration. The Governor may also receive nominations for appointments to the board from any other individual, group, or association. Notices of vacancies on the board must be published in newspapers of general statewide circulation. The director or his designee shall serve as an ex officio member of the board. The board shall develop a plan of operation which is subject to the approval of the director or his designee as provided in this article. The plan of operation shall provide for staggered terms of the members of the board. The approved plan of operation of the association may make provision for combining insurers under common ownership or management into groups for voting, assessment, and all other purposes and may provide that not more than one of the officers or employees of a group may serve as a director at any one time. The board shall elect a chairman and other necessary officers for two‑year terms. A vacancy must be filled for the unexpired portion of the term only. The Governor may receive recommendations from any individual, group, or association for any vacancy on the board. The board must meet at the call of the chairman or a majority of the members of the board, but in any event it must meet at least once a year.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830; 1997 Act No. 19, Section 2; 2000 Act No. 313, Section 4; 2015 Act No. 64 (H.3772), Section 1, eff June 4, 2015.

Effect of Amendment

2015 Act No. 64, Section 1, deleted the prior fourth to last sentence, relating to reappointment of members.

**SECTION 38‑79‑280.** Annual statement required.

 The association shall file in the office of the department annually, by March first, a statement which contains information with respect to its transactions, condition, operations, and affairs during the preceding year. The statement shall contain such matters and information as are prescribed by the director or his designee and must be in the form he directs. The director or his designee may, at any reasonable time, require the association to furnish additional information with respect to its transactions, condition, or any matter connected therewith considered to be material and of assistance in evaluating the scope, operation, and experience of the association.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830.

**SECTION 38‑79‑290.** Examination of Association.

 The director or his designee shall make an examination into the financial condition and affairs of the association at least annually and shall file a report thereon with the department, the Governor, and the General Assembly. The expenses of the examination must be paid by the association.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830.

ARTICLE 5

Patients’ Compensation Fund for Benefit of Licensed Health Care Providers

**SECTION 38‑79‑410.** “Licensed health care providers” defined.

 “Licensed health care providers” means physicians and surgeons; directors, officers, and trustees of hospitals; nurses; oral surgeons; dentists; pharmacists; chiropractors; optometrists; podiatrists; hospitals; nursing homes; or any similar category of licensed health care providers.

HISTORY: Former 1976 Code Section 38‑59‑110 [1976 Act No. 674 Section 1; 1979 Act No. 136 Section 1] recodified as Section 38‑79‑410 by 1987 Act No. 155, Section 1; 1988 Act No. 432, Section 8.

**SECTION 38‑79‑420.** Creation of Patients’ Compensation Fund; purpose.

 There is created the South Carolina Patients’ Compensation Fund (fund) for the purpose of paying that portion of a medical malpractice or general liability claim, settlement, or judgment which is in excess of two hundred thousand dollars for each incident or in excess of six hundred thousand dollars in the aggregate for one year, up to the amounts specified by the board pursuant to Section 38‑79‑430. The fund is liable only for payment of claims against licensed health care providers (providers) in compliance with the provisions of this article and includes reasonable and necessary expenses incurred in payment of claims and the fund’s administrative expense.

HISTORY: Former 1976 Code Section 38‑59‑120 [1976 Act No. 674 Section 2] recodified as Section 38‑79‑420 by 1987 Act No. 155, Section 1; 1990 Act No. 584, Section 1; 2003 Act No. 73, Section 17, eff June 25, 2003; 2008 Act No. 348, Section 8, eff June 16, 2008.

Editor’s Note

2005 Act No. 32, Section 15, provides as follows:

“As a majority of the health care community is insured through the South Carolina Medical Malpractice Joint Underwriting Association and the Patients’ Compensation Fund and as it is essential for the General Assembly to understand the effects of changes to tort laws, the South Carolina Department of Insurance is given authority to request data regarding changes in claims practices from the South Carolina Medical Malpractice Joint Underwriting Association and the Patients’ Compensation Fund. Such data may include paid claims, paid loss adjustment expense, case reserves, bulk reserves, and claim counts by quarter for the previous five years. The department may make such a request of the South Carolina Medical Malpractice Joint Underwriting Association and the Patients’ Compensation Fund and such information must be provided within thirty days.

“The Department of Insurance shall report annually to the Speaker of the House of Representatives, the President Pro Tempore of the Senate, and the Governor as to whether this and other related enactments have resulted in reductions in premiums and as to any other trends of significance which might impact premium cost.”

