

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2003

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SENATE BILL 802
Select Committee on Insurance and Civil Justice Reform Committee Substitute
Adopted 9/15/03

Short Title: Med. Provider Ins./Civil Justice Reform Act. (Public)

Sponsors:

Referred to:

April 3, 2003

1 A BILL TO BE ENTITLED
2 AN ACT TO REFORM THE LAWS RELATED TO MEDICAL PROVIDERS'
3 INSURANCE AND CIVIL JUSTICE ISSUES, AS RECOMMENDED BY THE
4 SENATE SELECT COMMITTEE ON INSURANCE AND CIVIL JUSTICE
5 REFORM.

6 The General Assembly of North Carolina enacts:

7
8 **PART I. MEASURES TO IMPROVE THE QUALITY OF PATIENT CARE,**
9 **PROTECT PATIENT-PHYSICIAN RELATIONSHIPS, AND STRENGTHEN**
10 **DISCIPLINARY PROCEDURES.**

11 SECTION 1.1. G.S. 131E-101 is amended by adding a new subdivision to
12 read:

13 "(8) "Quality assurance committee" means a committee, agency, or
14 department of a State or local professional organization, of a medical
15 staff of a licensed hospital, nursing home, of nurses or aides on the
16 staff of a nursing home, or adult care home, of physicians having
17 privileges within the nursing home, or adult care home, or of a peer
18 review corporation or organization that is formed for the purpose of
19 evaluating the quality, cost of, or necessity for health care services
20 under applicable federal and State statutes, regulations, and rules."

21 SECTION 1.2. G.S. 131E-107 reads as rewritten:

22 "§ 131E-107. **Medical-Quality assurance, medical, or peer review committees.**

23 (a) A member of a duly appointed ~~medical~~ quality assurance, medical or peer
24 review committee shall not be subject to liability for damages in any civil action on
25 account of any act, statement or proceeding undertaken, made, or performed within the
26 scope of the functions of the committee, if the committee member acts without malice
27 or fraud, and if such peer review committee is approved and operates in accordance
28 with G.S. 131E-108.

1 (b) The proceedings of a quality assurance, medical, or peer review committee,
2 the records and materials it produces, and the materials prepared for the committee or
3 considered by the committee shall be confidential wherever located, shall not be
4 considered public records within the meaning of G.S. 132-1, and shall not be subject to
5 discovery or introduction into evidence in any civil action against a nursing home or a
6 provider or professional health services that results from matters that are the subject of
7 evaluation and review by the committee. No person who was in attendance at a meeting
8 of the committee shall be required to testify in any civil action as to any evidence or
9 other matters produced or presented during the proceedings of the committee or as to
10 any findings, recommendations, evaluations, opinions, or other actions of the committee
11 or its members. However, information, documents, or records otherwise available are
12 not immune from discovery or use in a civil action merely because they were presented
13 during proceedings of the committee. A member of the committee or a person who
14 testifies before the committee may testify in a civil action but cannot be asked about the
15 person's testimony before the committee or any opinions formed as a result of the
16 committee hearings."

17 **SECTION 1.3.** G.S. 131E-76(5) reads as rewritten:

18 "(5) "Medical review committee" means ~~a committee of a State or local~~
19 ~~professional society, of a medical staff of a licensed hospital or a~~
20 ~~committee of a peer review corporation or organization which is~~ any
21 of the following committees formed for the purpose of evaluating the
22 quality, cost of, or necessity for hospitalization or health care,
23 including medical staff ~~credentialing~~ credentialing:

24 a. A committee of a State or local professional society.

25 b. A committee of a medical staff of a hospital.

26 c. A committee of a hospital or hospital system, if created by the
27 governing board or medical staff of the hospital or system or
28 operating under written procedures adopted by the governing
29 board or medical staff of the hospital or system.

30 d. A committee of a peer review corporation or organization."

31 **SECTION 1.4.** G.S. 131E-95 reads as rewritten:

32 "**§ 131E-95. Medical review committee.**

33 (a) A member of a duly appointed medical review committee who acts without
34 malice or fraud shall not be subject to liability for damages in any civil action on
35 account of any act, statement or proceeding undertaken, made, or performed within the
36 scope of the functions of the committee.

37 (b) The proceedings of a medical review committee, the records and materials it
38 produces and the materials it considers shall be confidential and not considered public
39 records within the meaning of G.S. 132-1, " 'Public records' defined", and shall not be
40 subject to discovery or introduction into evidence in any civil action against a hospital,
41 an ambulatory surgical facility licensed under Chapter 131E of the General Statutes, or
42 a provider of professional health services which results from matters which are the
43 subject of evaluation and review by the committee. No person who was in attendance at
44 a meeting of the committee shall be required to testify in any civil action as to any

1 evidence or other matters produced or presented during the proceedings of the
2 committee or as to any findings, recommendations, evaluations, opinions, or other
3 actions of the committee or its members. Proceedings, records and materials produced
4 or considered by a medical review committee relating to (i) a root cause analysis or
5 other analyses of systemic performance issues in the delivery of health care, (ii)
6 self-assessment of health care quality, (iii) preventative, corrective, or remedial actions
7 considered or taken to address quality issues, and (iv) incident reports used for quality
8 assurance or risk management purposes, are confidential and not subject to discovery or
9 use in a civil action. However, information, documents, or records otherwise available
10 are not immune from discovery or use in a civil action merely because they were
11 presented during proceedings of the committee. A member of the committee or a person
12 who testifies before the committee may testify in a civil action but cannot be asked
13 about ~~his~~ the person's testimony before the committee or any opinions formed as a result
14 of the committee hearings.

15 (c) Information that is confidential and is not subject to discovery or use in civil
16 actions under ~~subsection (b) of this section~~ may be released to a professional standards
17 review organization that performs any accreditation or certification ~~function including~~
18 the Joint Commission on Accreditation of Healthcare Organizations. Information
19 released under this ~~subdivision-subsection~~ shall be limited to that which is reasonably
20 necessary and relevant to the standards review organization's determination to grant or
21 continue accreditation or certification. Information released under this ~~subdivision~~
22 subsection retains its confidentiality and is not subject to discovery or use in any civil
23 actions as provided under ~~subsection (b) of this section~~, and the standards review
24 organization shall keep the information confidential subject to ~~that subsection~~. this
25 section."

26 **SECTION 1.5.** G.S. 90-21.22A reads as rewritten:

27 **"§ 90-21.22A. Medical review and quality assurance committees.**

28 (a) As used in this section, the following terms mean:

29 (1) ~~"medical-Medical review committee"~~ committee. – A ~~means~~—a
30 committee composed of health care providers licensed under this
31 Chapter that is formed for the purpose of evaluating the quality of, cost
32 of, or necessity for health care services, including provider
33 credentialing. "Medical review committee" does not mean a medical
34 review committee established under G.S. 131E-95.

35 (2) "Quality assurance committee." – Risk management employees of an
36 insurer licensed to write medical professional liability insurance in this
37 State, who work in collaboration with health care providers licensed
38 under this Chapter, and insured by that insurer, to evaluate and
39 improve the quality of health care services.

40 (b) A member of a duly appointed medical review or quality assurance
41 committee who acts without malice or fraud shall not be subject to liability for damages
42 in any civil action on account of any act, statement, or proceeding undertaken, made, or
43 performed within the scope of the functions of the committee.

1 (c) The proceedings of a medical review or quality assurance committee, the
2 records and materials it produces, and the materials it considers shall be confidential and
3 not considered public records within the meaning of G.S. 132-1, 131E-309, or 58-2-100;
4 and shall not be subject to discovery or introduction into evidence in any civil action
5 against a provider of health care services who directly provides services and is licensed
6 under this Chapter, a PSO licensed under Article 17 of Chapter 131E of the General
7 Statutes, an ambulatory surgical facility licensed under Chapter 131E of the General
8 Statutes, or a hospital licensed under Chapter 122C or Chapter 131E of the General
9 Statutes or that is owned or operated by the State, which civil action results from
10 matters that are the subject of evaluation and review by the committee. Proceedings,
11 records, and materials produced or considered by a medical review or quality assurance
12 committee relating to (i) a root cause analysis or other analyses of systemic performance
13 issues in the delivery of health care, (ii) self-assessment of health care quality, (iii)
14 preventative, corrective, or remedial actions considered or taken to address quality
15 issues, and (iv) incident reports used for quality assurance or risk management purposes,
16 are confidential and not subject to discovery or use in a civil action. No person who was
17 in attendance at a meeting of the committee shall be required to testify in any civil
18 action as to any evidence or other matters produced or presented during the proceedings
19 of the committee or as to any findings, recommendations, evaluations, opinions, or other
20 actions of the committee or its members. However, information, documents, or records
21 otherwise available are not immune from discovery or use in a civil action merely
22 because they were presented during proceedings of the committee. A member of the
23 committee may testify in a civil action but cannot be asked about his or her testimony
24 before the committee or any opinions formed as a result of the committee hearings.

25 (d) This section applies to a medical review committee, including a medical
26 review committee appointed by one of the entities licensed under Articles 1 through 67
27 of Chapter 58 of the General Statutes.

28 (e) Subsection (c) of this section does not apply to proceedings initiated under
29 G.S. 58-50-61 or G.S. 58-50-62."

30 **SECTION 1.6.** G.S. 122C-191(e) reads as rewritten:

31 "(e) For purposes of peer review functions only:

32 (1) A member of a duly appointed quality assurance committee who acts
33 without malice or fraud shall not be subject to liability for damages in
34 any civil action on account of any act, statement, or proceeding
35 undertaken, made, or performed within the scope of the functions of
36 the committee.

37 (2) The proceedings of a quality assurance committee, the records and
38 materials it produces, and the material it considers shall be confidential
39 and not considered public records within the meaning of G.S. 132-1,
40 "Public records' defined," and shall not be subject to discovery or
41 introduction into evidence in any civil action against a facility or a
42 provider of professional health services that results from matters which
43 are the subject of evaluation and review by the committee.
44 Proceedings, records, and materials produced or considered by a

1 quality assurance committee relating to (i) a root cause analysis or
2 other analyses of systemic performance issues in the delivery of health
3 care, (ii) self-assessment of health care quality, (iii) preventative,
4 corrective, or remedial actions considered or taken to address quality
5 issues, and (iv) incident reports used for quality assurance or risk
6 management purposes, are confidential and not subject to discovery or
7 use in a civil action. No person who was in attendance at a meeting of
8 the committee shall be required to testify in any civil action as to any
9 evidence or other matters produced or presented during the
10 proceedings of the committee or as to any findings, recommendations,
11 evaluations, opinions, or other actions of the committee or its
12 members. However, information, documents or records otherwise
13 available are not immune from discovery or use in a civil action
14 merely because they were presented during proceedings of the
15 committee, and nothing herein shall prevent a provider of professional
16 health services from using such otherwise available information,
17 documents or records in connection with an administrative hearing or
18 civil suit relating to the medical staff membership, clinical privileges
19 or employment of the provider. A member of the committee or a
20 person who testifies before the committee may be subpoenaed and be
21 required to testify in a civil action as to events of which the person has
22 knowledge independent of the peer review process, but cannot be
23 asked about his testimony before the committee for impeachment or
24 other purposes or about any opinions formed as a result of the
25 committee hearings.

