~~Indicates Matter Stricken~~

Indicates New Matter

COMMITTEE REPORT

April 30, 2019

**H. 3760**

Introduced by Rep. Sandifer

S. Printed 4/30/19--S.

Read the first time February 26, 2019.

**THE COMMITTEE ON BANKING AND INSURANCE**

To whom was referred a Bill (H. 3760) to amend the Code of Laws of South Carolina, 1976, by adding Section 38‑79‑500 so as to merge the Patients’ Compensation Fund with the South Carolina Medical, etc., respectfully

**REPORT:**

That they have duly and carefully considered the same and recommend that the same do pass with amendment:

Amend the bill, as and if amended, by striking all after the enacting words and inserting:

/ SECTION 1. Article 3, Chapter 79, Title 38 of the 1976 Code is amended to read:

“Article 3

South Carolina Medical Malpractice Liability

Joint Underwriting Association

Section 38‑79‑110. As used in this article:

(1) ‘Accumulated deficit’ means the amount that the association’s and the fund’s liabilities exceed their assets, as reported in the association’s and fund’s respective financial statements.

(2) ‘Association’ means any joint underwriting association established by the General Assembly in 1987 and managed and operated pursuant to the provisions of this article ~~including the South Carolina Joint Underwriting Association as provided for in Section 38‑79‑300~~.

~~(2)~~(3) ‘Fund’ means the Patients’ Compensation Fund.

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

~~(3)~~(5) ‘Medical malpractice insurance’ means medical professional liability insurance or insurance protection against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering or failing to render professional service by any licensed physician, licensed health care provider, or hospital.

~~(4)~~(6) ‘Net‑direct premiums’ means gross direct premiums written on ~~bodily injury liability insurance, other than automobile liability insurance, homeowners liability insurance, and farmowners liability insurance, including the liability component of multiple peril package policies, as computed by the director or his designee, less return premiums or the unused or unabsorbed portions of premium deposits.~~ medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, and any other type of professional liability insurance covering risks of licensed health care providers and facilities as determined and computed by the director or his designee, less return premiums or the unused or unabsorbed portions of premium deposits. The net‑direct premium calculation does not include premiums written by the fund.

Section 38‑79‑120. (1) A joint underwriting association (association) is created, consisting of ~~all insurers authorized to write within this State, on a direct basis, bodily injury liability insurance, other than automobile bodily injury liability insurance, homeowners liability insurance, and farmowners liability insurance, including insurers covering such peril in multiple peril package policies. Every such insurer is and must remain a member of the association as a condition of its authority to continue to transact such kind of insurance in this State.~~ all insurers authorized to write and report net‑direct written premiums for medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, or any other type of professional liability insurance in this State covering the professional liability risks of licensed health care providers. The fund and nonadmitted insurers are not members of the association. Each insurer described above is and must remain a member of the association as a condition of the authorization to transact the sale of insurance in this State.

(2) The purpose of the association is to ~~provide medical malpractice insurance~~ ensure the availability of a stable facility for medical malpractice insurance for healthcare providers and act as a residual market on a self‑supporting basis to the fullest extent possible.

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

Section 38‑79‑125. (1) As of January 1, 2020, all insurers authorized to write, on a direct basis, bodily injury liability insurance and insurers covering such peril in multiple peril package policies and bodily injury insurance, other than automobile bodily injury insurance, homeowners liability insurance, farmowners liability insurance including monoline farm liability insurance, medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, or any other type of professional liability insurance in this State covering the professional liability risks of licensed health care providers must pay an assessment equal to their share of twenty percent of the accumulated deficit of the association as determined by the director and contained in their most recently reported financial statements. Each insurer’s share of the assessment must be calculated based upon the net‑direct written premiums for the insurer’s liability lines described above on the most recent year preceding the effective date of this section. All money collected from this assessment must be applied to the accumulated deficit of the association. Each insurer may pay the assessment in one lump sum or, at the insurer’s option, in equal installments over a period not to exceed five years. The assessment may be incorporated into the rate filings of the insurer. Upon satisfaction of the assessment, each insurer may withdraw as members of the association upon submission of:

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

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

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

(2) The director may set the date on which the insurer’s withdrawal becomes effective by order.

(3) Insurers writing medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, or any other type of professional liability insurance in this State covering the professional liability risks of licensed health care providers are not eligible to withdraw from membership in the association.

Section 38‑79‑130. The association, pursuant to the provisions of this article and the approved plan of operation in respect to medical malpractice insurance, has the power on behalf of its members to:

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

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

(3) cede and assume reinsurance.

Section 38‑79‑140. (1) The association must operate pursuant to a plan of operation which shall provide for economic, fair, and nondiscriminatory administration and for the prompt and efficient provision of medical malpractice insurance and may contain other provisions including, but not limited to, preliminary assessment of all members for initial expenses necessary to commence operations, establishment of necessary facilities, management of the association, assessment of the members to defray losses and expenses, commissions arrangements, reasonable and objective underwriting standards, acceptance and cession of reinsurance, appointment of servicing carriers, and procedures for determining amounts of insurance to be provided by the association.