2005 Act No. 32, Section 21(B), provides as follows:

“Upon approval by the Governor, this act takes effect July 1, 2005, for causes of action arising after July 1, 2005, except that as of this act’s effective date, the State Treasurer shall relinquish the management of funds in the Patients’ Compensation Fund, created pursuant to Section 38‑79‑420, to the Board of Governors of the fund, and premiums paid on or after this act’s effective date must be deposited with the Board of Governors of the fund. The fund must be fully transferred to the Board of Governors, and the State Treasurer may not hold any deposits of the fund as of ninety days after this act’s effective date.”

**SECTION 38‑79‑430.** Creation of Board of Governors; members; terms; meetings; plan of operation for fund administration.

 The Board of Governors (board) is created to manage and operate the fund. The board is composed of three physicians to be appointed by the Governor after consultation with the South Carolina Medical Association, two dentists to be appointed by the Governor after consultation with the South Carolina Dental Association, two hospital representatives to be appointed by the Governor after consultation with the South Carolina Hospital Association, two insurance representatives to be appointed by the Governor after consultation with the insurance industry, one attorney to be appointed by the Governor after consultation with the South Carolina Bar, one attorney to be appointed by the Governor after consultation with the South Carolina Trial Lawyers Association, and two representatives of the general public appointed by the Governor who are unaffiliated with insurance or health care industries or the medical or legal professions. The appointed members shall serve for a term of six years. The board shall elect a chairman and other necessary officers for two‑year terms. The board must meet at the call of the chairman or a majority of the members but in any event it must meet at least once a year. A majority of the board members shall constitute a quorum for the transaction of any business of the board. The affirmative vote by a majority of the quorum present at a duly called meeting after notice is required to exercise any function of the board. The board may promulgate any regulations necessary to carry out the provisions of this article.

 The board shall develop a plan of operation for the efficient administration of the fund consistent with the provisions of this article. The fund must operate pursuant to a plan of operation which provides for the economic, fair, and nondiscriminatory administration and for the prompt and efficient provision of excess medical malpractice insurance and which may contain other provisions including, but not limited to, assessment of all members for expenses, deficits, losses, commissions’ arrangements, reasonable underwriting standards, acceptance and cession of reinsurance appointment of servicing carriers, and procedures for determining the amounts of insurance to be provided by the fund. The fund may not grant retroactive coverage to members. The plan of operation and any amendments to the plan are subject to the approval of the director or his designee. If the board fails to develop a plan of operation within the timeframe established by the Governor or his designee, the director or his designee shall develop the plan of operation for the fund.

HISTORY: Former 1976 Code Section 38‑59‑130 [1976 Act No. 674 Section 3; 1977 Act No. 104 Section 3] recodified as Section 38‑79‑430 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 831; 1997 Act No. 19, Section 3; 2000 Act No. 313, Section 5; 2008 Act No. 348, Section 9, eff June 16, 2008.

**SECTION 38‑79‑440.** Participation in Fund.

 All South Carolina licensed health care providers may participate in the Fund and maintain the participation by remitting to the board the appropriate membership fees and deficit assessments as are required by the board on or before the provider’s membership anniversary date.

HISTORY: Former 1976 Code Section 38‑59‑140 [1976 Act No. 674, Section 1; 1986 Act No. 443, Section 1] recodified as Section 38‑79‑440 by 1987 Act No. 155, Section 1.

**SECTION 38‑79‑450.** Membership fees and deficit assessments; responsibility of State.

 All Fund members shall pay annual membership fees set by the board. In addition to the annual membership fees, the board may make deficit assessments upon the determination by the board that insufficient money is available to meet the Fund’s liabilities.

 Membership in the Fund is contingent upon the Fund member making timely payment of all membership fees and deficit assessments.

 Self‑insureds are eligible for membership in the Fund upon compliance with the requirements of the Board of Governors and shall pay the same membership fees and deficit assessments as the members.

 Any deficit must be paid by the members of the fund. The State is not responsible for any costs, expenses, liabilities, judgments, or other obligations of the fund.

HISTORY: Former 1976 Code Section 38‑59‑150 [1976 Act No. 674, Section 5; 1979 Act No. 55; 1986 Act No. 443, Section 2] recodified as Section 38‑79‑450 by 1987 Act No. 155, Section 1; 2000 Act No. 313, Section 6.

**SECTION 38‑79‑460.** Management of fund.

 The fund, and any income from it, must be managed by the board according to its plan of operation developed pursuant to Section 38‑79‑430.