- 26 (3) Peer review information that is confidential and is not subject to
27 discovery or use in civil actions under ~~subdivision (2) of this~~
28 ~~subsection~~this section may be released to a professional standards
29 review organization that contracts with an agency of this State or the
30 federal government to perform any accreditation or certification
31 ~~function~~function, including the Joint Commission on Accreditation of
32 Healthcare Organizations. Information released under this subdivision
33 shall be limited to that which is reasonably necessary and relevant to
34 the standards review organization's determination to grant or continue
35 accreditation or certification. Information released under this
36 subdivision retains its confidentiality and is not subject to discovery or
37 use in any civil actions as provided under ~~subdivision (2) of this~~
38 ~~subsection~~this subsection, and the standards review organization shall
39 keep the information confidential subject to ~~that subdivision~~this
40 section."

41 **SECTION 1.7.** G.S. 122C-30 reads as rewritten:

42 **"§ 122C-30. Peer review committee; immunity from liability; confidentiality.**

43 For purposes of peer review functions of a ~~hospital~~facility licensed under the
44 provisions of this Chapter:

- 1 (1) A member of a duly appointed peer review committee or quality
2 review committee who acts without malice or fraud shall not be
3 subject to liability for damages in any civil action on account of any
4 act, statement, or proceeding undertaken, made, or performed within
5 the scope of the functions of the committee; and
- 6 (2) Proceedings of a peer review or quality review committee, the records
7 and materials it produces, and the material it considers shall be
8 confidential and not considered public records within the meaning of
9 G.S. 132-1, "Public records' defined," and shall not be subject to
10 discovery or introduction into evidence in any civil action against a
11 facility or a provider of professional health services that results from
12 matters which are the subject of evaluation and review by the
13 committee. Proceedings, records, and materials produced or
14 considered by a peer review or quality review committee relating to (i)
15 a root cause analysis or other analyses of systemic performance issues
16 in the delivery of health care, (ii) self-assessment of health care
17 quality, (iii) preventative, corrective, or remedial actions considered or
18 taken to address quality issues, and (iv) incident reports used for
19 quality assurance or risk management purposes, are confidential and
20 not subject to discovery or use in a civil action. No person who was in
21 attendance at a meeting of the committee shall be required to testify in
22 any civil action as to any evidence or other matters produced or
23 presented during the proceedings of the committee or as to any
24 findings, recommendations, evaluations, opinions, or other actions of
25 the committee or its members. However, information, documents or
26 records otherwise available are not immune from discovery or use in a
27 civil action merely because they were presented during proceedings of
28 the committee, and nothing herein shall prevent a provider of
29 professional health services from using such otherwise available
30 information, documents or records in connection with an
31 administrative hearing or civil suit relating to the medical staff
32 membership, clinical privileges or employment of the provider. A
33 member of the committee or a person who testifies before the
34 committee may be subpoenaed and be required to testify in a civil
35 action as to events of which the person has knowledge independent of
36 the peer review or quality review process, but cannot be asked about
37 his-~~the~~ person's testimony before the committee for impeachment or
38 other purposes or about any opinions formed as a result of the
39 committee hearings."

40 **SECTION 1.8.** Article 4 of Chapter 8C of the General Statutes is amended
41 by adding a new section to read:

42 **"Rule 413. Medical actions; statements to ameliorate or mitigate adverse outcome.**

43 Statements by a health care provider apologizing for an adverse outcome in medical
44 treatment, offers to undertake corrective or remedial treatment or actions, and gratuitous

1 acts to assist affected persons shall not be admissible to prove negligence or culpable
2 conduct by the health care provider in an action brought under Article 1B of Chapter 90
3 of the General Statutes."

4 **SECTION 1.9.** Article 1B of Chapter 90 of the General Statutes is amended
5 by adding a new section to read:

6 **"§ 90-21.12D. Reports of attorney misconduct in medical malpractice actions.**

7 (a) If a trial court dismisses an action for noncompliance with G.S. 1A-1, Rule
8 9(j) or imposes sanctions pursuant to G.S. 1A-1, Rule 11, against an attorney in a
9 medical malpractice action, the court shall report the dismissal or imposition of the
10 sanctions and the name of the attorney whose action is dismissed or who is sanctioned,
11 together with a copy of the order dismissing the action or imposing sanctions, to the
12 State Bar within 30 days of the dismissal or imposition of the sanctions.

13 (b) Within 90 days of receiving a third or subsequent report pursuant to
14 subsection (a) of this section, the State Bar shall conduct an investigation to determine
15 whether disciplinary action or other remedial measures against the attorney are
16 warranted. The State Bar shall publish the results of its investigation conducted pursuant
17 to this subsection.

18 (c) On or before January 31 of each year, the State Bar shall submit a report to
19 the General Assembly describing the State Bar's response in the preceding calendar year
20 to reports of attorneys with a history of multiple violations reported pursuant to this
21 section."

22 **SECTION 1.10.** G.S. 90-14.13 reads as rewritten:

23 **"§ 90-14.13. Reports of disciplinary action by health care institutions; immunity**
24 **from liability.**

25 (a) The chief administrative officer of every licensed hospital or other health care
26 institution, including Health Maintenance Organizations, as defined in G.S. 58-67-5,
27 preferred providers, as defined in G.S. 58-50-56, and all other provider organizations
28 that issue credentials to physicians who practice medicine in the State, shall, after
29 consultation with the chief of staff of that institution, report to the Board any revocation,
30 suspension, or limitation of a physician's privileges to practice in that institution. A
31 hospital is not required to report the suspension of a physician's privileges for failure to
32 timely complete medical records unless the suspension is the third within the calendar
33 year for failure to timely complete medical records. Upon reporting the third
34 suspension, the hospital shall also report the previous two suspensions. The institution
35 shall also report to the Board resignations from practice in that institution by persons
36 licensed under this Article. The Board shall report all violations of this subsection
37 known to it to the licensing agency for the institution involved.

38 (b) Any licensed physician who does not possess professional liability insurance
39 shall report to the Board any award of damages or any settlement of any malpractice
40 complaint affecting his or her practice within 30 days of the award or settlement.

41 (c) The chief administrative officer of each insurance company providing
42 professional liability insurance for physicians who practice medicine in North Carolina,
43 the administrative officer of the Liability Insurance Trust Fund Council created by G.S.
44 116-220, ~~and~~ the administrative officer of any trust fund operated by a hospital

1 authority, group, or ~~provider~~ provider, and the Board of Directors of the North Carolina
2 Health Care Excess Liability Fund created by G.S. 90-684, shall report to the Board
3 within 30 days:

4 (1) Any award of damages or settlement affecting or involving a physician
5 it insures, or

6 (2) Any cancellation or nonrenewal of its professional liability coverage of
7 a physician, if the cancellation or nonrenewal was for cause.

8 (d) The Board may request details about any action and the officers shall
9 promptly furnish the requested information. The reports required by this section are
10 privileged and shall not be open to the ~~public~~ public, except as provided in this section.
11 The Board shall report all violations of this paragraph to the Commissioner of
12 Insurance.

13 (e) The Board shall review all reports filed under this section and shall keep a
14 cumulative total of all reports by individual physicians. Within 90 days of determining
15 that a physician has three or more reports under this section affecting or involving the
16 physician, the Board shall conduct an investigation to determine whether disciplinary
17 sanctions or other remedial measures against the physician are warranted. The Board
18 shall publish the results of its investigation. On or before January 31 of each year, the
19 Board shall submit a report to the General Assembly describing the Board's response in
20 the preceding calendar year to reports of physicians with a history of multiple awards of
21 damages and settlements under this subsection.

22 (f) Any person making a report required by this section shall be immune from
23 any criminal prosecution or civil liability resulting therefrom unless such person knew
24 the report was false or acted in reckless disregard of whether the report was false."

25 **SECTION 1.11.** G.S. 90-21.14 is amended by adding a new subsection to
26 read:

27 "(b1) If, because of the limit of liability in this section, an action is dismissed or the
28 person against whom an action is brought is found not to be liable, the court shall, upon
29 motion of the defendant, impose appropriate monetary sanctions against the plaintiff's
30 attorney under Rule 11 of the Rules of Civil Procedure, including court costs and
31 attorneys' fees related to defending the action."

32 33 **PART II. LITIGATION REFORMS.**

34 **Subpart A. Changes to Definition of Medical Malpractice Action and** 35 **Standard of Care.**

36
37 **SECTION 2.1.** Article 1B of Chapter 90 of the General Statutes is amended
38 by adding the following new section to read:

39 **§ 90-21.18A. Medical directors; liability limitation.**

40 A medical director of a licensed nursing home shall not be named a defendant in an
41 action pursuant to this Article except under any of the following circumstances:

42 (1) Where allegations involve a patient under the direct care of the
43 medical director.

1 (2) Where allegations involve willful or intentional misconduct,
2 recklessness, or gross negligence in connection with the failure to
3 supervise, or other acts performed or failed to be performed, by the
4 medical director in a supervisory or consulting role."

5 **SECTION 2.2.** Article 1B of Chapter 90 of the General Statutes is amended
6 by adding the following new section to read:

7 **"§ 90-21.12B. Nonprofessional negligence actions.**

8 Civil actions for damages for personal injury or death arising out of the furnishing or
9 failure to furnish patient care services other than professional services by a health care
10 provider in conjunction with the performance of medical, dental, or other health care by
11 a health care provider shall be brought in accordance with the provisions of G.S.
12 90-21.11, 90-21.12A, 90-21.12C, 90-21.12D, 90-21.18A, and 90-21.18B, but shall not
13 be subject to the requirements of G.S. 1A-1, Rule 9(j)."

14
15 **Subpart B. Civil Procedural Changes.**

16
17 **SECTION 2.3.** G.S. 1-289 reads as rewritten:

18 **"§ 1-289. Undertaking to stay execution on money judgment.**

19 (a) If the appeal is from a judgment directing the payment of money, it does not
20 stay the execution of the judgment unless a written undertaking is executed on the part
21 of the appellant, by one or more sureties, as set forth in this section.

22 (a1) In an action where the judgment directs the payment of money, the court shall
23 specify the amount of the undertaking required to stay execution of the judgment
24 pending appeal as provided in subsections (a2) and (b) of this section. The undertaking
25 shall be to the effect that if the judgment appealed from, or any part thereof, is affirmed,
26 or the appeal is dismissed, the appellant will pay the amount directed to be paid by the
27 judgment, or the part of such amount as to which the judgment shall be affirmed, if
28 affirmed only in part, and all damages which shall be awarded against the appellant
29 upon the appeal, except as provided in subsection (b) of this section. Whenever it is
30 satisfactorily made to appear to the court that since the execution of the undertaking the
31 sureties have become insolvent, the court may, by rule or order, require the appellant to
32 execute, file and serve a new undertaking, as above. In case of neglect to execute such
33 undertaking within twenty days after the service of a copy of the rule or order requiring
34 it, the appeal may, on motion to the court, be dismissed with costs. Whenever it is
35 necessary for a party to an action or proceeding to give a bond or an undertaking with
36 surety or sureties, he may, in lieu thereof, deposit with the officer into court money to
37 the amount of the bond or undertaking to be given. The court in which the action or
38 proceeding is pending may direct what disposition shall be made of such money
39 pending the action or proceeding. In a case where, by this section, the money is to be
40 deposited with an officer, a judge of the court, upon the application of either party, may,
41 at any time before the deposit is made, order the money deposited in court instead of
42 with the officer; and a deposit made pursuant to such order is of the same effect as if
43 made with the officer. The perfecting of an appeal by giving the undertaking mentioned
44 in this section stays proceedings in the court below upon the judgment appealed from;

1 except when the sale of perishable property is directed, the court below may order the
2 property to be sold and the proceeds thereof to be deposited or invested, to abide the
3 judgment of the appellate court.

