GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H **D**

HOUSE DRH30168-LN-152 (3/14)

Short Title:	Reduce Health Care Costs.	(Public)
Sponsors:	Representatives Rapp, England, Nye, and Goforth (Primary Sponsors).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REDUCE HEALTH CARE COSTS BY AMENDING THE LAWS PERTAINING TO MEDICAL MALPRACTICE CIVIL ACTIONS AND INSURANCE RATES AND PROVIDING FOR A MEDICAL MALPRACTICE INSURANCE TAX CREDIT.

The General Assembly of North Carolina enacts:

PART I. MEDICAL MALPRACTICE LIABILITY INSURANCE CHANGES.

SECTION 1.1. Article 40 of Chapter 58 of the General Statutes is amended by adding a new section to read:

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

(a) As used in this section:

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

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

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

(c) Every insurer that desires to change any rate shall file a complete rate application with the Commissioner. A complete rate application shall include all data required by G.S. 58-40-30(b) and G.S. 58-41-50 and a detailed description of any experience rating or schedule-rating plan used by the insurer. The application shall also include such other information that the Commissioner requires. The applicant has the

burden of proving that the requested rate change is justified and meets the requirements of this Article.

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

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

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

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

(3) The proposed rate adjustment increases or decreases the then-applicable rate by fifteen percent (15%) or more, in which case the Commissioner must hold a hearing.

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

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

SECTION 1.2. G.S. 58-2-170 reads as rewritten:

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

(a) In addition to the financial statements required by G.S. 58-2-165, every insurer, self-insurer, and risk retention group that provides professional liability insurance in the State shall file with the ~~Commissioner, on or before the first day of February in each year, in form and detail as the Commissioner prescribes,~~ Commissioner a statement showing the items set forth in subsection (b) of this section, as of the preceding 31st day of December. The ~~annual statement~~ information shall not be reported or disclosed to the public in a manner or format ~~which~~ that identifies or could reasonably be used to identify any individual health care provider or medical center. The statement shall be signed and sworn to by the chief managing agent or officer of the insurer, self-insurer, or risk retention ~~group, before the Commissioner or some officer authorized by law to administer oaths.~~group. The Commissioner shall~~, in December of each year, furnish to each such person that provides professional liability insurance in the State forms~~ develop the forms for the annual ~~statements.~~statements and make the forms available for use by January 1 of each year. The Commissioner may, for

good cause, authorize an extension of the report due date upon written application of any person required to file. An extension is not valid unless the Commissioner's authorization is in writing and signed by the Commissioner or one of his deputies.

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

(1) Number of claims pending at beginning of year;
(2) Number of claims pending at end of year;
(3) Number of claims paid;
(4) Number of claims closed no payment;
(5) Number and amounts of claims in court in which judgment paid:
a. Highest amount
b. Lowest amount
c. Average amount
d. Median amount;
(6) Number and amounts of claims out of court in which settlement paid:
a. Highest amount
b. Lowest amount
c. Average amount
d. Median amount;
(7) Average amount per claim set up in reserve;
(8) Total premium collection;
(9) Total expenses less reserve expenses; and
(10) Total reserve expenses.

(c) In addition to the information required under subsection (b) of this section, ~~Every~~ every insurer, self-insurer, and risk retention group that provides professional liability insurance to health care ~~providers~~ providers, as defined in G.S. 90-21.11, in this State shall ~~file, within 90 days following the request of the Commissioner, a~~ file a separate report containing information for the purpose of allowing the Commissioner to analyze claims. Detail may be requested on a class, maturity, or policy limit basis. Claim data may be requested on an accident or report year basis, for North Carolina, a region including North Carolina, or national data. Data may be for primary coverage or extended reporting coverage, and may be on an occurrence or a claims-made basis. The report shall be in the form prescribed by the Commissioner. ~~The form prescribed by the Commissioner shall be a form that permits the public inspection, examination, or copying of any information contained in the report: Provided, however, that any data or other characteristics that identify or could be used to identify the names or addresses of the claimants or the names or addresses of the individual health care provider or medical center against whom the claims are or have been asserted or any data that could be used to identify the dollar amounts involved in such claims shall be treated as privileged information and shall not be made available to the public.~~ The data shall not be reported or disclosed to the public in a manner or ~~format which~~format that identifies, or could reasonably be used to identify, any individual insurer, claimant, health care provider; or medical center. However, the aggregate data of all reports shall be a public record.