(2) The plan of operation shall provide that any profit achieved by the association must be applied to the accumulated deficit. If there is no accumulated deficit, any profit achieved by the association must be added to the reserves of the association ~~or returned to the policyholders as a dividend~~.

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

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

Section 38‑79‑150. Any licensed health care provider in a category in which the department has declared an emergency exists is entitled to apply to the association for coverage. The application may be made on behalf of the applicant by a licensed agent or broker authorized in writing by the applicant. Beginning July 1, 2025, the board of directors may require evidence of declinations from the admitted medical malpractice market before quoting policies to a prospective policy owner. The board decision to require declinations must be subject to the approval of the director who may disapprove such requirement only if it can be reasonably shown that declinations will cause the accumulated deficit to worsen. If the association determines that the applicant meets the underwriting standards of the association as set forth in the approved plan of operation and there is no unpaid, uncontested premium due from the applicant for any prior insurance of the same kind, the association, upon receipt of the premium, or a portion thereof as prescribed by the plan of operation, shall cause to be issued a policy of medical malpractice liability insurance for a term of one year.

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

Section 38‑79‑160. ~~The director or his designee shall obtain complete statistical data in respect to medical malpractice losses and reparation costs as well as all other costs or expenses which underlie or are related to medical malpractice liability insurance. He shall promulgate any statistical plan he considers necessary for the purpose of gathering data referable to loss and loss adjustment expense experience and other expense experience. When a statistical plan is promulgated all members of the association shall adopt and use it. The director or his designee shall also obtain statistical data in respect to the costs of compensating or rehabilitating victims of medical malpractice without respect to insurance for purposes of studying the feasibility or desirability of alternative medical malpractice compensation systems and estimating the impact of medical malpractice loss and insurance costs upon other compensation and insurance systems such as workers’ compensation and accident and health insurance. He may require from any person obtaining insurance through the association loss, claim, or expense data. This information or data is confidential and the physician‑patient privilege must be preserved.~~ Reserved.

Section 38‑79‑170. In respect to the structuring of rates for medical malpractice liability insurance and the determination of the profit or loss of the association in respect to that insurance, due consideration must be given by the director or his designee to all investment income.

Section 38‑79‑180. Within a time that the director or his designee directs, the association shall submit, for the approval of the director or his designee, an initial filing, in proper form, of policy forms, classifications, rates, rating plans, and rating rules applicable to medical malpractice liability insurance to be written by the association. In the event the director or his designee disapproves the initial filing, in whole or in part, the association shall amend the filing, in whole or in part, in accordance with the direction of the director or his designee. If the director or his designee is unable to approve the filing or amended filing, within the time specified, he shall promulgate the policy forms, classifications, rates, rating plans, and rules to be used by the association in making rates for and writing the insurance.

Section 38‑79‑190. (1) The board of directors shall specify whether policy forms and the rate structure must be on a ‘claims‑made’ or ‘occurrence’ basis and coverage may be provided by the association only on the basis specified by the board of directors. The board of directors shall specify the ‘claims‑made’ basis only if the contract makes provision for residual ‘occurrence’ coverage upon the retirement, death, disability, or removal from the State of the insured. Provision may be made for a premium charge allocable to any such residual ‘occurrence’ coverage and the premium charges for the residual coverage must be segregated and separately maintained for such purpose which may include the reinsurance of all or a part of that portion of the risk.

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

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

(4) The premium rate charged for either or both ‘claims‑made’ or ‘occurrence’ coverage must be at rates established on an actuarially sound basis, including consideration of trends in the frequency and severity of losses~~, and must be calculated to be self supporting~~. After the accumulated deficit has been eliminated, the association must function as a residual market mechanism. After that time, the association must not offer rates competitive with the admitted market, but the rates for policies issued by the association must be adequate and established at a level that permits the association to operate as a self‑sustaining mechanism.

Section 38‑79‑200. The association is authorized to provide a rate increase or assessment on association policyholders which is subject to the approval of the director or his designee.

Section 38‑79‑210. Any operating deficit sustained by the association in any year must be recouped, ~~pursuant to the plan of operation and the rating plan then in effect, by one or both of the following procedures:~~

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

~~(2)~~ by a rate increase applicable prospectively.

Section 38‑79‑220. ~~Effective after the initial year of operation, rates, rating plans, and rating rules, and any provision for recoupment through policyholder assessment or premium rate increase, must be based upon the association’s loss and expense experience and investment income, together with any other information based upon such experience and income as the director or his designee considers appropriate. The resultant premium rates must be on an actuarially sound basis and must be calculated to be self‑supporting.~~

~~In the event that sufficient funds are not available for the sound financial operation of the association, pending recoupment as provided in Section 38‑79‑210, all members shall, on a temporary basis, contribute to the financial requirements of the association in the manner provided for in Section 38‑79‑230. Any such contribution must be reimbursed to the members following recoupment as provided in Section 38‑79‑210.~~ (1) Beginning July 1, 2019, the association, the fund, and every member association must assess and remit to the department a surcharge on all premiums written for the purpose of reducing the accumulated deficit of the fund and the association. The surcharge must be between four and ten percent and will be approved by the board and the director. Forty‑five percent of the surcharge must be remitted to the fund by the department and the remaining amount must be remitted to the association by the department. The assessment must continue until the director declares that the accumulated deficit has been eliminated or July 1, 2030, whichever is earlier. In the event that the accumulated deficit of the fund or association is eliminated, one hundred percent of the surcharge must be remitted to the entity with a remaining accumulated deficit. Any excess funds must be retained by the association or fund as capital. If the accumulated deficits have not been eliminated by July 1, 2030, the director may extend the surcharge for up to an additional five years.