4 (a2) Except as provided in subsection (b) of this section, the amount of the
5 undertaking that shall be required by the court shall be an amount determined by the
6 court after notice and hearing proper and reasonable for the security of the rights of the
7 adverse party, considering relevant factors including the following:

8 (1) The amount of the judgment.

9 (2) The amount of the limits of all applicable liability policies of the
10 appellant judgment debtor.

11 (3) The aggregate net worth of the appellant judgment debtor.

12 (b) If the appellee in a civil action brought under any legal theory obtains a
13 judgment directing the payment or expenditure of money in the amount of twenty five
14 million dollars (\$25,000,000) or more, and the appellant seeks a stay of execution of the
15 judgment within the period of time during which the appellant has the right to pursue
16 appellate review, including discretionary review and certiorari, the amount of the
17 undertaking that the appellant is required to execute to stay execution of the judgment
18 during the entire period of the appeal shall be twenty five million dollars (\$25,000,000).

19 (c) If the appellee proves by a preponderance of the evidence that the appellant
20 for whom the undertaking has been limited under ~~subsection~~ subsections (a2) and (b)
21 of this section is, for the purpose of evading the judgment, (i) dissipating its assets, (ii)
22 secreting its assets, or (iii) diverting its assets outside the jurisdiction of the courts of
23 North Carolina or the federal courts of the United States other than in the ordinary
24 course of business, then the ~~limitation~~ limitations in ~~subsection~~ subsections (a2) and (b)
25 of this section shall not apply and the appellant shall be required to make an undertaking
26 in the full amount otherwise required by this section."

27 **SECTION 2.4.** G.S. 1A-1, Rule 9(j) reads as rewritten:

28 "(j) Medical malpractice. – Any complaint alleging medical malpractice by a
29 health care provider as defined in G.S. 90-21.11 in failing to comply with the applicable
30 standard of care under G.S. 90-21.12 shall be dismissed unless:

31 (1) The pleading specifically asserts that the medical care ~~has~~ and all
32 medical records pertaining to the alleged injury then available to the
33 plaintiff after reasonable inquiry, have been reviewed by a person who
34 is reasonably expected to qualify as an expert witness under Rule 702
35 of the Rules of Evidence and who is willing to testify that the medical
36 care did not comply with the applicable standard of care;

37 (2) The pleading specifically asserts that the medical care ~~has~~ and all
38 medical records pertaining to the alleged injury then available to the
39 plaintiff after reasonable inquiry, have been reviewed by a person that
40 the complainant will seek to have qualified as an expert witness by
41 motion under Rule 702(e) of the Rules of Evidence and who is willing
42 to testify that the medical care did not comply with the applicable
43 standard of care, and the motion is filed with the complaint; or

1 (3) The pleading alleges facts establishing negligence under the existing
2 common-law doctrine of res ipsa loquitur.

3 Upon motion by the complainant prior to the expiration of the applicable statute of
4 limitations, a resident judge of the superior court for a judicial district in which venue
5 for the cause of action is appropriate under G.S. 1-82 or, if no resident judge for that
6 judicial district is physically present in that judicial district, otherwise available, or able
7 or willing to consider the motion, then any presiding judge of the superior court for that
8 judicial district may allow a motion to extend the statute of limitations for a period not
9 to exceed 120 days to file a complaint in a medical malpractice action in order to
10 comply with this Rule, upon a determination that good cause exists for the granting of
11 the motion and that the ends of justice would be served by an extension. ~~The plaintiff
12 shall provide, at the request of the defendant, proof of compliance with this subsection
13 through up to ten written interrogatories, the answers to which shall be verified by the
14 expert required under this subsection. These interrogatories do not count against the
15 interrogatory limit under Rule 33. At the request of the defendant, the plaintiff shall
16 furnish to the defendant, within 30 days, an affidavit from the expert certifying
17 compliance with this subsection."~~

18 **SECTION 2.5.** G.S. 1A-1, Rule 26(f1) reads as rewritten:

19 "(f1) Medical malpractice discovery conference. – In a medical malpractice action
20 as defined in G.S. 90-21.11, upon the case coming at issue or the filing of a responsive
21 pleading or motion requiring a determination by the court, the judge shall, within 30
22 days, direct the attorneys for the parties to appear for a discovery conference. At the
23 conference the court may consider the matters set out in Rule 16, and shall:

24 ...

25 (2) Establish an appropriate schedule for designating expert witnesses,
26 consistent with a discovery schedule pursuant to subdivision (3), ~~to be
27 complied with by all parties to the action such that there is a deadline
28 for designating all expert witnesses within an appropriate time for all
29 parties to implement discovery mechanisms with regard to the
30 designated expert witnesses;~~(3). As to each expert designated, the
31 designation shall be accompanied by a written report prepared and
32 signed by the witness. The report shall contain a complete statement of
33 all opinions to be expressed and the basis and reasons therefor; the
34 data or other information considered by the witness in forming the
35 opinions; the qualifications of the witness, including a list of all
36 publications authored by the witness within the preceding 10 years; the
37 compensation the witness is to be paid for the study and testimony;
38 and a listing of any other cases in which the witness has testified as an
39 expert at trial or by deposition within the preceding four years. The
40 party shall supplement the expert's report if the party learns that in
41 some material respect the report is incomplete or incorrect. The
42 expert's direct testimony shall not be inconsistent with or go beyond
43 the fair scope of the expert report as supplemented. The parties shall

1 not depose expert witnesses, unless the court otherwise orders for good
2 cause shown.

3 ..."

4 **SECTION 2.6.** G.S. 1A-1, Rule 53 reads as rewritten:

5 **"Rule 53. Referees.**

6 (a) Kinds of reference. –

7 (1) By Consent. – Any or all of the issues in an action may be referred
8 upon the written consent of the parties except in actions to annul a
9 marriage, actions for divorce, actions for divorce from bed and board,
10 actions for alimony without the divorce or actions in which a ground
11 of annulment or divorce is in issue.

12 (2) Compulsory. – Where the parties do not consent to a reference, the
13 court may, upon the application of any party or on its own motion,
14 order a reference in the following cases:

15 a. Where the trial of an issue requires the examination of a long or
16 complicated account; in which case the referee may be directed
17 to hear and decide the whole issue, or to report upon any
18 specific question of fact involved therein.

19 b. Where the taking of an account is necessary for the information
20 of the court before judgment, or for carrying a judgment or
21 order into effect.

22 c. Where the case involves a complicated question of boundary, or
23 requires a personal view of the premises.

24 d. Where a question of fact arises outside the pleadings, upon
25 motion or otherwise, at any stage of the action.

26 (3) Article 1B of Chapter 90 Actions. – In any action brought under
27 Article 1B of Chapter 90 of the General Statutes, the issue of liability
28 shall be referred.

29 (b) Jury trial. –

30 (1) Where the reference is by consent, the parties waive the right to have
31 any of the issues within the scope of the reference passed on by a jury.

32 (2) ~~A—~~Except as provided in subdivision (3) of this subsection, a
33 compulsory reference does not deprive any party of his—the party's
34 right to a trial by jury, which right he—the party may preserve by

35 a. Objecting to the order of compulsory reference at the time it is
36 made, and

37 b. By filing specific exceptions to particular findings of fact made
38 by the referee within 30 days after the referee files his report
39 with the clerk of the court in which the action is pending, and

40 c. By formulating appropriate issues based upon the exceptions
41 taken and demanding a jury trial upon such issues. Such issues
42 shall be tendered at the same time the exceptions to the referee's
43 report are filed. If there is a trial by jury upon any issue

1 referred, the trial shall be only upon the evidence taken before
2 the referee.

3 (3) A compulsory reference pursuant to subdivision (3) of subsection (a)
4 of this section does not deprive any party of the party's right to a trial
5 by jury, which right is hereby preserved.

6 (c) Appointment. –

7 (1) General Appointment. – ~~The~~ Except as provided for in subdivision (2)
8 of this subsection, the parties may agree in writing upon one or more
9 persons not exceeding three, and a reference shall be ordered to such
10 person or persons in appropriate cases. If the parties do not agree, the
11 court shall appoint one or more referees, not exceeding three, but no
12 person shall be appointed referee to whom all parties in the action
13 object.

14 (2) Article 1B of Chapter 90 Appointments. – In all actions referred
15 pursuant to subdivision (3) of subsection (a) of this section, the court
16 shall appoint three referees. The plaintiff or plaintiffs and the
17 defendant or defendants shall each furnish the court with a list of five
18 names. The court shall randomly select one name from each of the
19 separate lists for appointment. The parties shall then agree on a third
20 person for appointment acceptable to all parties, or in the event the
21 parties cannot agree, the court shall select for appointment as the third
22 referee a retired superior court judge or other person with significant
23 dispute resolution experience. The court shall insure that the referees
24 are fair and objective, that none of the referees are parties to the action,
25 related to any parties to the action, or are in any way financially
26 associated with any of the parties to the action or in the outcome of the
27 action. Any objection to the fairness or objectivity of any person
28 recommended by any party must be raised and ruled on by the court
29 prior to the appointment of the referees. The third referee designated in
30 this process shall serve as chair of the referees.

31 (d) Compensation. – The compensation to be allowed a referee shall be fixed by
32 the court and charged in the bill of costs. After appointment of a referee, the court may
33 from time to time order advancements by one or more of the parties of sums to be
34 applied to the referee's compensation. Such advancements may be apportioned between
35 the parties in such manner as the court sees fit. Advancements so made shall be taken
36 into account in the final fixing of costs and such adjustments made as the court then
37 deems proper. All referees serving jointly shall be paid equally.

38 (e) Powers. – ~~The~~ Except as otherwise provided by statute, the order of reference
39 to the referee may specify or limit ~~his~~ the referee's powers and may direct ~~him~~ the
40 referee to report only upon particular issues or to do or perform particular acts or to
41 receive and report evidence only and may fix the time and place for beginning and
42 closing the hearings and for the filing of the referee's report. Subject to the
43 specifications and limitations stated in the order, every referee has power to administer
44 oaths in any proceeding before ~~him~~ the referee, and has generally the power vested in a

1 referee by law. The referee shall have the same power to grant adjournments and to
2 allow amendments to pleadings and to the summons as the judge and upon the same
3 terms and with like effect. The referee shall have the same power as the judge to
4 preserve order and punish all violations thereof, to compel the attendance of witnesses
5 before ~~him~~the referee by attachment, and to punish them as for contempt for
6 nonattendance or for refusal to be sworn or to testify. The parties may procure the
7 attendance of witnesses before the referee by the issuance and service of subpoenas as
8 provided in Rule 45.