HISTORY: Former 1976 Code Section 38‑59‑160 [1976 Act No. 674, Section 6; 1986 Act No. 443, Section 3] recodified as Section 38‑79‑460 by 1987 Act No. 155, Section 1; 2005 Act No. 32, Section 8, eff July 1, 2005, for causes of action arising after that date.

**SECTION 38‑79‑470.** Method of withdrawing funds; audit of Fund; public inspection.

 (1) Monies may be withdrawn from the fund only upon the signature of the Chairman of the Board of Governors or his designee.

 (2) All books, records, and audits of the Fund are open for reasonable inspection to the general public.

 (3) On or before December thirty‑first of each year the State Auditor shall audit, or cause to be audited, the records of the Fund. Audit reports must be available to all Fund participants, the Department of Insurance, the Legislative Audit Council, and the State Fiscal Accountability Authority and the Department of Administration.

 (4) A licensed health care provider participating in the Fund may withdraw upon written notice of thirty days prior to the date of withdrawal. However, the provider remains subject to any assessment pertaining to any year in which he participated in the Fund. A member who withdraws during any year is entitled to a pro rata return of the annual membership fee.

HISTORY: Former 1976 Code Section 38‑59‑170 [1976 Act No. 674, Section 7; 1986 Act No. 443, Section 4] recodified as Section 38‑79‑470 by 1987 Act No. 155, Section 1; 2005 Act No. 32, Section 9, eff July 1, 2005, for causes of action arising after that date; 2005 Act No. 164, Section 10, eff June 10, 2005.

Code Commissioner’s Note

At the direction of the Code Commissioner, references in this section to the offices of the former State Budget and Control Board, Office of the Governor, or other agencies, were changed to reflect the transfer of them to the Department of Administration or other entities, pursuant to the directive of the South Carolina Restructuring Act, 2014 Act No. 121, Section 5(D)(1), effective July 1, 2015.

**SECTION 38‑79‑480.** Actions for damages.

 (1) In an action for damages arising out of the rendering of medical services against a licensed health care provider covered under the fund, the provider shall within five days of receipt of summons and complaint, excluding the first day and holidays, give notice to the board of the action. If after reviewing the facts upon which the action is based it appears that the claim will exceed two hundred thousand dollars, the board may appear and actively defend the fund. In so defending, the board may retain counsel and pay out of the fund attorney’s fees and expenses including court costs incurred in defending the fund. Any judgment affecting the fund may be appealed.

 (2) It is the responsibility of the insurer providing insurance for a licensed health care provider who is also covered by the fund or for the self‑insured provider covered by the fund to provide an adequate defense on any claim filed that potentially affects the fund with respect to these insurance contracts or a self‑insured’s liability. The insurers or self‑insured providers must act in a fiduciary relationship with respect to any claim affecting the fund. No settlement exceeding two hundred thousand dollars per incident, or six hundred thousand dollars in the aggregate for one year, may be agreed to unless approved by the board.

 (3) A person who has recovered a final judgment or a settlement approved by the board against a provider covered by the fund may file a claim with the board to recover that portion of the judgment or settlement which is in excess of two hundred thousand dollars for each incident or six hundred thousand dollars in the aggregate for one year, up to the amounts specified by the board pursuant to Section 38‑79‑430. If the fund incurs liability exceeding two hundred thousand dollars to any person under a single occurrence, the fund may not pay more than two hundred thousand dollars each year until the claim has been paid in full. However, the board may pay an amount in excess of two hundred thousand dollars so as to avoid the payment of interest.

 (4) Claims filed against the fund must be paid in the order received within ninety days after filing unless the judgment is appealed. If the fund does not have enough money to pay all of the claims, claims received after the funds are exhausted are immediately payable the following year in the order in which they were received.

HISTORY: Former 1976 Code Section 38‑59‑180 [1976 Act No. 674, Section 8; 1986 Act No. 443, Sections 5, 6] recodified as Section 38‑79‑480 by 1987 Act No. 155, Section 1; 2000 Act No. 313, Section 2; 2008 Act No. 348, Section 10, eff June 16, 2008.

**SECTION 38‑79‑490.** Judicial review.

 Any ruling, action, or decision by or on behalf of the Fund is subject to judicial review as provided in Section 1‑23‑380.

HISTORY: Former 1976 Code Section 38‑59‑190 [1978 Act No. 645, Section 2; 1986 Act No. 443, Section 7] recodified as Section 38‑79‑490 by 1987 Act No. 155, Section 1.