(2) Beginning on July 1, 2020, an additional one percent surcharge must be assessed on association policyholders. The surcharge must increase by one additional percentage point annually until it reaches ten percent and shall not sunset.

(3) Surcharges levied under this section are not premium and are not subject to premium tax, any fees, or any commissions; however, failure to pay the surcharges must be treated the same as failure to pay premium. Surcharges must not be included in the revenue or income of the association or fund.  
 (4) Beginning July 1, 2019, all surplus lines insurance producers or brokers placing insurance through nonadmitted insurers shall collect from the insured and remit to the department to be distributed to the association and fund a nonadmitted policy surcharge on all premiums for all insurance written by such surplus lines insurance producer or broker for a policy from a nonadmitted insurer for any and all medical malpractice risks in this State. By procuring or selling medical malpractice insurance in this State from a nonadmitted insurer, each surplus lines insurance producer or broker placing insurance through a nonadmitted insurer agrees to be bound by the provisions of this chapter and to collect and remit the nonadmitted policy surcharge provided for herein.

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

(6) The nonadmitted policy surcharge percentage must be the same percentage as the surcharge that has been approved by the board and director.

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

(8) Each insured in this State who directly procures or renews insurance with a nonadmitted insurer on medical malpractice insurance other than insurance procured through a surplus lines licensee, must be subject to the nonadmitted policy surcharge which must be paid by the insured according to the procedures provided for premium taxes in Section 38‑79‑220 (4).

(9) Monies derived from the nonadmitted policy surcharge collected under this section must be distributed by the department to the association and the fund, with the association receiving fifty‑five percent of the fee and the fund receiving forty‑five percent. The nonadmitted policy surcharge must continue until the surcharge established in Section 38-79-220(1) is eliminated.

Section 38‑79‑230. ~~All insurers which are members of the association shall participate in its writings, expenses, profits, and losses in the proportion that the net direct premiums of each member (excluding that portion of premiums attributable to the operation of the association) written during the preceding calendar year bear to the aggregate net‑direct premiums written in this State by all members of the association. Each insurer’s participation in the association must be determined annually on the basis of the net direct premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the insurer with the department. The assessment of a member insurer, after hearing, may be ordered deferred in whole or in part upon application by the insurer if, in the opinion of the director or his designee, payment of the assessment may render the insurer insolvent or in danger of insolvency or otherwise may leave the insurer in a condition that further transaction of the insurer’s business may be hazardous to its policyholders, creditors, members, subscribers, stockholders, or the public. If payment of an assessment against a member insurer is deferred by order of the director or his designee in whole or in part, the amount by which the assessment is deferred must be assessed against other member insurers in the same manner as provided in this section. In the order of deferral or in subsequent orders as may be necessary, the director or his designee shall prescribe a plan by which the assessment deferred must be repaid to the association by the impaired insurer with interest at the six‑month treasury bill rate adjusted semiannually. Profits, dividends, or other funds of the association to which the insurer is otherwise entitled may not be distributed to the impaired insurer but must be applied toward repayment of any assessment until the obligation has been satisfied. The association shall distribute the repayments, including interest on them, to the other member insurers on the basis on which assessments were made.~~ Reserved.

Section 38‑79‑240. Every member of the Association is bound by the approved plan of operation of the Association and by any other rules the board of directors of the Association lawfully prescribes.

Section 38‑79‑250. ~~(1)~~ ~~If the authority of an insurer to transact bodily injury liability insurance, other than automobile, homeowners, or farmowners, in this State terminates for any reason its obligations as a member of the association nevertheless continue until all its obligations have been fulfilled and the director or his designee has so found and certified to the board of directors.~~

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

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

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

Section 38‑79‑260. The association is governed by a board of ~~thirteen~~ eleven directors, all of whom must be appointed by the Governor within thirty days of the effective date of this Section. The director or his designee shall serve as an ex officio member of the board. The Governor shall appoint ~~five~~ four health care providers after consultation with the South Carolina Medical Association, the South Carolina Dental Association, the South Carolina Nurses’ Association, and the South Carolina ~~Health Alliance~~ Hospital Association; four medical malpractice insurance representatives after consultation with the ~~insurance industry~~ three members with the largest proportion of net‑direct premium; one consumer representative who is unaffiliated with the insurance or health care industries or the medical or legal professions; one representative representing property and casualty insurers; and ~~two~~ one licensed insurance ~~agents or brokers~~ agent or broker who is not employed by the same insurer or insurer group as any of the four insurance representatives. The professional associations listed and the insurance industry may nominate qualified individuals to the Governor for his consideration. The Governor may also receive nominations for appointments to the board from any other individual, group, or association. Notices of vacancies on the board must be published in newspapers of general statewide circulation. ~~The director or his designee shall serve as an ex officio member of the board.~~ The board shall develop a plan of operation which is subject to the approval of the director or his designee as provided in this article. The plan of operation shall provide for staggered terms of the members of the board. The approved plan of operation of the association may make provision for combining insurers under common ownership or management into groups for voting, assessment, and all other purposes and may provide that not more than one of the officers or employees of a group may serve as a director at any one time. The board shall elect a chairman, who must represent a voting member, and other necessary officers for two‑year terms. A vacancy must be filled for the unexpired portion of the term only. The Governor may receive recommendations from any individual, group, or association for any vacancy on the board. The board must meet at the call of the chairman or a majority of the members of the board, but in any event it must meet at least once a year.