9 (f) Proceedings. –

10 (1) Meetings. – When a reference is made, the clerk shall forthwith furnish
11 the referee with a copy of the order of reference. Upon receipt thereof
12 unless the order of reference otherwise provides, the referee shall
13 forthwith set a time and place for the first meeting of the parties or
14 their attorneys to be held within 20 days after the date of the order of
15 reference and shall notify the parties or their attorneys. It is the duty of
16 the referee to proceed with all reasonable diligence. Any party, on
17 notice to all other parties and the referee, may apply to the court for an
18 order requiring the referee to expedite the proceedings and to make ~~his~~
19 the referee's report. If a party fails to appear at the time and place
20 appointed, the referee may proceed ex parte, or, in ~~his~~the referee's
21 discretion, may adjourn the proceedings to a future day, giving notice
22 to the absent party of the adjournment.

23 (2) Statement of Accounts. – When matters of accounting are in issue
24 before the referee, ~~he~~the referee may prescribe the form in which the
25 accounts shall be submitted and in any proper case may require or
26 receive in evidence a statement by a certified public accountant or
27 other qualified accountant who is called as a witness. Upon objection
28 of a party to any of the items thus submitted or upon a showing that the
29 form of statement is insufficient, the referee may require a different
30 form of statement to be furnished, or the accounts of specific items
31 thereof to be proved by oral examination of the accounting parties or
32 upon written interrogatories or in such other manner as he directs.

33 (3) Testimony Reduced to Writing. – The testimony of all witnesses must
34 be reduced to writing by the referee, or by someone acting under ~~his~~
35 the referee's direction and shall be filed in the cause and constitute a
36 part of the record.

37 (g) Report. –

38 (1) Contents and Filing. – The referee shall prepare a report upon the
39 matters submitted to ~~him~~the referee by the order of reference and shall
40 include therein ~~his~~the referee's decision on all matters so submitted. If
41 required to make findings of fact and conclusions of law, ~~he~~the referee
42 shall set them forth separately in the report. ~~He~~The referee shall file
43 the report with the clerk of the court in which the action is pending and
44 unless otherwise directed by the order of reference, shall file with it a

1 transcript of the proceedings and of the evidence and the original
2 exhibits. Before filing ~~his~~ the referee's report a referee may submit a
3 draft thereof to counsel for all parties for the purpose of receiving their
4 suggestions. The clerk shall forthwith mail to all parties notice of the
5 filing. In situations where more than one referee is appointed, the
6 report and finding of the referees shall be agreed to by a majority vote.

- 7 (2) Exceptions and Review. – All or any part of the report may be
8 excepted to by any party within 30 days from the filing of the report.
9 Thereafter, and upon 10 days' notice to the other parties, any party may
10 apply to the judge for action on the report. The judge after hearing may
11 adopt, modify or reject the report in whole or in part, ~~render judgment,~~
12 or may remand the proceedings to the referee with instructions. Except
13 for action referred pursuant to subdivision (3) of subsection (a) of this
14 section, the judge after hearing may render judgment. No judgment
15 may be rendered on any reference except by the judge."

16 **SECTION 2.7.** Article 1B of Chapter 90 is amended by adding a new
17 section to read:

18 **"§ 90-21.12C. Report of referees.**

19 (a) In any action brought under this Article, the issue of liability shall be referred
20 as set forth in G.S. 1A-1, Rule 53. Upon completion of discovery on liability as
21 permitted under the Rules of Civil Procedure, the court shall issue an order of reference
22 directing the referees to issue a report and findings on the issue of liability.

23 (b) After receiving the report of the referees in accordance with G.S. 1A-1, Rule
24 53, upon the request of the plaintiff, the court shall proceed to schedule the case for
25 trial. After the issuance of the report of the referees, no additional discovery on the issue
26 of liability shall be permitted except by order of the court upon a finding of good cause.
27 The report of the referees shall be admissible as prima facie evidence on the issue of
28 liability sufficient for the issue to be decided by the jury. The parties may offer such
29 other evidence as the parties deem necessary and appropriate to supplement the report
30 and findings. The court shall instruct the jury that it may consider the report and
31 findings of the referees and may give the report and findings such weight as the jury
32 deems proper, but that the jury is not bound by the report and the findings.

33 (c) After presentation of evidence on liability and damages, if the jury finds for
34 the plaintiff on the issue of liability, the jury shall also determine damages. At the close
35 of all evidence and prior to final arguments to the jury, the plaintiff and defendant shall
36 each submit to the court in sealed form the amount of damages they contend the
37 plaintiff is entitled to recover if the jury finds that the defendant is liable for the
38 plaintiff's damages. The sealed amount of damages shall be unsealed by the court and
39 the parties informed of each amount of damages. The amount of damages submitted
40 may not be amended after being unsealed by the court. The parties may argue to the jury
41 the amount of damages proposed in their final arguments. If the plaintiff is found to be
42 entitled to a recovery of damages, then the issue submitted to the jury on damages shall
43 be whether the jury finds for the plaintiff's submission on damages or for the defendant's

1 submission on damages. The jury may not return a verdict for any other amount. Any
2 other finding by the jury on the issue of damages shall be grounds for a mistrial.

3 (d) In any action where the jury answers the issue of liability against the plaintiff
4 after a report and finding by the referees that the defendant was not liable, then the court
5 shall award to the defendant its court costs and reasonable attorneys' fees incurred after
6 the filing of the referees' report and finding. In any action where the jury answers the
7 issue of liability against the defendant after a report and finding by the referees that the
8 defendant was liable, then the court shall award to the plaintiff its court costs and
9 reasonable attorneys' fees incurred after the filing of the referees' report and finding.

10 (e) Notwithstanding the requirements set forth in subsection (a) of this section, if
11 a plaintiff refiles an action against the same defendant after voluntarily dismissing an
12 earlier action subsequent to the issuance of a report by referees, the report by referees
13 from a prior action against the same defendant will be admissible in lieu of a new
14 reference, except where the court, for good cause, orders a new reference."

15 **SECTION 2.8.** Article 4 of Chapter 8C of the General Statutes is amended
16 by adding a new section to read:

17 **"Rule 414. Evidence of medical expenses.**

18 In any action brought against a health care provider pursuant to Article 1B of
19 Chapter 90 of the General Statutes, evidence offered to prove past medical expenses
20 may include all bills reasonably paid or incurred and a statement of the amounts actually
21 necessary to satisfy the bills that have been incurred. Evidence of source of payment
22 shall not be admissible."

23 **SECTION 2.9.** G.S. 1-17(b) reads as rewritten:

24 "(b) Notwithstanding the provisions of subsection (a) of this section, an action on
25 behalf of a minor for malpractice arising out of the performance of or failure to perform
26 professional services shall be commenced within the limitations of time specified in
27 G.S. 1-15(c), except that if those time limitations expire before the minor attains the full
28 age of 19 years, the action may be brought before the minor attains the full age of 19
29 years-years, but in no event may an action arising from birth-related injuries be
30 commenced more than 10 years from the last act of the defendant giving rise to the
31 cause of action."

32
33 **Subpart C. Deferred Payment of Judgments in Certain Medical Actions.**

34
35 **SECTION 2.10.** Article 1B of Chapter 90 of the General Statutes is
36 amended by adding the following new section to read:

37 **"§ 90-21.18B. Periodic payment of future economic damages in medical negligence**
38 **actions.**

39 (a) As used in this section:

40 (1) 'Future economic damages' includes all economic damages for future
41 medical treatment, care or custody, and loss of future earnings of the
42 plaintiff following the date of the verdict or award.

43 (2) 'Periodic payments' means the payment of money to the plaintiff at
44 regular intervals.

1 (b) Upon the award of damages in any action brought under Article 1B of
2 Chapter 90 of the General Statutes, the court shall, at the request of either party, after
3 hearing and a determination by the court of the amount of the judgment that should be
4 attributed to future economic damages, enter a judgment ordering that the amount of
5 future economic damages of the plaintiff in excess of the sum of:

6 (1) One hundred thousand dollars (\$100,000),

7 (2) The amount of the future medical expenses expected to be incurred by
8 the plaintiff within the next 12 months, including the cost of any
9 special equipment or adaptations necessary for daily care and living
10 arrangements, due to the negligence of the defendant, plus

11 (3) An amount equal to the costs and attorneys' fees incurred and payable
12 by the plaintiff in litigating the case multiplied by a fraction, the
13 numerator of which is the amount of future economic damages in
14 excess of one hundred thousand dollars (\$100,000) and the
15 denominator of which is the amount of the total judgment in favor of
16 the plaintiff,

17 be paid in whole or in part by periodic payments rather than by a lump-sum payment. If
18 the court finds that the sum of subdivisions (1), (2), and (3) of this subsection are
19 insufficient to provide for the plaintiff's immediate needs, the court may make such
20 adjustments in the amount to be paid by periodic payments as the court finds are
21 necessary to ensure that the amount of the nondeferred compensation will be adequate
22 for the plaintiff's immediate needs. In entering a judgment under this section ordering
23 the payment of future economic damages by periodic payments, the court shall make a
24 specific finding of the total dollar amount of periodic payments that will equal the
25 present value of the jury's lump-sum award to compensate the plaintiff for future
26 economic damages.

27 (c) As a condition to authorizing periodic payments of future economic damages,
28 the court in its order of judgment, shall require the defendant to post a bond or security,
29 or otherwise to assure full payment of future damages awarded by the judgment
30 including that payments be made through the establishment of a trust fund or the
31 purchase of an annuity for the life of the plaintiff or during the continuance of the
32 plaintiff's compensable injury or disability. The purchase of an annuity found by the
33 court to be through a duly licensed and adequately capitalized insurance company shall
34 satisfy the requirements of this subsection. A trust fund found by the court to be
35 adequately funded and insured shall satisfy the requirements of this subsection. For
36 periodic payments to be made directly by the defendant, the court shall approve periodic
37 payments of future damages only if it finds that all payments which are due to be made
38 are secured by a bond issued by an insurance company authorized to write such bonds
39 in this State and which is rated "A plus" (A+) or better by Best's Insurance Reports. If
40 the defendant is unable to adequately assure full payment of future damages, the court
41 shall order that all future damages be paid to the plaintiff in a lump sum pursuant to the
42 verdict. No bond may be canceled or be subject to cancellation unless at least 60 days'
43 advance written notice is filed with the court and the plaintiff. Upon termination of

1 periodic payments, the court shall order the return of the security, or so much as
2 remains, to the defendant.

3 (d) The judgment providing for payment of future economic damages by periodic
4 payments shall specify the recipient of the payments, the dollar amounts of the
5 payments, the interval between payments, and the number of payments or the period of
6 time over which payments shall be made. Periodic payments shall be subject to
7 modification by the court in the event of death of the plaintiff as provided in subsection
8 (e) of this section.

9 (e) In any judgment that orders future economic damages payable in periodic
10 payments, liability for payment of future medical damages not yet due shall terminate
11 upon the death of the plaintiff; however, the court that rendered the original judgment
12 may modify the judgment to provide that damages awarded for loss of future earnings
13 shall not be reduced or payments terminated by reason of the death of the plaintiff, but
14 shall be paid to persons to whom the plaintiff owed a duty of support, as provided by
15 law, immediately prior to the plaintiff's death.

16 (f) In the event the court finds that the defendant has exhibited a pattern of
17 failing to make the payment specified in subsection (b) of this section, the court may do
18 one or more of the following:

19 (1) Order that all remaining amounts of the award be paid by lump sum
20 within 30 days after entry of the order.

