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; agreements to provide voluntary noncompensated service; continuing education.

(A) No licensed health care provider, as defined in Section 38‑79‑110, 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 in writing, which may include use of an electronic medical record device, before rendering service in the case of a nonemergency and may be evidenced by the provider's giving notice in writing, which may include use of an electronic medical record device, 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.

(B) Any licensed health care provider who renders medical services voluntarily and without compensation or the expectation or promise of compensation and seeks no reimbursement from charitable and governmental sources may fulfill one hour of continuing education for each hour of volunteer medical services rendered, up to a maximum of twenty‑five percent of the provider's required continuing education credits for the licensure period.

(C) For purposes of this section, a health care provider includes a dentist maintaining a restricted volunteer license pursuant to Section 40‑15‑177, a practitioner maintaining a special volunteer license pursuant to Section 40‑47‑34, and a chiropractor maintaining a special volunteer license pursuant to Section 40‑9‑85.

HISTORY: 1994 Act No. 461, Section 2; 2010 Act No. 153, Section 1, eff May 11, 2010; 2016 Act No. 189 (H.4999), Sections 4, 5, eff May 25, 2016.

Code Commissioner's Note

At the direction of the Code Commissioner, pursuant to the authority to codify permanent law, the provisions of Section 5 of 2016 Act No. 189 were codified as (B) of this Section, and former (B) was redesignated as (C).

Effect of Amendment

2016 Act No. 189, Sections 4, 5, in (A), added the paragraph identifier, and twice inserted "in writing, which may include use of an electronic medical record device,"; and added (B) and (C).

**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) "Accumulated deficit" means the amount that the association's and the fund's liabilities exceed their assets, as reported in the association's and fund's respective most recently reported financial statements on June 30, 2019.

(2) "Association" means any joint underwriting association established by the General Assembly in 1987 and managed and operated pursuant to the provisions of this article.

(3) "Fund" means the Patients' Compensation Fund.

(4) "Future deficit" means any deficit accumulated by the association and fund after the most recently reported financial statements as of June 30, 2019.

(5) "Licensed health care providers" means physicians and surgeons, nurses, oral surgeons, dentists, pharmacists, 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.

(6) "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.

(7) "Net‑direct premiums" means gross‑direct premiums written on medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, and any other type of professional liability insurance covering risks of licensed health care providers and facilities as determined and computed by the director or his designee, less return premiums or the unused or unabsorbed portions of premium deposits. The net‑direct premium calculation does not include premiums written by the fund.

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; 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

Effect of Amendment

2019 Act No. 67, Section 1, inserted (1), relating to "Accumulated deficit" and redesignated (1) as (2); in (2), inserted "by the General Assembly in 1987 and managed and operated"; inserted (3) and (4), relating to the definitions of "Fund" and "Future deficit", and redesignated former (2) to (4) as (5) to (7); in (5), in the first sentence, deleted "chiropractors," following "pharmacists,"; and rewrote (7), relating to the definition of "Net‑direct premiums".

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

(1) A joint underwriting association (association) is created, containing as members all insurers authorized to write and report net‑direct written premiums for medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, or any other type of professional liability insurance in this State covering the professional liability risks of licensed health care providers. Membership also includes foreign and domestic risk retention groups and captive insurers authorized to write and report net‑direct premiums for medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, or any other type of professional liability insurance in this State covering the professional liability risk of licensed health care providers, and authorized to do business in accordance with the provisions of this title. The South Carolina Insurance Reserve Fund is not a member of the association. Each insurer described above is and must remain a member of the association as a condition of the authorization to transact the sale of insurance in this State. The membership of the association shall continue as members in the South Carolina Medical Malpractice Association upon its creation as provided in Section 38‑79‑300.

(2) The purpose of the association is to ensure the availability of medical malpractice and other types of professional liability insurance for health care providers on a self‑supporting basis to the fullest extent possible. The intent of the General Assembly in enacting this section is to eliminate the accumulated deficit of the association and of the fund and to transition the association over time to a market of last resort so that it is no longer in competition with the private market. Specifically, the General Assembly does not intend that the South Carolina Joint Underwriting Association offer rates that are competitive to the private market.

HISTORY: 1987 Act No. 155, Section 1; 1988 Act No. 306, Section 2; 1993 Act No. 181, Section 830; 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

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."

Effect of Amendment

2019 Act No. 67, Section 1, rewrote the section, altering the membership of the association.

**SECTION 38‑79‑125.** Members to pay assessment equal to member's proportional share of accumulated deficit of the association.