Section 38‑79‑280. The association shall file in the office of the department annually, by March first, a statement which contains information with respect to its transactions, condition, operations, and affairs during the preceding year. The statement shall contain such matters and information as are prescribed by the director or his designee and must be in the form he directs. The director or his designee may, at any reasonable time, require the association to furnish additional information with respect to its transactions, condition, or any matter connected therewith considered to be material and of assistance in evaluating the scope, operation, and experience of the association.

Section 38‑79‑290. The director or his designee shall make an examination into the financial condition and affairs of the association at least annually and shall file a report thereon with the department, the Governor, and the General Assembly. The expenses of the examination must be paid by the association.”

SECTION 2. Section 38‑79‑430 of the 1976 Code is amended to read:

“Section 38‑79‑430. The Board of Governors (board) is created to manage and operate the fund. The board is composed of three physicians to be appointed by the Governor after consultation with the South Carolina Medical Association, two dentists to be appointed by the Governor after consultation with the South Carolina Dental Association, two hospital representatives to be appointed by the Governor after consultation with the South Carolina Hospital Association, two insurance representatives to be appointed by the Governor after consultation with the medical malpractice insurance industry, one attorney to be appointed by the Governor after consultation with the South Carolina Bar, one attorney to be appointed by the Governor after consultation with the South Carolina Trial Lawyers Association, and two representatives of the general public appointed by the Governor who are unaffiliated with insurance or health care industries or the medical or legal professions. The appointed members shall serve for a term of six years. The board shall elect a chairman and other necessary officers for two‑year terms. The board must meet at the call of the chairman or a majority of the members but in any event it must meet at least once a year. A majority of the board members shall constitute a quorum for the transaction of any business of the board. The affirmative vote by a majority of the quorum present at a duly called meeting after notice is required to exercise any function of the board. The board may promulgate any regulations necessary to carry out the provisions of this article.

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

SECTION 3. This act takes effect upon approval by the Governor. /

Renumber sections to conform.

Amend title to conform.

RONNIE W. CROMER for Committee.

**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING SECTION 38‑79‑500 SO AS TO MERGE THE PATIENTS’ COMPENSATION FUND WITH THE SOUTH CAROLINA MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION; BY ADDING SECTION 40‑15‑390 SO AS TO ESTABLISH A SURCHARGE FEE FOR A DENTIST’S LICENSE TO REDUCE THE OPERATING DEFICIT OF THE SOUTH CAROLINA MEDICAL MALPRACTICE LIABILITY JOINT UNDERWRITING ASSOCIATION; BY ADDING SECTION 40‑47‑55 SO AS TO ESTABLISH A SURCHARGE FEE FOR A PHYSICIAN’S LICENSE FOR THE PURPOSE OF REDUCING THE OPERATING DEFICIT OF THE SOUTH CAROLINA MEDICAL MALPRACTICE LIABILITY JOINT UNDERWRITING ASSOCIATION; AND TO AMEND ARTICLE 3, CHAPTER 79, TITLE 38, RELATING TO THE SOUTH CAROLINA MEDICAL MALPRACTICE LIABILITY JOINT UNDERWRITING ASSOCIATION, SO AS TO DEFINE THE TERM “DEFICIT”, TO ALTER THE MEMBERSHIP OF THE ASSOCIATION, TO ESTABLISH CERTAIN REQUIREMENTS FOR THE INITIAL FILING OF POLICY FORMS, TO PROVIDE CERTAIN ACTIONS THAT MUST BE DONE WHEN THE ASSOCIATION ACCUMULATES OR SUSTAINS A DEFICIT, TO ESTABLISH CERTAIN OBLIGATIONS FOR TERMINATED MEMBERS OF THE ASSOCIATION, TO ALTER THE COMPOSITION OF THE BOARD OF THE ASSOCIATION, TO ESTABLISH CERTAIN CONDITIONS REGARDING THE ASSOCIATION’S ANNUAL FINANCIAL STATEMENT AND THE EXAMINATION OF THE ASSOCIATION BY THE DIRECTOR OF THE DEPARTMENT OF INSURANCE, AND TO PROVIDE FOR THE MERGER OF THE ASSOCIATION WITH THE PATIENTS’ COMPENSATION FUND.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Article 1, Chapter 15, Title 40 of the 1976 Code is amended by adding:

“Section 40‑15‑390. (A) All dentists licensed before January 1, 2020, must pay a total surcharge fee of one hundred fifty dollars to the department for purposes of reducing the operating deficit of the South Carolina Medical Malpractice Joint Underwriting Association or any successor thereto. This surcharge fee is in addition to any initial or renewal license fee and payable as either a one‑time fee of one hundred fifty dollars or in installments payable in consecutive renewal cycles, but not more than three consecutive renewal cycles, until the total surcharge fee is paid in full. The surcharge fee is due at the same time as the payment of the initial or renewal license fee. This surcharge fee for dentists licensed before January 1, 2020, expires upon payment of the total surcharge fee unless extended by the General Assembly.