21 (2) Find the defendant in contempt of court and, in addition to the required
22 periodic payments, order the defendant to pay the plaintiff all damages
23 caused by the failure to timely make periodic payments, including
24 court costs and attorneys' fees.

25 (3) Enter other orders or sanctions as appropriate to protect the defendant.

26 (g) Nothing in this section shall preclude any other method of payment of
27 awards, if the method is consented to by the parties."

29 **PART III. PROFESSIONAL LIABILITY INSURANCE CHANGES.**

30 **SECTION 3.1.** Article 40 of Chapter 58 of the General Statutes is amended
31 by adding a new section to read:

32 **"§ 58-40-32. Health care provider professional malpractice insurance rates.**

33 (a) As used in this section:

34 (1) "Health care provider" has the same meaning as defined in G.S.
35 90-21.11.

36 (2) "Insurer" means an insurer or State-chartered risk retention group that
37 provides professional malpractice insurance to health care providers in
38 this State.

39 (b) No insurer's rate shall be approved or remain in effect that is excessive,
40 inadequate, unfairly discriminatory, as defined in G.S. 58-40-20, or otherwise in
41 violation of this Chapter. In considering whether a rate is excessive, inadequate, or
42 unfairly discriminatory, no consideration shall be given to the degree of competition,
43 and the Commissioner shall consider whether the rate mathematically reflects the
44 insurer's investment income.

1 (c) Every insurer that desires to change any rate shall file a complete rate
2 application with the Commissioner. A complete rate application shall include all data
3 required by G.S. 58-40-30(b) and G.S. 58-41-50, and a detailed description of any
4 experience rating or schedule-rating plan used by the insurer. The application shall also
5 include such other information that the Commissioner requires. The applicant has the
6 burden of proving that the requested rate change is justified and meets the requirements
7 of this Article.

8 (d) Within 10 days of receiving the rate change application, the Commissioner
9 shall notify the public on the Department's Internet web site of any application by an
10 insurer for a rate change and shall provide written notification of the rate change
11 application to any trade association or organization that represents health care providers
12 and that registers with the Department to receive notification.

13 (e) The application shall be deemed to be approved 60 days after public notice
14 and written notification under subsection (d) of this section unless any of the following
15 occur:

16 (1) An insured health care provider, the health care provider's
17 representative, or an association of health care providers, requests a
18 hearing within 30 days after public notice and the Commissioner
19 grants the hearing, or determines not to grant the hearing and issues
20 written findings in support of that decision.

21 (2) The Commissioner on the health care provider's own motion
22 determines to hold a hearing.

23 (3) The proposed rate adjustment exceeds fifteen percent (15%) of the
24 then-applicable rate, in which case the Commissioner must hold a
25 hearing.

26 In any event, a rate change application shall be deemed to be approved 120 days
27 after the Commissioner receives the rate application unless that application has been
28 disapproved by a final order of the Commissioner after a hearing. For purposes of this
29 section, "received" means the date delivered to the Department.

30 (f) The provisions of G.S. 58-40-45 governing the disapproval and interim use of
31 rates shall apply to this section."

32 **SECTION 3.2.** G.S. 58-2-170 reads as rewritten:

33 "**§ 58-2-170. Annual statements by professional liability insurers; medical**
34 **malpractice claim reports.**

35 (a) In addition to the financial statements required by G.S. 58-2-165, every
36 insurer, self-insurer, and risk retention group that provides professional liability
37 insurance in the State shall file with the Commissioner, on or before the first day of
38 February in each year, in form and detail as the Commissioner prescribes, a statement
39 showing the items set forth in subsection (b) of this section, as of the preceding 31st day
40 of December. The annual statement shall not be reported or disclosed to the public in a
41 manner or format which identifies or could reasonably be used to identify any
42 individual health care provider or medical center. The statement shall be signed and
43 sworn to by the chief managing agent or officer of the insurer, self-insurer, or risk
44 retention group, before the Commissioner or some officer authorized by law to

1 administer oaths. The Commissioner shall, in December of each year, furnish to each
2 such person that provides professional liability insurance in the State forms for the
3 annual statements. The Commissioner may, for good cause, authorize an extension of
4 the report due date upon written application of any person required to file. An extension
5 is not valid unless the Commissioner's authorization is in writing and signed by the
6 Commissioner or one of his deputies.

7 (b) The statement required by subsection (a) of this section shall contain:

- 8 (1) Number of claims pending at beginning of year;
- 9 (2) Number of claims pending at end of year;
- 10 (3) Number of claims paid;
- 11 (4) Number of claims closed no payment;
- 12 (5) Number and amounts of claims in court in which judgment ~~paid~~ was
13 entered, the amount of the judgment, and the actual amount paid on the
14 judgment or in settlement of the judgment. For both the amount of the
15 judgment and the actual amount paid, provide the:
 - 16 a. Highest amount
 - 17 b. Lowest amount
 - 18 c. Average amount
 - 19 d. Median amount;
- 20 (6) Number and amounts of claims out of court in which settlement paid:
 - 21 a. Highest amount
 - 22 b. Lowest amount
 - 23 c. Average amount
 - 24 d. Median amount;
- 25 (7) Average amount per claim set up in reserve;
- 26 (8) Total premium collection;
- 27 (9) Total expenses less reserve expenses; and
- 28 (10) Total reserve expenses.

29 (b1) The Commissioner shall analyze the reports described in subsections (a) and
30 (b) of this section and shall file statistical and other summaries with the General
31 Assembly no later than March 1 of each year. Summaries filed by the Commissioner
32 pursuant to this subsection shall include all of the following:

- 33 (1) Any trends noted or observed from the data.
- 34 (2) All actions taken by the Commissioner in response to these trends.
- 35 (3) Any legislative or other recommendations from the Commissioner
36 with respect to actions by the General Assembly in response to these
37 trends.

38 (c) Every insurer, self-insurer, and risk retention group that provides professional
39 liability insurance to health care providers in this State shall file, within 90 days
40 following the request of the Commissioner, a report containing information for the
41 purpose of allowing the Commissioner to analyze claims. The report shall be in the
42 form prescribed by the Commissioner. The form prescribed by the Commissioner shall
43 be a form that permits the public inspection, examination, or copying of any information
44 contained in the report: Provided, however, that any data or other characteristics that

1 identify or could be used to identify the names or addresses of the claimants or the
2 names or addresses of the individual health care provider or medical center against
3 whom the claims are or have been asserted or any data that could be used to identify the
4 dollar amounts involved in such claims shall be treated as privileged information and
5 shall not be made available to the public. The Commissioner shall analyze these reports
6 and shall file statistical and other summaries based on these reports with the General
7 Assembly as soon as practicable after receipt of the reports. The Commissioner shall
8 assess a penalty against any person that willfully fails to file a report required by this
9 subsection. Such penalty shall be one thousand dollars (\$1,000) for each day after the
10 due date of the report that the person willfully fails to file: Provided, however, the
11 penalty for an individual who self insures shall be two hundred dollars (\$200.00) for
12 each day after the due date of the report that the person willfully fails to file: Provided,
13 however, that upon the failure of a person to file the report as required by this
14 subsection, the Commissioner shall send by certified mail, return receipt requested, a
15 notice to that person informing him that he has 10 business days after receipt of the
16 notice to either request an extension of time or file the report. The Commissioner may,
17 for good cause, authorize an extension of the report due date upon written application of
18 any person required to file. An extension is not valid unless the Commissioner's
19 authorization is in writing and signed by the Commissioner or one of his deputies.

20 (d) Every person that self-insures against professional liability in this State shall
21 provide the Commissioner with written notice of such self-insurance, which notice shall
22 include the name and address of the person self-insuring. This notice shall be filed with
23 the Commissioner each year for the purpose of apprising the Commissioner of the
24 number and locations of persons that self-insure against professional liability."

25 **SECTION 3.3.** G.S. 58-40-25 reads as rewritten:

26 **"§ 58-40-25. Rating methods.**

27 In determining whether rates comply with the standards under G.S. 58-40-20, the
28 following criteria shall be applied:

29 (1) Due consideration shall be given to past and prospective loss and
30 expense experience within this State, to catastrophe hazards, to a
31 reasonable margin for underwriting profit and contingencies, to trends
32 within this State, to dividends or savings to be allowed or returned by
33 insurers to their policyholders, members, or subscribers, and to all
34 other relevant factors, including judgment factors; however, regional
35 or countrywide expense or loss experience and other regional or
36 countrywide data may be considered only when credible North
37 Carolina expense or loss experience or other data is not available.

38 (1a) Notwithstanding the provisions of subdivision (1) of this section, an
39 insurer or State-chartered risk retention group that provides
40 professional malpractice insurance to health care providers, as defined
41 in G.S. 90-21.11, may use regional or countrywide expense or loss
42 experience and other regional or countrywide data only upon written
43 approval by the Commissioner. The Commissioner may approve the
44 use of regional or countrywide data only upon a finding of good cause.

1 (2) Risks may be grouped by classifications for the establishment of rates
2 and minimum premiums. Classification rates may be modified to
3 produce rates for individual risks in accordance with rating plans
4 which establish standards for measuring variations in hazards or
5 expense provisions, or both. Those standards may measure any
6 differences among risks that have probable effect upon losses or
7 expenses. Classifications or modifications of classifications of risks
8 may be established based upon size, expense, management, individual
9 experience, location or dispersion of hazard, or any other reasonable
10 considerations. Those classifications and modifications shall apply to
11 all risks under the same or substantially the same circumstances or
12 conditions.

13 (3) The expense provisions included in the rates to be used by an insurer
14 may reflect the operating methods of the insurer and, as far as it is
15 credible, its own expense experience.

16 (4) In the case of property insurance rates under this Article, consideration
17 shall be given to the insurance public protection classifications of fire
18 districts established by the Commissioner. The Commissioner shall
19 establish and modify from time to time insurance public protection
20 districts for all rural areas of the State and for cities with populations
21 of 100,000 or fewer, according to the most recent annual population
22 estimates certified by the State Planning Officer. In establishing and
23 modifying these districts, the Commissioner shall use standards at least
24 equivalent to those used by the Insurance Services Office, Inc., or any
25 successor organization. The standards developed by the Commissioner
26 are subject to Article 2A of Chapter 150B of the General Statutes. The
27 insurance public protection classifications established by the
28 Commissioner issued pursuant to the provisions of this Article shall be
29 subject to appeal as provided in G.S. 58-2-75, et seq. The exceptions
30 stated in G.S. 58-2-75(a) do not apply."

31 **SECTION 3.4.** The Commissioner of Insurance shall study the utilization
32 and efficacy of experience rating plans and premium stabilization funds as proposed in
33 Senate Bill 1018 of the 2003 General Assembly. The Commissioner shall report his
34 findings and recommendations, including any proposed alternatives to the solutions
35 proposed in Senate Bill 1018, to the General Assembly on or before January 1, 2005.

36 **SECTION 3.5.** Chapter 90 of General Statutes is amended by adding a new
37 Article to read:

38 "Article 40.

39 "North Carolina Health Care Excess Liability Fund.

40 "**§ 90-681. Findings of General Assembly; legislative intent.**

41 (a) The General Assembly finds that:

42 (1) The potential for the inability of health care providers to obtain
43 professional malpractice insurance at affordable and stable rates could

1 have an adverse effect on the provision of health care to the people of
2 this State.