Information reported under this subsection shall include:

(1) Market share data. – This may be provided on the basis of premium, revenue, payroll, number of insured professionals, number of beds, or number of visits. The data shall be reconciled as fully as possible to the annual statement required under G.S. 58-2-165.
(2) Premiums charged and collected.
(3) Number of exposures.
(4) Dollar amount of claim payments and claim adjustment expenses on a paid and incurred basis.
(5) Number of claim payments and claim adjustment expenses on a paid and incurred basis.
(6) Judgments. – This shall include the amount of each judgment, the amount of each judgment attributable to noneconomic damages and punitive damages, and the amount actually paid on each judgment.
(7) Settlements. – This shall include the amount of each settlement and the amount of each settlement attributable to economic damages.

The Commissioner shall assess a penalty against any person that ~~willfully~~ fails to file a report required by this subsection. ~~Such~~ The penalty shall be one thousand dollars ($1,000) for each day after the due date of the report that the person willfully fails to ~~file: Provided, however,~~ file, except the penalty for an individual who self insures shall be two hundred dollars ($200.00) for each day after the due date of the report that the person ~~willfully~~ fails to ~~file: Provided, however, that upon~~ file. Upon the failure of a person to file the report as required by this subsection, the Commissioner shall send by certified mail, return receipt requested, a notice to that ~~person informing him that he~~ person. The notice shall provide that the person has 10 business days after receipt of the notice to either request an extension of time or file the report. The Commissioner may, for good cause, authorize an extension of the report due date upon written application of any person required to file. An extension is not valid unless the Commissioner's authorization is in writing and signed by the Commissioner or one of his deputies.

(c1) The Commissioner shall analyze the information received under this section and shall file statistical and other summaries with the General Assembly by October 1 of each year. The Commissioner's reports shall include:

(1) Comments on trends in the data.
(2) Actions taken by the Commissioner in response to the data.
(3) Recommendations with respect to actions by the General Assembly in response to the data.

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

SECTION 1.3. G.S. 58-40-25 reads as rewritten:

"**§ 58-40-25. Rating methods.**

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

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

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

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

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

(4) In the case of property insurance rates under this Article, consideration shall be given to the insurance public protection classifications of fire districts established by the Commissioner. The Commissioner shall establish and modify from time to time insurance public protection districts for all rural areas of the State and for cities with populations of 100,000 or fewer, according to the most recent annual population estimates certified by the State Planning Officer. In establishing and modifying these districts, the Commissioner shall use standards at least equivalent to those used by the Insurance Services Office, Inc., or any successor organization. The standards developed by the Commissioner are subject to Article 2A of Chapter 150B of the General Statutes. The

insurance public protection classifications established by the Commissioner issued pursuant to the provisions of this Article shall be subject to appeal as provided in G.S. 58-2-75, et seq. The exceptions stated in G.S. 58-2-75(a) do not apply."

PART II. MEASURES TO IMPROVE THE QUALITY OF PATIENT CARE.

SECTION 2.1. G.S. 131E-95(b) reads as rewritten:

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

…

(b) The proceedings of a medical review committee, the records and materials it produces and the materials it considers shall be confidential and not considered public records within the meaning of G.S. 132-1, " 'Public records' defined", and shall not be subject to discovery or introduction into evidence in any civil action against a hospital, an ambulatory surgical facility licensed under Chapter 131E of the General Statutes, or a provider of professional health services which results from matters which are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. Proceedings, records, and materials produced or considered by a medical review committee relating to (i) a root cause analysis or other analyses of systemic performance issues in the delivery of health care, (ii) self-assessment of health care quality, (iii) preventative, corrective, or remedial actions considered or taken to address quality issues, and (iv) incident reports used for quality assurance or risk management purposes are confidential and not subject to discovery or use in a civil action. However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee. Documents otherwise available as public records within the meaning of G.S. 132-1 do not lose their status as public records merely because they were presented or considered during proceedings of the committee. A member of the committee or a person who testifies before the committee may testify in a civil action but cannot be asked about the person's testimony before the committee or any opinions formed as a result of the committee hearings.