(B) Failure to pay the surcharge fee shall result in a monthly late fee not to exceed five percent of the surcharge fee and accrues until the surcharge fee is paid in full, but in no event may the fee accrue for more than six months. All late fees collected must be remitted to the South Carolina Medical Malpractice Joint Underwriting Association or any successor thereto and applied to the reduction of the operating deficit of the association. No action may be taken by the department against the license of any dentist for failure to pay surcharge fees. The department shall remit all surcharge fee payments and late fee payments in full to the board of the association.

(C) The department may charge a transaction fee for licensees who pay the surcharge fee by credit card.”

SECTION 2. Article 1, Chapter 47, Title 40 of the 1976 Code is amended by adding:

“Section 40‑47‑55. (A) All medical doctors, surgeons, and osteopathic physicians licensed before January 1, 2020, must pay a total surcharge fee of three hundred dollars to the department for purposes of reducing the operating deficit of the South Carolina Medical Malpractice Joint Underwriting Association or any successor thereto. This surcharge fee must be in addition to any initial or renewal license fee and payable as either a one‑time fee of three hundred dollars or in installments in consecutive renewal cycles, but not more than three consecutive renewal cycles, until the total surcharge fee is paid in full. The surcharge fee is due at the same time as the payment of the initial or renewal license fee. This surcharge fee for medical doctors, surgeons, and osteopathic physicians licensed before January 1, 2020, expires upon payment of the total surcharge fee unless extended by the General Assembly.

(B) Failure to pay the surcharge fee shall result in a monthly late fee not to exceed five percent of the surcharge fee and accrues until the surcharge fee is paid in full, but in no event may the fee accrue for more than six months. All late fees collected must be remitted to the South Carolina Medical Malpractice Joint Underwriting Association or any successor thereto and applied to the reduction of the operating deficit of the association. No action may be taken by the department against the license of any medical doctor, surgeon, or osteopathic physician for failure to pay surcharge fees. The department shall remit all surcharge fee payments and late fee payments in full to the board of the association.

(C) The department may charge a transaction fee for licensees who pay the surcharge fee by credit card.”

SECTION 3. Article 3, Chapter 79, Title 38 of the 1976 Code is amended to read:

“Article 3

South Carolina Medical Malpractice Liability

Joint Underwriting Association

Section 38‑79‑110. As used in this article:

(1) ‘Association’ means any joint underwriting association established by the General Assembly in 1987 and managed and operated pursuant to the provisions of this article including the South Carolina Joint Underwriting Association as provided for in Section 38‑79‑300.

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

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

(4) ‘Net‑direct premiums’ means gross direct premiums written on ~~bodily injury liability insurance, other than automobile liability insurance, homeowners liability insurance, and farmowners liability insurance, including the liability component of multiple peril package policies, as~~ medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, and any other type of professional liability insurance covering risks of licensed health care providers and facilities as determined and computed by the director or his designee, less return premiums or the unused or unabsorbed portions of premium deposits. The net direct premium calculation does not include premiums written by the association or the South Carolina Patients’ Compensation Fund established pursuant to the provisions of Article 5 of this chapter.

(5) ‘Deficit’ means all operating losses of the association as reported in the association’s financial statements.

Section 38‑79‑120. (1) A joint underwriting association (association) is created, ~~consisting of~~ containing as members all insurers authorized to write and report net‑direct written premiums for medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, or any other type of professional liability insurance in this State covering the professional liability risks of licensed health care providers. Membership also includes foreign and domestic risk retention groups and surplus lines insurers authorized to write and report net‑direct written premiums for medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, or any other type of professional liability insurance in this State covering the professional liability risk of licensed health care providers, and authorized to do business in accordance with the provisions of this title. Each insurer, risk retention group, or surplus lines insurer described above is and must remain a member of the association as a condition of the authorization to transact the sale of insurance in this State. If the net‑direct premiums written by all carriers are less than twenty‑five million dollars in a given year, then in such year the membership of the association must be expanded to include all insurers authorized to write within this State, on a direct basis, bodily injury liability insurance, other than automobile bodily injury liability insurance, homeowners liability insurance, and farmowners liability insurance, including insurers covering such peril in multiple peril package policies. ~~Every such insurer is and must remain a member of the association as a condition of its authority to continue to transact such kind of insurance in this State.~~ In such event, the term ‘net‑direct premiums’ shall include the gross direct premiums written on bodily injury liability insurance other than automobile liability insurance, homeowners liability insurance, and farmowners liability insurance including the liability component of multiple peril package policies as computed by the director or his designee, less return premiums of the unused or unabsorbed portions of premium deposits.