3 (2) The current liability insurance difficulties in the United States are the
4 third such development in the past 30 years. Each has been associated
5 with insurance underwriting cycles and general economic downturns.
6 Economists cannot explain the causes of these cycles of economic
7 expansion and contraction. In essence, profitability creates
8 competition, which leads to underpricing that breeds unprofitability
9 and the flight of competitors from the market; then 'hard' markets
10 produce higher premiums and profitability that attract new companies
11 or encourage expansion, starting the cycle again.

12 (3) An excess liability fund could ultimately provide insureds lower
13 premiums, and that there are an adequate number of potential insureds
14 to fund an excess liability fund.

15 (4) The uninterrupted delivery of health care services is essential to the
16 health and welfare of the citizens of North Carolina.

17 (5) It is essential to the health and welfare of the citizens of North
18 Carolina that all health care providers have sufficient amounts of
19 professional malpractice insurance.

20 (b) It is the policy and intent of the General Assembly that a health care provider
21 who participates in the Fund set forth in this Article, maintains the designated amounts
22 of professional malpractice protection, and contributes to the Fund for the protection of
23 the provider's patients, fulfills the objectives of this public policy.

24 **"§ 90-682. Definitions.**

25 As used in this Article:

26 (1) 'Board.' – The Board of Directors of the North Carolina Health Care
27 Excess Liability Fund created in G.S. 90-684.

28 (2) 'Commissioner.' – The Commissioner of Insurance of the State of
29 North Carolina.

30 (3) 'Department.' – The Department of Insurance of the State of North
31 Carolina.

32 (4) 'Fund.' – The North Carolina Health Care Excess Liability Fund
33 created in G.S. 90-683.

34 (5) 'Health care provider.' – As defined in G.S. 90-21.11.

35 (6) 'Manager.' – The person appointed by the Board to administer the Fund
36 as provided for in G.S. 90-684.

37 (7) 'Secretary.' – The Secretary of the Department of Health and Human
38 Services of the State of North Carolina.

39 **"§ 90-683. North Carolina Health Care Excess Liability Fund; creation;**
40 **investment; coverage.**

41 (a) Fund Created. – The North Carolina Health Care Excess Liability Fund is
42 created. Funds collected and received by the Board shall be used solely for the purposes
43 stated in this Article. The Fund shall be comprised of the following three separate
44 sub-funds:

1 (1) The Hospital Excess Liability Sub-Fund, which shall be funded
2 through assessments and surcharges levied on hospitals licensed under
3 Chapter 131E of the General Statutes, to pay claims from a hospital
4 under this Article.

5 (2) The Nursing Home Excess Liability Sub-Fund, which shall be funded
6 through assessments and surcharges levied on nursing homes licensed
7 under Chapter 131E of the General Statutes, to pay claims from a
8 nursing home under this Article.

9 (3) The Health Care Provider Excess Liability Sub-Fund, which shall be
10 funded through assessments and surcharges levied on health care
11 providers not included in subdivisions (1) and (2) of this subsection, to
12 pay claims from the health care provider under this Article.

13 The provisions of this Article shall apply to each sub-fund and to health care providers
14 contributing to each sub-fund. Each sub-fund shall be subject to the direction and
15 oversight of the Board, as provided in this Article. Actuarial services and analyses
16 required under this Article shall apply to each sub-fund. The Board shall apply costs
17 associated with the administration, operation, and defense of each sub-fund to each
18 sub-fund separately. Each sub-fund shall be managed so as to be actuarially sound.

19 (b) Investment and Management. – All moneys that belong to the Fund and are
20 collected or received under this Article shall be held in trust, deposited in a segregated
21 account, invested and reinvested by the Board in accordance with the investment
22 requirements of G.S. 58-7-160 through G.S. 58-7-205, and shall not become a part of
23 the General Fund of the State. All interest and revenues from moneys belonging to the
24 Fund shall inure solely to the benefit and use of the Fund. The Board may withdraw
25 funds from the account as amounts payable under G.S. 90-687 and other expenses
26 become due and payable. No part of the revenues or assets of the Fund shall inure to the
27 benefit of or be distributable to the Board or any member thereof or any officer or
28 employee of the Board, except for services rendered. All expenses and salaries
29 connected with the administration and operation of the Fund shall be paid out of the
30 Fund.

31 (c) Excess Earnings of the Fund. – The Board shall establish a surplus account
32 that, in the sound business judgment of the Board, will be sufficient to meet the normal
33 contingencies of its operations. All other excess earnings of the Fund shall be returned
34 to the participating health care providers by adjustment of the assessments.

35 (d) Prohibition of Use by State. – No moneys, funds, reserves, investments, or
36 property, whether real or personal, acquired, administered, possessed, or held by the
37 Fund, nor any earnings by the Fund, may be taken, used, or appropriated by the State of
38 North Carolina for any purpose.

39 **"§ 90-684. Board of Directors; creation; membership; terms; vacancies; powers**
40 **and duties; manager of fund; immunity from liability of Board members,**
41 **officers, and employees.**

42 (a) The Board of Directors of the North Carolina Health Care Excess Liability
43 Fund has the power to:

- 1 (1) Adopt administrative rules that are necessary for the implementation,
2 administration, and interpretation of this Article.
- 3 (2) Employ officers and employees as the Board considers necessary to
4 carry out the provisions of this Article or to perform the duties and
5 exercise the powers conferred upon the Board by law. The Board shall
6 fix the compensation for the officers and employees.
- 7 (3) Sue and be sued in all actions arising out of any act or omission in
8 connection with the business or affairs of the Fund.
- 9 (4) Enter into any contracts or obligations relating to the Fund that are
10 authorized or permitted by law, including contracts for claims
11 management services, including the evaluation, negotiation, defense,
12 and settlement of medical malpractice claims against participating
13 health care providers.
- 14 (5) Conduct all business affairs and perform all acts relating to the Fund,
15 whether or not specifically designated in this Article.
- 16 (6) Assess each person covered by the Fund for contributions to the Fund.
- 17 (7) Establish definitions of coverage to be provided by the Fund.
- 18 (8) Contract with an insurer to administer the Fund.
- 19 (9) Cause all or any part of the potential liability of the Fund to be
20 reinsured, if such reinsurance is available, on a fair and reasonable
21 basis.
- 22 (b) The membership of and appointments to the Board shall be as follows:
- 23 (1) One medical doctor and one hospital administrator to be appointed by
24 the General Assembly upon the recommendation of the President Pro
25 Tempore of the Senate in accordance with G.S. 120-121.
- 26 (2) One medical doctor and one hospital administrator to be appointed by
27 the General Assembly upon the recommendation of the Speaker of the
28 House of Representatives in accordance with G.S. 120-121.
- 29 (3) One nurse to be appointed by the General Assembly upon the
30 recommendation of the President Pro Tempore of the Senate in
31 accordance with G.S. 120-121.
- 32 (4) One dentist to be appointed by the General Assembly upon the
33 recommendation of the Speaker of the House of Representatives in
34 accordance with G.S. 120-121.
- 35 (5) One nursing home administrator to be appointed by the General
36 Assembly upon the recommendation of the Speaker of the House of
37 Representatives in accordance with G.S. 120-121.
- 38 (6) One member from a health care profession other than those
39 enumerated in subdivisions (1) through (5) of this subsection to be
40 appointed by the General Assembly upon the recommendation of the
41 President of the Senate in accordance with G.S. 120-121.
- 42 (7) One patient advocate who is unaffiliated with insurance or health care
43 industries or the medical or legal professions to be appointed by the
44 Governor.

1 (c) Members appointed pursuant to this section shall be residents of the State and
2 shall serve terms of four years, provided that the initial appointees shall serve terms as
3 follows:

4 (1) Members appointed under subdivision (b)(1) of this section shall serve
5 initial terms of two and three years respectively.

6 (2) Members appointed under subdivision (b)(2) of this section shall serve
7 initial terms of two and four years respectively.

8 (3) Members appointed under subdivisions (b)(3), (4), and (5) of this
9 section shall serve initial terms of two, three, and four years
10 respectively.

11 (4) Members appointed under subdivisions (b)(6) and (b)(7) of this section
12 shall serve initial terms of two and four years respectively.

13 (d) The Secretary and the Commissioner shall be ex officio members of the
14 Board. The Secretary and the Commissioner or their designees shall each have a vote on
15 all matters before the Board.

16 (e) Initial appointments to the Board shall be made on or before October 1, 2004.
17 The organizational meeting of the Board shall be held upon the call of the Secretary and
18 within 30 days after initial appointments are completed.

19 (f) Any appointment to fill a vacancy on the Board created by the resignation,
20 dismissal, death, or disability of a member shall be for the balance of the unexpired
21 term. At the expiration of each member's term, the appointing authority shall reappoint
22 or replace the member with a member from the same category. At its organizational
23 meeting and on or after July 1 of each year thereafter, the Board shall designate by
24 election one of its members as chair. The Board shall also elect or appoint, and
25 prescribe the duties of such other officers, as the Board deems necessary or advisable,
26 including a secretary and treasurer.

27 (g) Any appointing authority shall have the power to remove any member for
28 misfeasance, malfeasance, or nonfeasance in accordance with G.S. 143B-13.
29 Compensation and allowances for members of the Board shall be as provided in G.S.
30 138-5. The Secretary and Commissioner shall not receive compensation and allowances.

31 (h) There shall be a manager of the Fund, who shall be appointed by the Board.
32 The manager shall conduct the business affairs of the Fund under the general direction
33 of the Board. Before entering the duties of the office, the manager shall qualify by
34 giving an official bond approved by the Board. The Board may delegate to the manager
35 of the Fund, subject to such conditions as it from time to time prescribes, any power,
36 function, or duty conferred by law on the Board in connection with the administration,
37 management, and conduct of the business affairs of the Fund. The manager may
38 exercise those powers and functions and perform those duties with the same force and
39 effect as the Board.

40 (i) There is no personal liability on the part of any member of the Board, the
41 manager, or any officer or employee of the Fund, for or on account of any act performed
42 or obligation entered into in an official capacity, when done in good faith, without intent
43 to defraud, and in connection with the administration, management, or conduct of the
44 Fund or affairs relating to the Fund.

1 **§ 90-685. Participation in the Fund.**

2 (a) When a health care provider has proved to the satisfaction of the Board that
3 the health care provider is insured by an insurer authorized by the Department or under
4 a self-insurance plan approved by the Board against legal liability for damages arising
5 out of professional malpractice in the sums required under subsection (b) of this section,
6 and if the health care provider has paid the current assessment required under G.S.
7 90-686, the health care provider shall be deemed to be a bona fide participant in the
8 Fund and shall become subject to the provisions of this Article and the administrative
9 rules of the Board. The financial responsibility requirements herein shall include an
10 obligation of the insurer or self-insurer to defend an action against the participating
11 health care provider irrespective of payment or offer of payment of the limits provided
12 by the insurer or self-insurer.

13 (b) The Board shall establish the minimum limits of professional liability
14 insurance or approved self-insurance required for participation in the Fund and may
15 increase or decrease such limits as may be necessary to keep the Fund actuarially sound.
16 Unless modified by the Board, the presumptive minimum limits for participation shall
17 be as follows:

18 (1) For health care providers providing emergency services and for
19 obstetricians-gynecologists, five hundred thousand dollars (\$500,000)
20 for each occurrence and an aggregate liability amount for all
21 occurrences or claims made in any policy year of two million dollars
22 (\$2,000,000).