…."

SECTION 2.2. G.S. 90-21.22A(c) reads as rewritten:

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

…

(c) The proceedings of a medical review or quality assurance committee, the records and materials it produces, and the materials it considers shall be confidential and not considered public records within the meaning of G.S. 132-1, 131E-309, or 58-2-100; and shall not be subject to discovery or introduction into evidence in any civil action against a provider of health care services who directly provides services and is licensed under this Chapter, a PSO licensed under Article 17 of Chapter 131E of the General Statutes, an ambulatory surgical facility licensed under Chapter 131E of the General Statutes, or a hospital licensed under Chapter 122C or Chapter 131E of the General

Statutes or that is owned or operated by the State, which civil action results from matters that are the subject of evaluation and review by the committee. Proceedings, records, and materials produced or considered by a medical review or quality assurance committee relating to (i) a root cause analysis or other analyses of systemic performance issues in the delivery of health care, (ii) self-assessment of health care quality, (iii) preventative, corrective, or remedial actions considered or taken to address quality issues, and (iv) incident reports used for quality assurance or risk management purposes are confidential and not subject to discovery or use in a civil action. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee. Documents otherwise available as public records within the meaning of G.S. 132-1 do not lose their status as public records merely because they were presented or considered during proceedings of the committee. A member of the committee may testify in a civil action but cannot be asked about the person's testimony before the committee or any opinions formed as a result of the committee hearings.

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

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

SECTION 2.3. G.S. 122C-191(e) reads as rewritten:

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

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

(2) The proceedings of a quality assurance committee, the records and materials it produces, and the material it considers shall be confidential and not considered public records within the meaning of G.S. 132-1, " 'Public records' defined," and shall not be subject to discovery or introduction into evidence in any civil action against a facility or a provider of professional health services that results from matters which are the subject of evaluation and review by the committee. Proceedings, records, and materials produced or considered by a quality assurance committee relating to (i) a root cause analysis or other analyses of systemic performance issues in the delivery of health care, (ii) self-assessment of health care quality, (iii) preventative, corrective, or remedial actions considered or taken to address quality issues, and (iv) incident reports used for quality assurance or risk

management purposes are confidential and not subject to discovery or use in a civil action. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee, and nothing herein shall prevent a provider of professional health services from using such otherwise available information, documents or records in connection with an administrative hearing or civil suit relating to the medical staff membership, clinical privileges or employment of the provider. Documents otherwise available as public records within the meaning of G.S. 132-1 do not lose their status as public records merely because they were presented or considered during proceedings of the committee. A member of the committee or a person who testifies before the committee may be subpoenaed and be required to testify in a civil action as to events of which the person has knowledge independent of the peer review process, but cannot be asked about the person's testimony before the committee for impeachment or other purposes or about any opinions formed as a result of the committee hearings.

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

SECTION 2.4. G.S. 122C-30 reads as rewritten:

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

For purposes of peer review functions of a facility licensed under the provisions of this Chapter:

(1) A member of a duly appointed peer review committee or quality assurance committee who acts without malice or fraud shall not be subject to liability for damages in any civil action on account of any

act, statement, or proceeding undertaken, made, or performed within the scope of the functions of the committee; and

(2) Proceedings of a peer review or quality assurance committee, the records and materials it produces, and the material it considers shall be confidential and not considered public records within the meaning of G.S. 132-1, "Public records' defined," and shall not be subject to discovery or introduction into evidence in any civil action against a facility or a provider of professional health services that results from matters which are the subject of evaluation and review by the committee. Proceedings, records, and materials produced or considered by a peer review or quality review committee relating to (i) a root cause analysis or other analyses of systemic performance issues in the delivery of health care, (ii) self-assessment of health care quality, (iii) preventative, corrective, or remedial actions considered or taken to address quality issues, and (iv) incident reports used for quality assurance or risk management purposes are confidential and not subject to discovery or use in a civil action. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee, and nothing herein shall prevent a provider of professional health services from using such otherwise available information, documents or records in connection with an administrative hearing or civil suit relating to the medical staff membership, clinical privileges or employment of the provider. Documents otherwise available as public records within the meaning of G.S. 132-1 do not lose their status as public records merely because they were presented or considered during proceedings of the committee. A member of the committee or a person who testifies before the committee may be subpoenaed and be required to testify in a civil action as to events of which the person has knowledge independent of the peer review or quality assurance process, but cannot be asked about the person's testimony before the committee for impeachment or other purposes or about any opinions formed as a result of the committee hearings."