(2) The purpose of the association is to ~~provide medical malpractice insurance~~ ensure the availability of medical malpractice and other types of liability insurance for health care providers on a self‑supporting basis to the fullest extent possible. The intent of the General Assembly in enacting this section is to eliminate the accumulated deficit of the association and of the Patients’ Compensation Fund and to transition the association over time to a market of last resort so that it is no longer in competition with the private market. Specifically, the General Assembly does not intend that the South Carolina Joint Underwriting Association offer rates that are competitive to the private market. Rates for policies issued by the association must be adequate and established at a level that permits the association to operate without accumulating additional deficits over time. The General Assembly encourages the board, in consultation with the director or his designee, to develop a five‑year plan to increase rates gradually to achieve this legislative intent.

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

Section 38‑79‑130. The association, pursuant to the provisions of this article and the approved plan of operation in respect to medical malpractice insurance, has the power on behalf of its members to:

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

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

(3) cede and assume reinsurance.

Section 38‑79‑140. (1) The association must operate pursuant to a plan of operation which shall provide for economic, fair, and nondiscriminatory administration and for the prompt and efficient provision of medical malpractice insurance and may contain other provisions including, but not limited to, preliminary assessment of all members for initial expenses necessary to commence operations, establishment of necessary facilities, management of the association, assessment of the members to defray losses and expenses, commissions arrangements, reasonable and objective underwriting standards, acceptance and cession of reinsurance, appointment of servicing carriers, and procedures for determining amounts of insurance to be provided by the association.

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

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

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

Section 38‑79‑150. Any licensed health care provider in a category in which the department has declared an emergency exists is entitled to apply to the association for coverage. The application may be made on behalf of the applicant by a licensed agent or broker authorized in writing by the applicant. If the association determines that the applicant meets the underwriting standards of the association as set forth in the approved plan of operation and there is no unpaid, uncontested premium due from the applicant for any prior insurance of the same kind, the association, upon receipt of the premium, or a portion thereof as prescribed by the plan of operation, shall cause to be issued a policy of medical malpractice liability insurance for a term of one year.

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

Section 38‑79‑160. The director or his designee shall obtain complete statistical data in respect to medical malpractice losses and reparation costs as well as all other costs or expenses which underlie or are related to medical malpractice liability insurance. He shall promulgate any statistical plan he considers necessary for the purpose of gathering data referable to loss and loss adjustment expense experience and other expense experience. When a statistical plan is promulgated all members of the association shall adopt and use it. The director or his designee shall also obtain statistical data in respect to the costs of compensating or rehabilitating victims of medical malpractice without respect to insurance for purposes of studying the feasibility or desirability of alternative medical malpractice compensation systems and estimating the impact of medical malpractice loss and insurance costs upon other compensation and insurance systems such as workers’ compensation and accident and health insurance. He may require from any person obtaining insurance through the association loss, claim, or expense data. This information or data is confidential and the physician‑patient privilege must be preserved.

Section 38‑79‑170. In respect to the structuring of rates for medical malpractice liability insurance and the determination of the profit or loss of the association in respect to that insurance, due consideration must be given by the director or his designee to all investment income.

Section 38‑79‑180. ~~Within a time that the director or his designee directs, the association shall submit, for the approval of the director or his designee, an initial filing, in proper form, of policy forms, classifications, rates, rating plans, and rating rules applicable to medical malpractice liability insurance to be written by the association. In the event the director or his designee disapproves the initial filing, in whole or in part, the association shall amend the filing, in whole or in part, in accordance with the direction of the director or his designee. If the director or his designee is unable to approve the filing or amended filing, within the time specified, he shall promulgate the policy forms, classifications, rates, rating plans, and rules to be used by the association in making rates for and writing the insurance.~~ The association shall submit, for the approval of the director or his designee, all policy forms, classifications, rates, rating plans, or rules applicable to its insurance product offerings to customers in this State. Such filings must be submitted for approval to the director no less than sixty days prior to their intended effective date. The director may extend the time for his review by an additional sixty days to allow the department sufficient time to evaluate the proposed form, classification, rate, rating plan, or rule to be used by the association. Rates must be actuarially sound, self supporting, and may not be excessive, inadequate, or unfairly discriminatory.

Section 38‑79‑190. (1) The board of directors shall specify whether policy forms and the rate structure must be on a ‘claims‑made’ or ‘occurrence’ basis and coverage may be provided by the association only on the basis specified by the board of directors. The board of directors shall specify the ‘claims‑made’ basis only if the contract makes provision for residual ‘occurrence’ coverage upon the retirement, death, disability, or removal from the State of the insured. Provision may be made for a premium charge allocable to any such residual ‘occurrence’ coverage and the premium charges for the residual coverage must be segregated and separately maintained for such purpose which may include the reinsurance of all or a part of that portion of the risk.

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

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

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

Section 38‑79‑200. The association is authorized to provide a rate increase or assessment which is subject to the approval of the director or his designee.

Section 38‑79‑210. Any deficit accumulated or sustained by the association ~~in any year~~ must be recouped, pursuant to the plan of operation and the rating plan then in effect, ~~by one or both~~ by one or more of the following procedures:

(1) ~~An assessment upon the policyholders which may not exceed one additional annual premium at the then current rate.~~ a surcharge fee as provided in Sections 40‑15‑390 and 40‑47‑55;

(2) a rate increase applicable prospectively approved by the director or his designee pursuant to the provisions of Section 38‑79‑180; and

(3) an assessment against all members of the association according to any plan agreed to by the association’s board and submitted to the director for his approval. The board shall make an annual recommendation by July first of each year regarding the need for an assessment against the members, the size and scope of such assessment, and the percentages to be assessed against each member pursuant to this chapter.