23 (2) For all other health care providers not specified in subdivisions (1),
24 (3), and (4) of this subsection, one million dollars (\$1,000,000) for
25 each occurrence and an aggregate liability amount for all occurrences
26 or claims made in any policy year of three million dollars
27 (\$3,000,000), except as otherwise provided in this section.

28 (3) Notwithstanding any other provisions of this section, for a hospital
29 licensed under Chapter 131E of the General Statutes with 500 or fewer
30 beds, two million dollars (\$2,000,000) for each occurrence and an
31 aggregate liability amount for all occurrences or claims made in any
32 policy year or risk-loss trust year of six million dollars (\$6,000,000).
33 The policy may be written on either an occurrence or a claims-made
34 basis.

35 (4) Notwithstanding any other provisions of this section, for a hospital
36 licensed under Chapter 131E of the General Statutes with more than
37 500 beds, three million dollars (\$3,000,000) for each occurrence and
38 an aggregate liability amount for all occurrences or claims made in any
39 policy year or risk-loss trust year of eight million dollars (\$8,000,000).

40 (c) If a health care provider participating in the Fund has insurance or
41 self-insurance coverage in excess of the amounts stated in subsection (b) of this section,
42 the Board shall grant an appropriate reduction of the provider's assessment for the Fund.

1 (d) The Board shall afford a participating health care provider the same type of
2 coverage, occurrence or claims made, as is provided by his insurer or approved
3 self-insurer in subsection (a) of this section.

4 **"§ 90-686. Assessment for the Fund.**

5 (a) Regardless of a health care provider's participation in the Fund, all health care
6 providers are subject to an assessment under this section in an amount to be determined
7 by the Board. The assessment shall be collected on the same basis as premiums by each
8 insurer, risk manager, or surplus lines licensee. The assessment is due and payable
9 within 30 days after the premium for professional liability insurance has been received
10 by the insurer, risk manager, or surplus lines licensee from a health care provider in this
11 State. If an assessment is not paid as required by this section, the insurer, risk manager,
12 or surplus lines licensee responsible for the delinquency is liable for the assessment plus
13 a penalty equal to ten percent (10%) of the amount of the assessment. If the annual
14 assessment is not paid within the time limit specified in this subsection, the license of
15 the insurer, risk manager, and surplus lines licensee shall be suspended until the annual
16 assessment is paid.

17 (b) Subject to G.S. 90-698 and beginning July 1, 2005, the assessment shall be
18 set by the Board.

19 (c) In determining the assessment, the Board shall consider the rate standards in
20 G.S. 58-40-20. If the Board determines that a health care provider would subject the
21 Fund to a greater risk of payment of funds, the Board may, in its discretion, increase the
22 assessment against that provider. Moneys received by the Board under subsection (a) of
23 this section shall be handled in accordance with the provisions of G.S. 90-683 and G.S.
24 90-688. The Fund is not subject to any premium taxes.

25 (d) Any health care provider who carries a claims-made policy or is protected by
26 an approved self-insurance plan and who discontinues participation in the Fund may
27 obtain full occurrence coverage from the Board by purchasing an extended reporting
28 endorsement under G.S. 58-40-140 on the claims-made policy or self-insurance plan by
29 payment of the assessment then required by the Board on the same basis as the insurer
30 or self-insurer requires a reporting endorsement premium to be paid.

31 (e) The Fund is not subject to premium taxes in G.S. 105-228.5.

32 **"§ 90-687. Payment of claims by the Fund; claims management and services;**
33 **personal liability for malpractice and amount of compensation not**
34 **limited; actions against Board or Fund.**

35 (a) For health care providers licensed under this Chapter, any amount due from a
36 judgment, alternative dispute resolution award, or Board-approved settlement that is in
37 excess of a participating health care provider's insurance or self-insurance coverage
38 required by G.S. 90-685 shall be paid from the Fund up to the applicable limits of
39 coverage under the Fund. The presumed amount to be paid from the Fund is subject to
40 the following limits:

- 41 (1) Notwithstanding any other provision of this section, for hospitals
42 licensed under Chapter 131E of the General Statutes an amount not to
43 exceed eight million dollars (\$8,000,000) for each occurrence or claim

1 made and fifteen million dollars (\$15,000,000) aggregate for
2 occurrences in or claims made in any one year.

- 3 (2) For all other health care providers not specified in subdivision (1) of
4 this subsection, an amount not to exceed four million dollars
5 (\$4,000,000) for each occurrence or claim made and six million dollars
6 (\$6,000,000) aggregate for occurrences in or claims made in any one
7 year.

8 The Board, in its discretion, may increase or decrease the presumed limits for payments
9 to health care providers under this subsection as necessary to maintain the Fund's
10 financial solvency.

11 (b) Payment of claims by the Fund as provided in subsection (a) of this section
12 shall only be made when the Board issues a voucher or other appropriate request after
13 the Board receives either of the following:

- 14 (1) A certified copy of a final judgment or alternative dispute resolution
15 award against a participating health care provider.
16 (2) A certified copy of a Board-approved settlement between a
17 participating health care provider and a claimant.

18 Payments of claims from the Fund on behalf of a participating health care provider shall
19 inure to the benefit of the health care provider.

20 (c) A participating health care provider or the health care provider's insurer or
21 self-insurer or any claimant shall notify the Board of all claims made or reported or
22 actions filed against the health care provider. The notice shall be in writing, mailed to
23 the Board within a reasonable time to provide the Board adequate preparation time to
24 defend or negotiate the claim or action, and shall include the date of the alleged
25 occurrence, the date of the making, reporting, or filing of the claim or action, and the
26 amount demanded, if declared, by the claimant. The Board shall not pay claims on
27 behalf of or provide the services in subsection (d) of this section to any participating
28 health care provider unless adequate notice to the Board has been provided.

29 (d) The Board may provide for claims management and services, including the
30 legal defense of participating health care providers in actions filed against them and in
31 settlement negotiations.

32 (e) Nothing in this Article:

- 33 (1) Limits the personal liability of any participating health care provider
34 for malpractice arising out of the performance of or failure to perform
35 professional services.
36 (2) Limits the amount of compensation from any final judgment,
37 alternative dispute resolution award, or Board-approved settlement to
38 any claimant injured as a result of the malpractice.
39 (3) Permits the filing by any claimant of an action against the Board or
40 Fund except upon a final judgment obtained by the claimant against a
41 participating health care provider or upon a Board-approved settlement
42 agreement.

43 (f) The Fund shall not be liable for awards for punitive damages against
44 participating health care providers.

1 (g) The Board shall report to the North Carolina Medical Board payment of a
2 claim on behalf of a physician within 30 days of payment as required by G.S.
3 90-14.13(c).

4 **"§ 90-688. Withdrawals; fidelity bond; Fund accounting and audit.**

5 (a) Moneys shall be withdrawn from the Fund only upon vouchers approved and
6 as authorized by the Board.

7 (b) Every person who is authorized to receive deposits, withdraw funds, issue
8 vouchers, or otherwise disburse or handle any Fund moneys shall post a blanket fidelity
9 bond in an amount to be determined by the Board and reasonably sufficient to protect
10 Fund assets. The cost of the bond shall be paid from the Fund.

11 (c) The Board shall annually furnish an audited financial report and the actuarial
12 study required by G.S. 90-694 to the Department, the State Auditor, and to Fund
13 participants upon request. An independent certified public accountant shall prepare the
14 audited financial report in accordance with accepted accounting principles.

15 (d) The Board shall report annually to the General Assembly and the Governor
16 on the financial condition of the Fund and its statistical claims experience and may
17 make recommendations as to any further legislative actions that may be needed to carry
18 out the intent of this Article. All such reports shall be considered public records.

19 **"§ 90-689. Duty of insurers, self-insurers, and health care providers.**

20 It shall be the responsibility of an insurer or self-insurer and a health care provider to
21 act in good faith and in a fiduciary relationship to the Fund with respect to any claim
22 affecting the Fund. The Board may bring a civil action against an insurer, self-insurer,
23 or health care provider for failure to act in good faith or for breach of fiduciary
24 responsibility.

25 **"§ 90-690. Commencement of operations; effective date of coverage.**

26 (a) The Fund shall provide the excess coverage provided in this Article only for
27 causes of action arising out of occurrences on and after the effective date of
28 participation of a health care provider.

29 (b) The Board may provide coverage by the Fund when, in the Board's discretion,
30 the Fund has sufficient moneys and a sufficient number of participants.

31 **"§ 90-691. Acceptance of and compliance with Article and administrative rules of**
32 **the Board.**

33 Compliance with the provisions of G.S. 90-685 and G.S. 90-686 constitute, on the
34 part of a participating health care provider, a conclusive and unqualified acceptance of
35 the provisions of this Article and the administrative rules of the Board.

36 **"§ 90-692. Records; insurance laws; legal defense.**

37 Records held by the Board are not subject to Chapter 132 of the General Statutes.
38 The Fund is not subject to Chapter 58 of the General Statutes, and shall not participate
39 in the North Carolina Insurance Guaranty Association under Article 48 of Chapter 58 of
40 the General Statutes. Except for the Secretary and the Commissioner, the Department of
41 Justice is not responsible for legal defense of the Fund or the Board members.

42 **"§ 90-693. Fund consulting actuary.**

43 (a) In accordance with Article 3C of Chapter 143 of the General Statutes, the
44 manager shall retain a qualified, competent, and independent consulting actuary to

1 advise and consult the Fund on all aspects of the Fund's administration, operation, and
2 defense that require application of the actuarial science and to perform and submit the
3 annual actuarial study required by G.S. 90-694. An individual actuary contracted by the
4 Fund, or a principal actuary assigned to the engagement and employed by a partnership,
5 firm, or corporation contracted by the Fund, shall possess formal education and at least
6 a baccalaureate degree in the actuarial sciences, shall be a full member of the Casualty
7 Actuarial Society, and shall have had substantial prior experience in providing services
8 as a consulting actuary to insurance companies underwriting professional health care
9 liability insurance.

10 (b) The Fund's contract with a consulting actuary shall provide that the
11 consulting actuary shall be responsible for:

12 (1) Advising the manager with respect to the necessary and proper content
13 and form of claims experience data collected and maintained by the
14 manager.

15 (2) Advising the manager and the Office of Risk Management with
16 respect to the establishment, maintenance, and adjustment of reserves
17 on individual claims against the Fund and each sub-fund and the
18 establishment, maintenance, and adjustment of reserves for incurred
19 but not reported claims.

20 (3) Performing actuarial analysis of claims experience data collected and
21 maintained by the manager with respect to the Fund and each
22 sub-fund, commercial professional liability insurers doing business in
23 this State, self-insured health care providers, together with, as
24 necessary or appropriate, regional or national professional health care
25 liability claims experience data.

26 (4) Development, in consideration of the Fund's and each sub-fund's
27 allocated and unallocated expenses, its organization, administration,
28 and legal and regulatory constraints, of an assessment and surcharge
29 rate structure, rated and classified according to the several classes or
30 risks against which the Fund and each sub-fund provides
31 compensation, that shall reasonably ensure that the Fund and each
32 sub-fund is sufficiently funded so as to be and remain financially and
33 actuarially capable of providing the compensation for which it is
34 organized.