PART III. MEDICAL MALPRACTICE PRETRIAL LIABILITY PANEL.

SECTION 3.1. G.S. 1A-1, Rule 53 reads as rewritten:

"**Rule 53. Referees.**

(a) Kinds of reference. –

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

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

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

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

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

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

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

(b) Jury trial. –

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

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

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

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

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

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

(c) Appointment. –

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

(2) Article 1B of Chapter 90 Appointments. – In all actions referred pursuant to subdivision (3) of subsection (a) of this section, the court shall appoint three referees to be selected from the list of emergency superior court judges eligible to be called to service by the Administrative Office of the Courts. The parties to the action, beginning with the plaintiff, shall alternatively strike names from the list until three names remain and the court shall appoint the three persons whose names remain on the list. In the event that one or more of those persons cannot serve, the last persons whose names were struck from the list shall be appointed. The referees shall be fair and objective, and shall not be parties to the action, related to any parties to the action, or in any way financially associated with any of the parties to the action or in the outcome of the action. The members of the panel shall select a chair of the panel among themselves.

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

(e) Powers. – ~~The~~ Except as otherwise provided by statute, the order of reference to the referee may specify or limit ~~his~~ the referee's powers and may direct ~~him~~ the referee to report only upon particular issues or to do or perform particular acts or to receive and report evidence only and may fix the time and place for beginning and closing the hearings and for the filing of the referee's report. Subject to the specifications and limitations stated in the order, every referee has power to administer oaths in any proceeding before ~~him~~the referee, and has generally the power vested in a referee by law. The referee shall have the same power to grant adjournments and to allow amendments to pleadings and to the summons as the judge and upon the same terms and with like effect. The referee shall have the same power as the judge to preserve order and punish all violations thereof, to compel the attendance of witnesses before ~~him~~ the referee by attachment, and to punish them as for contempt for nonattendance or for refusal to be sworn or to testify. The parties may procure the attendance of witnesses before the referee by the issuance and service of subpoenas as provided in Rule 45.

(f) Proceedings. –

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

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

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

(g) Report. –

(1) Contents and Filing. – The referee shall prepare a report upon the matters submitted to ~~him~~ the referee by the order of reference and shall include therein ~~his~~ the referee's decision on all matters so submitted. If required to make findings of fact and conclusions of law, ~~he~~ the referee shall set them forth separately in the report. ~~He~~ The referee shall file the report with the clerk of the court in which the action is pending and unless otherwise directed by the order of reference, shall file with it a transcript of the proceedings and of the evidence and the original exhibits. Before filing ~~his~~ the referee's report a referee may submit a draft thereof to counsel for all parties for the purpose of receiving their suggestions. The clerk shall forthwith mail to all parties notice of the filing. In situations where more than one referee is appointed, the report and finding of the referees shall be agreed to by a majority vote.

(2) Exceptions and Review. – All or any part of the report may be excepted to by any party within 30 days from the filing of the report. Thereafter, and upon 10 days' notice to the other parties, any party may

apply to the judge for action on the report. The judge after hearing may adopt, modify or reject the report in whole or in part, ~~render judgment,~~ or may remand the proceedings to the referee with instructions. Except for action referred pursuant to subdivision (3) of subsection (a) of this section, the judge after hearing may render judgment. No judgment may be rendered on any reference except by the judge."

SECTION 3.2. Article 1B of Chapter 90 is amended by adding a new section to read:

"**§ 90-21.12D. Report of referees.**

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

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

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

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

PART IV. MEASURES TO DISCOURAGE FRIVOLOUS MEDICAL MALPRACTICE ACTIONS AND STRENGTHEN RULE 9(j) OF THE RULES OF CIVIL PROCEDURE.