Section 38‑79‑220. ~~Effective after the initial year of operation, rates, rating plans, and rating rules, and any provision for recoupment through policyholder assessment or premium rate increase, must be based upon the association’s loss and expense experience and investment income, together with any other information based upon such experience and income as the director or his designee considers appropriate. The resultant premium rates must be on an actuarially sound basis and must be calculated to be self‑supporting.~~

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

Section 38‑79‑230. All insurers which are members of the association pursuant to the provisions of Section 38‑79‑120 shall participate in its writings, expenses, profits, and losses in the proportion that the net-direct premiums of each member ~~(excluding that portion of premiums attributable to the operation of the association)~~ written during the preceding calendar year bear to the aggregate net-direct premiums written in this State by all members of the association. However, no member may share in any profits or otherwise financially gain or benefit from the operation of the association unless and until the board and the director have mutually determined that all deficits of the association have been satisfactorily recovered. Each insurer’s participation in the association must be determined annually on the basis of the net-direct premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the insurer with the department or as reported by the insurer in reports or financial statements requested by the director to effectuate the provisions of this section. The assessment of a member insurer~~, after hearing,~~ may be ordered deferred in whole or in part upon application by the insurer if, in the opinion of the director or his designee, payment of the assessment may render the insurer insolvent or in danger of insolvency or otherwise may leave the insurer in a ~~condition that further transaction of the insurer’s business may be hazardous to its policyholders, creditors, members, subscribers, stockholders, or the public~~ hazardous financial condition or the insurer has been placed into administrative supervision or receivership by their domestic state’s insurance regulator. If payment of an assessment against a member insurer is deferred by order of the director or his designee in whole or in part, the amount by which the assessment is deferred must be assessed against other member insurers in the same manner as provided in this section. ~~In the order of deferral or in subsequent orders as may be necessary~~ When ordering a deferral in whole or in part, the director or his designee shall prescribe a plan by which the assessment deferred must be repaid to the association by the impaired insurer with interest at the six‑month treasury bill rate adjusted semiannually. Profits, dividends, or other funds of the association to which the insurer is otherwise entitled may not be distributed to the impaired insurer but must be applied toward repayment of any assessment until the obligation has been satisfied. The association shall distribute the repayments, including interest on them, to the other member insurers on the basis on which assessments were made.

Section 38‑79‑240. Every member of the Association is bound by the approved plan of operation of the Association, including any amendments made, and by any other rules the board of directors of the Association lawfully prescribes.

Section 38‑79‑250. (1) ~~If the authority of an insurer to transact bodily injury liability insurance, other than automobile, homeowners, or farmowners, in this State terminates for any reason its obligations as a member of the association nevertheless continue until all its obligations have been fulfilled and the director or his designee has so found and certified to the board of directors.~~ If any member insurer ceases writing business in this State, voluntarily or involuntarily, or by order or authority of the director shall continue to be a member of the association until all of its obligations have been satisfied and the director has certified the satisfaction to the association’s board.

(2) If a member insurer merges into, acquires, or consolidates with another insurer ~~authorized to transact such insurance in this State or another insurer authorized to transact such insurance in this State has reinsured the insurer’s entire general liability business in this State, both the insurer and its successor or assuming reinsurer, as the case may be, are liable for the insurer’s~~ transacting business subject to this article or if any other insurer or entity has reinsured or assumed a member insurer’s entire liability business in this State, the surviving insurer, acquiring insurer, its legal successor, or its assuming reinsurer nonetheless remains liable for the member insurer’s obligations in respect to the association.

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

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

Section 38‑79‑260. Until the association is merged with the Patients’ Compensation Fund on March 31, 2020, the association is governed by a board of thirteen directors, all of whom must be appointed by the Governor. Each member of the board shall serve a term of four years and may be reappointed for up to two additional four‑year terms. The Governor shall appoint five health care providers after consultation with the South Carolina Medical Association~~,~~ and the South Carolina Dental Association~~, and the South Carolina Health Alliance~~; four insurance representatives after consultation with the insurance industry; one consumer representative who is unaffiliated with the insurance or health care industries or the medical or legal professions; and two licensed insurance agents or brokers. The professional associations listed and the insurance industry may nominate qualified individuals to the Governor for his consideration. The Governor may also receive nominations for appointments to the board from any other individual, group, or association. ~~Notices of vacancies on the board must be published in newspapers of general statewide circulation.~~ The association and the director must publicize all vacancies on the board to the general public. The director or his designee shall serve as an ex officio member of the board. The board shall develop a plan of operation which is subject to the approval of the director or his designee as provided in this article. The plan of operation shall provide for staggered terms of the members of the board. The approved plan of operation of the association may make provision for combining insurers under common ownership or management into groups for voting, assessment, and all other purposes and may provide that not more than one of the officers or employees of a group may serve as a director at any one time. The board shall elect a chairman and other necessary officers for two‑year terms. The chairman of the board must be elected by the board and be a licensed physician or dentist. A vacancy must be filled for the unexpired portion of the term only. ~~The Governor may receive recommendations from any individual, group, or association for any vacancy on the board.~~ The board must meet at the call of the chairman or a majority of the members of the board, but in any event it must meet at least once a year. A board member serving as of the effective date of this section may be reappointed by the Governor.