(1) As of January 1, 2020, all insurers authorized to write on a direct basis bodily injury liability insurance, other than automobile bodily injury insurance, homeowners liability insurance, an insurer which insures only churches and their property, and farmowners liability insurance including monoline farm liability insurance, including insurers covering such peril in multiple peril package policies and bodily injury insurance, must pay an assessment equal to their proportional share of twenty percent of the accumulated deficit of the association as contained in their most recently reported financial statements as of June 30, 2019, as determined by the director. Each insurer's share of the assessment must be calculated based upon the net‑direct written premiums for the insurer's liability lines as identified in this subsection on the most recent year preceding the effective date of this section. All money collected from this assessment must be applied to the accumulated deficit of the association. Each insurer may pay the assessment in one lump sum or, at the insurer's option, in equal installments over a period not to exceed five years. The assessment may be incorporated into the rate filings of the insurer. Upon satisfaction of the assessment, each insurer may withdraw as members of the association upon submission of:

(a) an application for withdrawal in the format prescribed by the director or his designee;

(b) evidence that it has not written any medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, or any other type of professional liability insurance in this State covering the professional liability risks of licensed health care providers in the consecutive five years preceding the insurer's withdrawal application; and

(c) certification by the association and the director or his designee that all obligations to the association have been fully satisfied.

HISTORY: 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

**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 one million dollars for each claim under one policy and three million dollars for all claims under one policy in any one year; provided, however, that the association may offer higher limits per claim and for all claims under one policy in any one year only upon approval of the board of the association and with the written approval of the director;

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

(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; 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

Effect of Amendment

2019 Act No. 67, Section 1, in (1), substituted "one million dollars" for "two hundred thousand dollars", "three million dollars" for "six hundred thousand dollars", "higher limits per" for "policies up to one million dollars for each", "and for all claims" for "under one policy and three million dollars for all claims", and "approval of the director" for "concurrence of the Board of Governors of the South Carolina Patients' Compensation Fund"; and in (2), made a nonsubstantive change.

**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. The plan of operation must be amended within thirty days following the merger provided for in Section 38‑79‑300. The amended plan must address the orderly and expeditious winding down of the Patients' Compensation Fund.

(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. If there is no accumulated deficit, any profit achieved by the association must be added to the reserves of the association.

(3) The approved plan of operation may make provisions for combining insurers under common ownership or management into groups for voting, assessment, and all other purposes and may provide that no more than one of the officers or employees of a group may serve as a director at any one time.

(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; 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

Effect of Amendment

2019 Act No. 67, Section 1, in (1), added the second and third sentences; in (2), added the second sentence; and rewrote (3).

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

Any licensed health care provider 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; 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

Effect of Amendment

2019 Act No. 67, Section 1, in the first undesignated paragraph, in the first sentence, deleted "in a category in which the department has declared an emergency exists" following "Any licensed health care provider".

**SECTION 38‑79‑160.** Reserved.

HISTORY: Former Section, titled Statistical data and plan, had the following history: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830. Reserved by 2019 Act No. 67, Section 1, eff May 16, 2019.

**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; 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

Effect of Amendment

2019 Act No. 67, Section 1, reenacted the section with no apparent change.

**SECTION 38‑79‑180.** Submission of all policy forms, classifications, rates, rating plans, or rules for approval.

The association shall submit, for the approval of the director or his designee, all policy forms, classifications, rates, rating plans, or rules applicable to its insurance product offerings to customers in this State. Such filings must be submitted for approval to the director no less than sixty days prior to their intended effective date. The director may extend the time for his review by an additional sixty days to allow the department sufficient time to evaluate the proposed form, classification, rate, rating plan, or rule to be used by the association. Rates must be actuarially sound, self supporting, and may not be excessive, inadequate, or unfairly discriminatory.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830; 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

Effect of Amendment

2019 Act No. 67, Section 1, rewrote the section.

**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. After the accumulated deficit has been eliminated, the association must function as a residual market mechanism. After that time, the association may not offer rates competitive with the admitted market but the rates for policies issued by the association must be adequate and established at a level that permits the association to operate as a self‑sustaining mechanism.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830; 1997 Act No. 19, Section 1; 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

Effect of Amendment

2019 Act No. 67, Section 1, in (4), in the first sentence, deleted ", and must be calculated to be self‑supporting" following "severity of losses", and added the second and third sentences.