SECTION 4.1. G.S. 1A-1, Rule 9(j) reads as rewritten:

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

(1) The pleading specifically has attached a sworn affidavit from a person who is reasonably expected to qualify as an expert witness under Rule

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

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

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

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

SECTION 4.2. G.S. 90-21.14 is amended by adding a new subsection to read:

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

PART V. MEDICAL MALPRACTICE LITIGATION REFORMS.

SECTION 5.1. G. S. 1A-1, Rule 42(b) reads as rewritten:

"(b) Separate trials. –

(1) The court may in furtherance of convenience or to avoid prejudice and shall for considerations of venue upon timely motion order a separate

trial of any claim, cross-claim, counterclaim, or third-party claim, or of any separate issue or of any number of claims, cross-claims, counterclaims, third-party claims, or issues.

(2) Upon motion of any party in an action that includes a claim commenced under Article 1G of Chapter 90 of the General Statutes involving a managed care entity as defined in G.S. 90-21.50, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against a physician or other medical provider.

(3) Upon motion of any party in a medical malpractice action commenced under Article 1B of Chapter 90 of the General Statutes wherein the plaintiff alleges damages greater than one hundred thousand dollars ($100,000), the court shall order separate trials for the issue of liability and the issue of damages. Evidence relating solely to pecuniary damages shall not be admissible until the trier of fact has determined that the defendant is liable for medical malpractice. The same trier of fact that tried the issues relating to liability shall try the issues relating to damages."

SECTION 5.2. Article 1B of Chapter 90 of the General Statutes is amended by adding the following new sections to read:

"**§ 90-21.12E. Verdicts in medical malpractice actions; noneconomic damages indicated.**

(a) In any medical malpractice action, any verdict or award of damages shall indicate specifically what amount is awarded for noneconomic damages. As used in this section, 'noneconomic damages' includes all damages to compensate mental anguish; emotional distress; emotional pain and suffering; loss of consortium; loss of society, companionship, comfort, guidance, kindly offices, or advice; pain and suffering; inconvenience; disfigurement; loss of limbs or body parts; physical impairment; and any other nonpecuniary damages.

(b) In any wrongful death medical malpractice action, any verdict or award of damages shall indicate specifically the amount of damages, if any, awarded for each of the elements of damages provided in G.S. 28A-12-2 for which there was evidence presented at trial. The verdict or award shall also specify the amount of noneconomic damages as provided in subsection (a) of this section.

"**§ 90-21.12G. Settlements in medical malpractice actions; reporting.**

(a) In any medical malpractice action in which the parties agree to settle the claim, the insurer for the health care provider shall report the settlement as required under G.S. 58-2-170. The insurer shall identify the amount of the settlement attributable to economic damages and provide documentation to substantiate that amount. A claim is settled if at any time after the claim is made and before, during, or after trial, the parties mutually agree to end the litigation in exchange for monetary payment.

(b) As used in this section, 'economic damages' means damages to compensate for present and future medical costs, hospital costs, custodial care, rehabilitation costs, lost earnings, loss of bodily function, and any other pecuniary damages.

(c) As used in this section, 'insurer' means every insurer, self-insurer, and risk retention group, as those terms are defined in Chapter 58 of the General Statutes, that provides professional malpractice insurance to health care providers in this State."

SECTION 5.3. G.S. 1A-1, Rule 26(f1)(2) reads as rewritten:

"(2) Establish an appropriate schedule for designating expert witnesses, consistent with a discovery schedule pursuant to ~~subdivision (3), to be complied with by all parties to the action such that there is a deadline for designating all expert witnesses within an appropriate time for all parties to implement discovery mechanisms with regard to the designated expert witnesses;~~ subdivision (3) of this subsection. As to each expert designated, the designation shall be accompanied by a written report prepared and signed by the witness. The report shall contain a complete statement of all opinions to be expressed and the basis and reasons therefor; the data or other information considered by the witness in forming the opinions; the qualifications of the witness, including a list of all publications authored by the witness within the preceding 10 years; the compensation the witness is to be paid for the study and testimony; and a listing of any other cases in which the witness has testified as an expert at trial or by deposition within the preceding four years. The party shall supplement the expert's report if the party learns that in some material respect the report is incomplete or incorrect. The expert's direct testimony shall not be inconsistent with or go beyond the fair scope of the expert report as supplemented. The parties shall not depose expert witnesses, unless the court otherwise orders for good cause shown."