Section 38‑79‑280. ~~The association shall file in the office of the department annually, by March first, a statement which contains information with respect to its transactions, condition, operations, and affairs during the preceding year.~~ The association shall file a financial statement with the department by March first of each year detailing its transactions, financial condition, operations, and affairs during the previous calendar year. In addition, the director may require the association to file quarterly financial statements with the department on the fifteenth of May, August, and November of each year. The statement shall contain such matters and information as are prescribed by the director or his designee and must be ~~in the form he directs~~ prepared in the format the director prescribes. The director or his designee may~~, at any reasonable time,~~ require the association to furnish additional information with respect to its transactions, condition, or any matter connected therewith considered to be material and of assistance in evaluating the scope, operation, and experience of the association.

Section 38‑79‑290. The director or his designee shall ~~make~~ conduct an examination into the financial condition and affairs of the association at least annually and shall file a report thereon with the department, the Governor, and the General Assembly. The expenses of the examination must be paid by the association. The director or his designee may accept an audit of the association performed by a qualified public accounting firm in lieu of conducting his own examination.

Section 38‑79‑300. (A) Effective on March 31, 2020, the Patients’ Compensation Fund provided for in Article 5 of this chapter shall merge into the Joint Underwriting Association created by this article. The surviving entity is the Joint Underwriting Association and referred to herein as the South Carolina Joint Underwriting Association. The South Carolina Joint Underwriting Association shall assume all obligations and responsibilities of the Patients’ Compensation Fund, while retaining all obligations and responsibilities of the Joint Underwriting Association.

(B) Beginning on the effective date of this section, the board of the Patients’ Compensation Fund shall, with oversight of the Department of Insurance, exercise due diligence in providing for the orderly and expeditious winding down of the Patients’ Compensation Fund. All outstanding affairs and existing contractual obligations of the Patients’ Compensation Fund including, but not limited to, all existing property, assets, liabilities, claims, member dues, and assessments (or potential for assessments) existing on March 31, 2020, shall contemporaneously become the responsibility of the South Carolina Joint Underwriting Association on that date. After March 31, 2020, the Patients’ Compensation Fund shall cease to exist except as required by law for purposes of winding down its affairs.

(C) The Board of Directors of the South Carolina Joint Underwriting Association must:

(1) be appointed on the effective date of this legislation and in no event later than October 2, 2019, and is authorized to enter into contracts for the management of the South Carolina Joint Underwriting Association in accordance with governing law;

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

(3) replace the existing board of the Joint Underwriting Association on March 31, 2020;

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

(a) two members after consultation with the South Carolina Medical Association;

(b) one member, who must be a physician, after consultation with the South Carolina Hospital Association;

(c) three representatives from the insurance industry representing member companies of this association;

(d) two representatives after consultation with the South Carolina Dental Association; and

(e) one insurance agent or broker;

(5) elect a chairperson who must be drawn from subitems (4)(a), (b), or (d) above. The director or his designee must be an ex officio member of the board.

(D) Upon consultation with and consent of the director, the board of the South Carolina Joint Underwriting Association:

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

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

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

(E) Each member of the board of the South Carolina Joint Underwriting Association shall serve a term of four years; however, any board member may be reappointed for up to two additional four‑year terms. The professional associations listed and the insurance industry may nominate qualified individuals to the Governor for his consideration. The Governor also may receive nominations for appointments to the board from any other individual, group, or association. The South Carolina Joint Underwriting Association and director must publicize all board vacancies to the general public. The board of the South Carolina Joint Underwriting Association shall develop a plan of operation which is subject to the approval of the director or his designee as provided in this article. The approved plan of operation of the South Carolina Joint Underwriting Association may make provisions for combining insurers under common ownership or management into groups for voting, assessment, and all other purposes and may provide that no more than one of the officers or employees of a group may serve as a director at any one time. The Board of the South Carolina Joint Underwriting Association Board shall elect a chairman and other necessary officers for two‑year terms. The chairman of the board must be elected by the board and be either a licensed physician or dentist. Any vacancy must be filled for the unexpired portion of the term only. The Board of the South Carolina Joint Underwriting Association Board must meet at the call of the chairman or a majority of the members of the board, but in any event it must meet at least once a year. Any board members of the Joint Underwriting Association or the Patients’ Compensation Fund serving at the time of this enactment may be reappointed by the Governor to the Board of the South Carolina Joint Underwriting Association.”

SECTION 4. Article 5, Chapter 79, Title 38 of the 1976 Code is amended by adding:

“Section 38‑79‑400. This article must be repealed upon the merger of the Patients’ Compensation Fund for benefit of licensed health care providers into the South Carolina Joint Underwriting Association as provided for in Section 38‑79‑300 on March 31, 2020.”

SECTION 5. This act takes effect upon approval by the Governor.

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