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

The association is authorized to provide a rate increase or assessment on policyholders 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; 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

Effect of Amendment

2019 Act No. 67, Section 1, inserted "on policyholders" following "rate increase or assessment".

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

Any future deficit must be recouped, pursuant to the plan of operation and the rating plan then in effect, by a rate increase applicable prospectively approved by the director or his designee pursuant to the provisions of Section 38‑79‑180.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830; 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

Effect of Amendment

2019 Act No. 67, Section 1, rewrote the section.

**SECTION 38‑79‑220.** Elimination of accumulated deficit; uniform assessment; surcharges.

(1) All members of the association, excluding companies who have withdrawn from the association pursuant to Section 38‑79‑125, must contribute to the elimination of the association's and fund's accumulated deficit. Beginning on January 1, 2020, a uniform assessment of not less than two percent and not more than six percent of the net‑direct written premium must be assessed against each member of the association in order to eliminate the accumulated deficits of the association and the fund. Association members must be notified of the assessment at least sixty days prior to each year end. After each quarter during the year following notification of the assessment, each member of the association must remit an amount equal to the assessment percentage of the previous quarter's direct written premiums. Monies derived from this assessment and collected must be distributed by the association to the accumulated deficits of the association and fund as determined appropriate by the director. Every member must directly recover from each policyholder one percent of the assessment and is authorized to recoup up to the remaining amount if they so choose. Amounts recouped under this section are not premium and are not subject to premium taxes, fees, or commissions. If one deficit is eliminated before the other, all subsequent monies collected must be distributed to the remaining deficit until it is eliminated. Assessments must cease when both accumulated deficits have been fully eliminated or on December 31, 2035, or whichever occurs first. Funds received by the association under this section will not be considered revenue or considered part of their operating income and will only be used to reduce the accumulated deficit.

(2) Beginning on January 1, 2020, a surcharge on premium shall be assessed on association policyholders equal to the assessment percentage amount on members in any given year pursuant to the provisions of Section 38‑79‑220. Association policyholders will be notified of the surcharge percentage at least sixty days prior to each year end. Surcharges levied under this section are not premiums and are not subject to premium tax, any fees, or any commissions. Monies derived from this assessment and collected under this section must be distributed by the association to the accumulated deficits of the association and fund as determined appropriate by the director. Should one deficit be eliminated before the other deficit, all subsequent monies collected shall be distributed to the remaining deficit until it is eliminated. This surcharge shall cease when the accumulated deficits of both the association and the fund have been fully eliminated or on December 31, 2035, whichever occurs first. Funds received by the association under this section will not be considered revenue or considered part of their operating income and will only be used to reduce the accumulated deficit.

(3) Each member shall remit to the association payment in full of its assessed amount under this section within thirty days of the end of each quarter. If a member fails to remit its assessed amount by the deadline, the association shall report the failure to the director or designee who may immediately take action to suspend or revoke such insurer's certificate of authority to transact the business of insurance in the State of South Carolina or issue a fine on that member until such time as the association certifies to the director or his designee that such assessment has been paid in full. The issuance of a fine, suspension, or revocation of an insurer's certificate of authority to transact business in the State of South Carolina shall not affect the right of the association to proceed against such insurer in any court for any remedy provided by law or contract to the association, including the right to collect such insurer's assessment. In addition to any other remedy, the association may offset assessments due from an insurer against any amounts in any account of such delinquent insurer. By mailing payment of its allocated amount of assessment, as provided herein, a member shall not waive any right it may have to contest the computation of its allocated amount of assessment. Such contest shall not, however, toll the time within which assessments must be paid or the report to be made to the director or his designee or affect or impede any action to be taken by the director or his designee upon receipt of such report.

(4) Beginning January 1, 2020, all surplus lines insurance producers or brokers placing insurance through nonadmitted insurers shall collect from the insured and remit to the department to be distributed to the association and fund a nonadmitted policy surcharge on all premiums for all insurance written by such surplus lines insurance producer or broker for a policy from a nonadmitted insurer for any and all medical malpractice risks in this State. By procuring or selling medical malpractice insurance in this State from a nonadmitted insurer, each surplus lines insurance producer or broker placing insurance through a nonadmitted insurer agrees to be bound by the provisions of this chapter and to collect and remit the nonadmitted policy surcharge provided for herein.

(a) The nonadmitted policy surcharge must be a percentage of the total policy premium, but the nonadmitted policy surcharge shall not be considered premium and is not subject to premium taxes or commissions. However, failure to pay the nonadmitted policy surcharge must be treated the same as failure to pay premium. "Total policy premium" includes taxes and commissions.

(b) The nonadmitted policy surcharge percentage must be the same percentage as the assessment that has been approved by the board and director as applied to the insurers writing medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, or any other type of professional liability insurance in this State covering the professional liability risks of licensed health care providers as described in Section 38‑79‑220.