35 (5) Developing, in conjunction with the manager, assessment and
36 surcharge rate applications and requests for surcharge rate changes in
37 accordance with the consulting actuary's actuarial analyses, for
38 submission to and filing with the Department.

39 (6) Personal presentation of the assessment and surcharge rate structure to
40 the Department and with such other interested or affected persons,
41 firms, organizations, and entities as the manager may request.

42 (7) Reviewing and advising the manager with respect to the funding and
43 actuarial adequacy of self-insurance trusts and other plans submitted to

1 the manager by self-insured applicants for enrollment with the Fund as
2 evidence of financial responsibility.

3 (8) Generally advising and consulting with the manager and the
4 Department on all actuarial questions affecting the administration,
5 operation, and defense of the Fund.

6 "**§ 90-694. Annual actuarial study.**

7 (a) An actuarial study of the Fund and each sub-fund, and the assessment and
8 surcharge rate structure necessary and appropriate to ensure that the Fund and each
9 sub-fund is and remains financially and actuarially sound shall be performed annually
10 by the Fund's consulting actuary on the basis of an actuarial analysis of all relevant
11 claims experience data collected and maintained by the Fund.

12 (b) In the performance of the annual actuarial study and the development of a
13 financially sound and appropriate assessment and surcharge rate structure, the Fund's
14 consulting actuary and the manager shall accord the greatest weight to the claims
15 experience of the Fund and each sub-fund and of commercial professional health care
16 liability insurance underwriters and self-insurance funds with respect to the risk
17 underwritten by such insurers and self-insurance funds in this State and as particularly
18 reflected in such insurers' then most recent premium rate filings with the Department or
19 such self-insurance funds' current rate structure and supporting data. However, the data
20 shall be viewed in light of national claims experience data, and the Fund's consulting
21 actuary may place reliance on national claims experience data when, in the opinion of
22 the actuary, claims experience within this State as to any class of risks provides an
23 insufficient basis for reliance thereon for purposes of actuarial analysis or in calculating
24 indicated surcharge rates.

25 (c) Without respect to the rate structure indicated by any annual actuarial study
26 of the Fund and each sub-fund, no rate that, if approved and implemented, would or
27 could result in a reduction of the aggregate annual assessments and surcharges collected
28 by a sub-fund, shall be approved when the total amount of the sub-fund is, or by effect
29 of such rate change could become, less than one hundred fifty percent (150%) of the
30 sum of the aggregate annual assessment and surcharges collected by the sub-fund,
31 reserves against individual claims, reserves for incurred but not reported claims, and
32 allocated and unallocated expenses of the sub-fund's administration, operation, and
33 defense.

34 "**§ 90-695. Surcharge on health care providers.**

35 Subject to G.S. 90-698 and if appropriations from the General Assembly are
36 insufficient to adequately capitalize the Fund, in order to adequately capitalize the Fund
37 an annual surcharge may be levied on all health care providers in this State until the
38 Fund is actuarially sound and self-supporting, as determined by the Board. If the Board
39 determines the Fund is actuarially sound and self-supporting, the surcharge under this
40 section shall not be levied.

41 "**§ 90-696. Amount of surcharge.**

42 (a) As used in this section, 'actuarial program' means a program used or created
43 by the Board to determine the actuarial risk posed to the Fund by a health care provider.
44 The program must be:

- 1 (1) Developed to calculate actuarial risk posed by a health care provider
2 taking into consideration risk management programs used by the
3 provider.
- 4 (2) An efficient and accurate means of calculating a provider's malpractice
5 actuarial risk.
- 6 (3) Publicly identified by the Board by July 1 of each year.
- 7 (4) Made available to a provider's malpractice insurance carrier for
8 purposes of calculating the provider's surcharge under subsection (g)
9 of this section.
- 10 (b) Subject to G.S. 90-698 and beginning July 1, 2005, the annual surcharge shall
11 be set by the Board.
- 12 (c) The amount of the surcharge shall be determined based upon actuarial
13 principles and actuarial studies and shall be adequate for the payment of claims and
14 expenses from the Fund.
- 15 (d) There is imposed a minimum annual surcharge of one hundred dollars
16 (\$100.00), until the Board determines the Fund is actuarially sound and self-supporting.
- 17 (e) Subject to a final determination by the Board, the surcharge for a qualified
18 health care provider who is licensed under this Chapter is calculated as follows:
- 19 (1) Not later than July 1 of each year, the Fund's consulting actuary shall
20 calculate the median of the premiums paid for professional liability
21 policies to the three professional liability insurance carriers in this
22 State that have underwritten the most professional liability insurance
23 policies for all health care providers practicing in the same specialty
24 class in this State during the previous 12-month period. In calculating
25 the median, the actuary shall consider the:
- 26 a. Manual rates of the three leading malpractice insurance carriers
27 in this State.
- 28 b. Aggregate credits or debits to the manual rates given during the
29 previous 12-month period.
- 30 (2) After making the calculation described in subdivision (1) of this
31 subsection, the actuary shall establish a uniform surcharge for all
32 health care providers practicing in the same specialty class. This
33 surcharge shall be based on a percentage of the median calculated in
34 subdivision (1) of this subsection for all health care providers
35 practicing in the same specialty class under rules adopted by the
36 Board. The surcharge shall be sufficient to cover and shall not exceed
37 the actuarial risk posed to the Fund by health care providers practicing
38 in the specialty class.
- 39 (f) The surcharge for a health care provider shall be established by the Board
40 through the use of an actuarial program. At the time financial responsibility is
41 established for the provider, the provider shall pay the surcharge amount established for
42 the provider under this section. The surcharge shall be sufficient to cover and shall not
43 exceed the actuarial risk posed to the Fund by the provider.

1 (g) An actuarial program used or developed under subsection (a) of this section
2 shall be treated as a public record under Chapter 132 of the General Statutes.

3 **"§ 90-697. Collection of surcharge; time for payment.**

4 (a) The surcharge shall be collected on the same basis as premiums by each
5 insurer, risk manager, or surplus lines licensee.

6 (b) The surcharge is due and payable within 30 days after the premium for
7 professional liability insurance has been received by the insurer, risk manager, or
8 surplus lines licensee from a health care provider in this State. If a surcharge is not paid
9 as required by this section, the insurer, risk manager, or surplus lines licensee
10 responsible for the delinquency is liable for the surcharge plus a penalty equal to ten
11 percent (10%) of the amount of the surcharge.

12 (c) If the annual premium surcharge is not paid within the time limit specified in
13 subsection (b) of this section, the license of the insurer, risk manager, and surplus lines
14 licensee shall be suspended until the annual premium surcharge is paid.

15 **"§ 90-698. Approval of assessments and surcharges.**

16 The Board shall present all initial proposed assessments and surcharges to the
17 General Assembly for approval and such assessments and surcharges shall not become
18 law unless approved by a separate act of the General Assembly. The Board shall not
19 establish any assessment or surcharge except as specifically authorized by the General
20 Assembly.

21 **"§ 90-699. Adoption of rules; comparability of rates.**

22 (a) In addition to the rule-making authority under G.S. 90-694, the Board may
23 adopt rules establishing the following:

24 (1) The manner of determination of the surcharge for a health care
25 provider.

26 (2) The manner of payment of the surcharge by that health care provider.

27 (b) The surcharge calculation established under subsection (a) of this section
28 shall be comparable for insured and self-insured health care providers."

29 **SECTION 3.6.** There is appropriated from the General Fund to the North
30 Carolina Excess Liability Fund the sum of twenty million dollars (\$20,000,000) for the
31 2004-2005 fiscal year for the purpose of implementation of Article 40 of Chapter 90 of
32 the General Statutes including capitalization of the Fund, payment of compensation and
33 allowances of Board members and employees, and retention of actuarial, economic, and
34 legal advice. No unexpended surplus of the Fund shall revert to the General Fund.

35 **SECTION 3.7.(a)** There is appropriated from the General Fund to the
36 Department of Health and Human Services the sum of five million dollars (\$5,000,000)
37 for the 2004-2005 fiscal year. These funds shall be used to establish the Rural
38 Obstetrical and Emergency Department Care Incentive Fund as provided in this act.

39 **SECTION 3.7.(b)** The Rural Obstetrical and Emergency Department Care
40 Incentive Fund shall be established within the Office of Rural Health and shall be used
41 to make grants to physicians who are practicing obstetrics, or providing emergency
42 department services, in rural and underserved areas of the State and are adversely
43 affected by the high cost of liability insurance. The grants shall be used solely for the
44 purpose of subsidizing in whole or in part the costs associated with obtaining or

1 maintaining liability insurance for physicians in rural and underserved health care
2 manpower shortage areas of the State as defined by the Office of Rural Health. The
3 Office of Rural Health shall establish guidelines for administering grant funds.

4 **SECTION 3.8.** The Commissioner of Insurance, the Industrial Commission,
5 and the Department of Health and Human Services shall jointly study the utility,
6 efficacy, and advisability of creating a system of no-fault compensation, with such
7 compensation based on scheduled amounts and subject to limits on total compensation
8 paid, for injuries resulting from regular and ordinary course of care provided at nursing
9 homes, homes for the elderly, other long-term care facilities, and assisted living
10 facilities. The results of this study, including findings and recommendations for
11 suggested legislation, shall be reported to the General Assembly on or before January 1,
12 2005.

13 **SECTION 3.9.** The Legislative Research Commission shall study the issues
14 related to the collateral source rule including whether evidence of collateral sources of
15 payments of expenses recoverable in negligence actions should be admissible and
16 considered by the jury in negligence actions, including medical negligence actions.
17 This study should also consider the alternative of not presenting evidence of collateral
18 sources to the jury but requiring the court to adjust any jury award by the amount of
19 collateral sources for which the payor of the collateral source does not have a right of
20 subrogation. This study should also examine whether the right of subrogation should be
21 extended to medical insurance and medical benefit providers, whether just in medical
22 negligence matters or to all negligence claims. The Legislative Research Commission
23 shall report the results of its study to the 2005 General Assembly.

24 25 **PART IV. MISCELLANEOUS.**

26 **SECTION 4.1.** The provisions of this act are severable. If a court of
27 competent jurisdiction holds any provision of this act invalid, the invalidity does not
28 affect other provisions of the act that can be given effect without the invalid provision.

29 30 **PART V. EFFECTIVE DATE PROVISIONS.**

31 **SECTION 5.1.** Sections 1.1 through 1.7, 3.4 through 3.9, 4.1, and 5.1 are
32 effective when this act becomes law. Section 1.8 is effective when this act becomes law
33 and applies to statements made and actions taken on or after that date. Sections 1.9 and
34 1.10 become effective October 1, 2004. Sections 1.11, 2.1, 2.3, 2.4, 2.7, and 2.9
35 become effective October 1, 2004, and apply to actions filed on or after that date.
36 Section 2.2 becomes effective October 1, 2004, and applies to judgments entered on or
37 after that date. Section 2.8 becomes effective October 1, 2004, and applies to causes of
38 action arising on or after that date. Sections 2.5 and 2.6 become effective October 1,
39 2004, and expire October 1, 2011, and apply to actions commenced on or after the
40 effective date and before the expiration date. Sections 3.1, 3.2, and 3.3 become
41 effective January 1, 2005, and apply to rate changes filed on or after that date. The
42 remainder of this act is effective when it becomes law."