SECTION 5.4. Article 1B of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"**§ 90-21.12C. Evidence of medical expenses.**

In any action brought against a health care provider pursuant to this Article, evidence offered to prove past medical expenses may include all bills reasonably paid or incurred. If a health care provider has agreed to accept a lesser amount in full payment of a bill, that lesser amount shall also be offered. Evidence of the source of payment shall only be admissible if offered by or on behalf of the party that incurred the medical bill, but shall otherwise be prohibited. The party who has incurred the medical bill shall also be entitled to present evidence of any requirement or obligation to repay the collateral source and of the amount requested to be repaid."

SECTION 5.5. G.S. 1-17(b) reads as rewritten:

"(b) Notwithstanding the provisions of subsection (a) of this section, an action on behalf of a minor for malpractice arising out of the performance of or failure to perform professional services shall be commenced within the limitations of time specified in G.S. 1-15(c), except that if those time limitations expire before the minor attains the full age of 19 years, the action may be brought before the minor attains the full age of 19 ~~years.~~years, but in no event may an action arising from injuries related to the birth of the

minor be commenced more than 10 years from the last act of the defendant giving rise to the cause of action."

PART VI. AVOIDING EXCESSIVE DAMAGES IN MEDICAL MALPRACTICE ACTIONS.

SECTION 6.1. Article 1B of Chapter 90 the General Statutes is amended by adding a new section to read:

"**§ 90-21.12F. Voluntary remittitur.**

(a) In any action brought under this Article in which a jury awards noneconomic damages in excess of two hundred fifty thousand dollars ($250,000), upon motion of the plaintiff in accordance with Rule 59(b) of the Rules of Civil Procedure, the court shall conduct a posttrial hearing to determine whether the noneconomic damage award is reasonable or excessive.

(b) In addition to the grounds set forth in Rule 59 of the Rules of Civil Procedure for granting a new trial, the court shall consider all of the following in regards to the noneconomic damage award:

(1) Whether it appears the trier of fact ignored the evidence when reaching the damage award or misconceived the merits of the case relating to the amount of noneconomic damages recoverable.

(2) Whether it appears that the trier of fact arrived at the amount of noneconomic damages by speculation or conjecture.

(3) Whether the amount awarded bears a reasonable relation to the amount of noneconomic damages proved and injury suffered.

(c) This section requires the court to review, upon proper motion, noneconomic damage awards in excess of two hundred fifty thousand dollars ($250,000) only and does not in any other way modify the procedures and requirements of Rule 59 of the Rules of Civil Procedure.

(d) The court must make a finding as to the reasonableness of the award of noneconomic damages based on matters presented to the court in the posttrial hearing. If the court finds that the amount of the award of noneconomic damages is reasonable, the court must enter judgment in accordance with the verdict. If the court finds that the amount of the award of noneconomic damages is excessive, it must offer the plaintiff an option of remittitur for noneconomic damages to an amount determined by the court to be reasonable, but in no event is the court to award less than two hundred fifty thousand dollars ($250,000).

(e) If the plaintiff accepts the option of remittitur, the court shall enter judgment on the verdict as remitted. If the plaintiff does not accept the option of remittitur, the court shall order a new trial solely on the issue of damages and not on liability. If, as a result of a new trial under this section, the plaintiff is not awarded noneconomic damages in an amount greater than or equal to the amount offered by the court as remittitur under subsection (c) of this section, then the amount of the judgment awarded in favor of the plaintiff at the new trial must be reduced by the amount of the defendant's costs, including reasonable attorneys' fees as awarded by the court, incurred in connection with the new trial."

SECTION 6.2. Article 1B of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"**§ 90-21.12B. Limitation on noneconomic damages in medical malpractice and certain other actions.**

(a) As used in this section, 'noneconomic damages' is as defined in G.S. 90-21.12E.

(b) In any medical malpractice action, the plaintiff may be entitled to recover noneconomic damages. The total amount of all noneconomic damages shall not exceed five hundred thousand dollars ($500,000) per plaintiff.

(c) Any award of damages in a medical malpractice action shall be stated in accordance with G.S. 90-21.12E. If a jury is determining the facts, the court shall not instruct the jury with respect to the limit on noneconomic damages under subsection (b) of this section, and neither the attorney for any party nor a witness shall inform the jury or potential members of the jury panel of that limit.