(5) Within thirty days of the end of the quarter, surplus lines insurance producers or brokers placing insurance through nonadmitted insurers shall remit to the department all nonadmitted policy surcharges collected in the preceding quarter. Surplus lines insurance producers or brokers placing insurance through nonadmitted insurers may designate another surplus lines insurance producer or broker that actually procured the insurance from the nonadmitted carrier to collect and remit the nonadmitted policy surcharges.

(6) Each insured in this State who directly procures or renews insurance with a nonadmitted insurer on medical malpractice insurance other than insurance procured through a surplus lines licensee, must be subject to the nonadmitted policy surcharge which must be paid by the insured according to the procedures provided for premium taxes in Chapter 45 of this title.

Monies derived from the nonadmitted policy surcharge collected under this section must exclusively be used to reduce the accumulated deficits of the association and fund by equal amounts unless the director or his designee determines that different proportions are appropriate. Once the accumulated deficit of the association or the fund is eliminated, whichever occurs first, all subsequent monies collected through the assessment shall exclusively be used to reduce the remaining deficit until it has also been eliminated. The nonadmitted policy surcharge must continue until the surcharge provided in subsection (1) is eliminated.

(7) The accumulated deficits of the association and the fund have accrued and persisted over a period of decades and being partially attributable to state agencies or institutions or their employees, until the director determines that the accumulated deficits of the association and the fund have been eliminated, he may receive appropriations that are explicitly provided for purposes of reducing the accumulated deficits of the association and fund.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830; 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

Effect of Amendment

2019 Act No. 67, Section 1, rewrote the section.

**SECTION 38‑79‑230.** Additional surcharge on premium; annual increase.

Beginning on January 1, 2021, an additional one percent surcharge on the premium must be assessed on association policyholders. The premium surcharge must increase by one additional percentage point annually until it reaches ten percent and does not sunset. Surcharges levied under this section are not premium and therefore not subject to premium taxes, fees, or commissions. Surcharges may not be considered when evaluating whether rates are excessive, adequate, or unfairly discriminatory.

HISTORY: 1987 Act No. 155, Section 1; 1989 Act No. 129, Section 1; 1993 Act No. 181, Section 830; 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

Effect of Amendment

2019 Act No. 67, Section 1, rewrote the section.

**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, including any amendments made, 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; 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

Effect of Amendment

2019 Act No. 67, Section 1, substituted "association" for "Association" in three places, and inserted ", including any amendments made,".

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

(1) If any member insurer ceases writing business in this State, voluntarily or involuntarily, or by order or authority of the director, the insurer shall continue to be a member of the association until all of its obligations have been satisfied and the director has certified the satisfaction to the association's board.

(2) If a member insurer merges into, acquires, or consolidates with another insurer transacting business subject to this article or if any other insurer or entity has reinsured or assumed a member insurer's entire liability business in this State, the surviving insurer, acquiring insurer, its legal successor, or its assuming reinsurer nonetheless remains liable for the member 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 on 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; 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

Effect of Amendment

2019 Act No. 67, Section 1, rewrote (1) and (2), and made a nonsubstantive change in (3).

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

(1) The provisions of this section only apply until January 1, 2020.

(2) 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; 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

Effect of Amendment

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

2019 Act No. 67, Section 1, inserted (1), and inserted the (2) identifier.

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

The association shall file a financial statement with the department by March first of each year detailing its transactions, financial condition, operations, and affairs during the previous calendar year. In addition, the director may require the association to file quarterly financial statements with the department on the fifteenth of May, August, and November of each year. The statement shall contain such matters and information as are prescribed by the director or his designee and must be prepared in the format the director prescribes. The director or his designee may 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; 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

Effect of Amendment

2019 Act No. 67, Section 1, rewrote the first sentence, inserted the second sentence, in the third sentence, substituted "must be prepared in the format the director prescribes" for "must be in the form he directs", and in the fourth sentence, deleted ", or at any reasonable time," following "or his designee may".

**SECTION 38‑79‑290.** Examination of association; audit in lieu of examination.

The director or his designee shall conduct 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. The director or his designee may accept an audit of the association performed by a qualified public accounting firm in lieu of conducting his own examination.

HISTORY: 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 830; 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

Effect of Amendment

2019 Act No. 67, Section 1, in the first sentence, substituted "shall conduct" for "shall make", and added the third sentence.

**SECTION 38‑79‑300.** Merger of Patients' Compensation Fund into South Carolina Medical Malpractice Association; obligations and responsibilities; accumulated deficits; Board of Directors.