(d) Damages awarded on account of personal injury in any action against a health care provider shall be considered subject to the limitations on the noneconomic damages in this section, regardless of the nature of the cause of action asserted by the parties or found by the trier of fact as a basis for the health care provider's liability."

PART VII. MEDICAL MALPRACTICE INSURANCE TAX CREDIT.

SECTION 7.1. Article 3B of Chapter 105 of the General Statutes is amended by adding a new section to read:

"**§ 105-129.16E. Credit for medical malpractice insurance expenses.**

(a) Tax Credit. – A medical care provider that provides medical care services in this State is allowed a credit equal to either of the following, at the option of the taxpayer:

(1) Ten percent (10%) of the amount by which the taxpayer's annual medical liability insurance premiums for the taxable year exceed thirty thousand dollars ($30,000) per practitioner covered by the insurance.

(2) Twenty percent (20%) of the amount by which the taxpayer's annual medical liability insurance premiums for the taxable year exceed seventy thousand dollars ($70,000) per practitioner covered by the insurance.

(b) Allocation. – If the taxpayer is an individual who is a nonresident or a part-year resident, the taxpayer must reduce the amount of the credit by multiplying it by the fraction calculated under G.S. 105-134.5(b) or (c), as appropriate. If the taxpayer is not an individual and is required to apportion its multistate business income to this State, the taxpayer must reduce the amount of the credit by multiplying it by the apportionment fraction used to apportion its business income to this State.

(c) Definitions. – The following definitions apply in this section:

(1) Annual medical liability insurance premiums. – The actual amount of insurance premiums paid by the taxpayer during the taxable year for medical malpractice insurance coverage under a claims-made malpractice insurance policy and for tail insurance.

(2) Claims-made malpractice insurance policy. – A medical malpractice liability insurance policy that covers claims that satisfy all of the following conditions:
a. Are reported during the policy period.
b. Meet the provisions specified by the policy.
c. Are for an incident that occurred during the policy period or occurred before the policy period, as specified by the policy.
(3) Medical care provider. – Either of the following:
a. A practitioner.
b. A business entity, including a professional corporation, a professional limited liability corporation, or a partnership, authorized by law to provide medical care services in the regular course of business or practice of a profession.
(4) Medical care services. – The practice of medicine, surgery, and nursing as regulated by Chapter 90 of the General Statutes.
(5) Practitioner. – A physician, physician's assistant, or nurse authorized by Chapter 90 of the General Statutes to provide medical services in the regular course of business or practice of a profession.
(6) Tail insurance. – Insurance that covers a medical care provider insured once a claims-made malpractice insurance policy is canceled, not renewed, or terminated and that covers claims made or asserted after the cancellation or termination for acts relating to the provision of medical care services by the medical care provider occurring during the period the prior malpractice insurance was in effect."

SECTION 7.2. G.S. 105-129.15A is repealed.

SECTION 7.3. G.S. 105-129.16 is repealed.

SECTION 7.4. G.S. 105-129.16A is amended by adding a new subsection to read:

"(e) Sunset. – This section is repealed for renewable energy property placed in service on or after January 1, 2006."

SECTION 7.5. G.S. 105-129.16C is amended by adding a new subsection to read:

"(d) Sunset. – This section is repealed for taxable years beginning on or after January 1, 2006."

PART VIII. MISCELLANEOUS.

SECTION 8.1. The provisions of this act are severable. If a court of competent jurisdiction holds any provision of this act invalid, the invalidity does not affect other provisions of this act than can be given effect without the invalid provisions.

PART IX. EFFECTIVE DATES.

SECTION 9.1. Sections 3.1, 3.2, 4.1, 4.2, 5.1, 5.2, and 5.3 of this act become effective October 1, 2005, and apply to actions filed on or after that date. Sections 5.4, 5.6, 6.1, and 6.2 of this act become effective October 1, 2005, and apply to causes of action arising on or after that date. Section 7.1 becomes effective January 1,

2005, and applies to taxable years beginning on or after that date and expires January 1, 2010, for taxable years beginning on and after that date. The remainder of this act is effective when it becomes law.