(A) Effective on January 1, 2020, the Patients' Compensation Fund provided for in Article 5 of this chapter shall merge into the South Carolina Medical Malpractice Association as created by this article. The surviving entity is the Joint Underwriting Association and referred to herein as the South Carolina Medical Malpractice Association. The South Carolina Medical Malpractice Association shall assume all obligations and responsibilities of the Patients' Compensation Fund, while retaining all obligations and responsibilities of the Joint Underwriting Association. However, the accumulated deficits of the former Joint Underwriting Association and the Patients' Compensation Fund must be separately accounted for until such time as the director determines each of them is fully eliminated.

(B) On January 1, 2020, the Board of the Patients' Compensation Fund shall, with oversight of the Department of Insurance, exercise due diligence in providing for the orderly and expeditious winding down of the Patients' Compensation Fund. All outstanding affairs and existing contractual obligations of the Patients' Compensation Fund shall contemporaneously become the responsibility of the South Carolina Medical Malpractice Association on January 1, 2020. After January 1, 2020, the Patients' Compensation Fund shall cease to exist except as required by law for purposes of winding down its affairs.

(C) The Board of Directors of the South Carolina Medical Malpractice Association must:

(1) be appointed on or before January 1, 2020, and is authorized to enter into contracts for the management of the South Carolina Joint Underwriting Association in accordance with governing law;

(2) have the right to attend any regular or special meeting of the Board of Directors of the Joint Underwriting Association or the Board of Governors of the Patients' Compensation Fund, but shall have no vote at these meetings;

(3) replace the existing Board of the Joint Underwriting Association as provided for in Section 38‑79‑260;

(4) consist of eleven members all appointed by the Governor, as follows:

(a) four medical providers after consultation with the South Carolina Medical Association, the South Carolina Hospital Association, the South Carolina Nurses Association, and the South Carolina Dental Association;

(b) four representatives from the medical malpractice insurance industry representing member companies of the association after consultation with the three largest members;

(c) two consumer representatives;

(d) one independent insurance agent or broker not affiliated with one of the three medical malpractice insurance companies already represented on the board; and

(e) the Director of the Department of Insurance, who serves ex‑officio and does not have any voting privileges.

(5) elect other necessary officers for two‑year terms after the accumulated deficits of the South Carolina Joint Underwriting Association and the Patients' Compensation Fund are eliminated. The director or his designee shall serve as chairman of the board.

(D) Upon consultation with and consent of the director, the Board of the South Carolina Medical Malpractice Association:

(1) must select a person or firm for the administration and management of the South Carolina Joint Underwriting Association using a competitive bidding process;

(2) is responsible for the negotiation of the administrator's contract including, without limitation, compensation, fees, and the length of the contract; and

(3) shall have the authority to terminate or retain the administrator.

(E) Each member of the Board of the South Carolina Medical Malpractice Association shall serve a term of four years; however, any board member may be reappointed for up to two additional four‑year terms. The professional associations listed and the insurance industry may nominate qualified individuals to the Governor for his consideration. The Governor also may receive nominations for appointments to the board from any other individual, group, or association. The South Carolina Medical Malpractice Association and director must publicize all board vacancies to the general public. A vacancy must be filled for the unexpired portion of the term only. The Board of the South Carolina Medical Malpractice Association 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. Any board members of the Joint Underwriting Association or the Patients' Compensation Fund serving at the time of this enactment may be reappointed by the Governor to the Board of the South Carolina Joint Underwriting Association. The prior service of a board member on the Board of the Joint Underwriting Association or Patients' Compensation Fund does not count toward the term limits on members of the Board of the South Carolina Medical Malpractice Association.

(F) Each member of the Board of the South Carolina Medical Malpractice Association has a fiduciary relationship to the organization and must discharge his duties accordingly.

HISTORY: 2019 Act No. 67 (H.3760), Section 1, eff May 16, 2019.

ARTICLE 5

Patients' Compensation Fund for Benefit of Licensed Health Care Providers

Repeal

ARTICLE repealed upon the merger of the Patients' Compensation Fund for benefit of licensed health care providers into the South Carolina Joint Underwriting Association as provided for in Section 38‑79‑300 on January 1, 2020.

**SECTION 38‑79‑400.** Repeal of article.

This article must be repealed upon the merger of the Patients' Compensation Fund for benefit of licensed health care providers into the South Carolina Joint Underwriting Association as provided for in Section 38‑79‑300 on January 1, 2020.

HISTORY: 2019 Act No. 67 (H.3760), Section 2, eff May 16, 2019.

**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.