House Bill 662

By: Representatives Cheokas of the 138th and Stephens of the 164th

A BILL TO BE ENTITLED
AN ACT

1 To establish the "Patient Injury Act"; to amend Title 51 of the Official Code of Georgia
2 Annotated, relating to torts, so as to create an alternative to medical malpractice litigation
3 whereby patients are compensated for medical injuries; to provide for legislative intent; to
4 provide for a short title; to establish the Patient Compensation System and the Patient
5 Compensation Board; to provide for the filing of and disposition of applications; to provide
6 administrative and judicial review; to provide for funding; to provide for related matters; to
7 provide for an effective date and applicability; to repeal conflicting laws; and for other
8 purposes.

9 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

10 **SECTION 1.**

11 WHEREAS, the lack of legal representation for the vast majority of patients with legitimate
12 injuries denies such patients access to courts;

13 WHEREAS, seeking compensation through medical malpractice litigation is a costly and
14 protracted process and legal counsel may only afford to finance a small number of legitimate
15 claims;

16 WHEREAS, because of continued exposure to liability, an overwhelming majority of
17 physicians practice defensive medicine by ordering unnecessary tests and procedures, driving
18 up the cost of health care for individuals covered by public and private health insurance and
19 exposing patients to unnecessary clinical risks; and

20 WHEREAS, recruiting physicians to Georgia and ensuring that existing Georgia physicians
21 continue to practice in this state is a significant public health issue.

22 NOW, THEREFORE, the General Assembly intends to create an alternative to medical
23 malpractice litigation whereby patients are fairly and expeditiously compensated for
24 avoidable medical injuries. This alternative is also intended to significantly reduce health
25 care costs, increase the number of physicians practicing in this state, and providing patients
26 fair and timely compensation without the expense and delay of the court system.

27 **SECTION 2.**

28 Title 51 of the Official Code of Georgia Annotated, relating to torts, is amended by repealing
29 in its entirety Chapter 13, relating to recovery in medical malpractice actions, and enacting
30 a new Chapter 13 to read as follows:

31 "CHAPTER 13

32 51-13-1.

33 This chapter shall be known and may be cited as the 'Patient Injury Act.'

34 51-13-2.

35 As used in this chapter, the term:

36 (1) 'Applicant' means a person who files an application under this chapter requesting the
37 investigation of an alleged occurrence of a medical injury.

38 (2) 'Application' means a request for investigation by the Patient Compensation System
39 of an alleged occurrence of a medical injury.

40 (3) 'Board' means the Patient Compensation Board created in Code Section 51-13-4.

41 (4) 'Collateral source' means any payments made to the applicant, or made on his or her
42 behalf, by or pursuant to:

43 (A) The federal Social Security Act; any federal, state, or local income disability act;
44 or any other public program providing medical expenses, disability payments, or other
45 similar benefits, except as prohibited by federal law;

46 (B) Any health, sickness, or income disability insurance; automobile accident
47 insurance that provides health benefits or income disability coverage; or any other
48 similar insurance benefits except life insurance benefits available to the applicant,
49 whether purchased by the applicant or provided by others;

50 (C) Any contract or agreement of any group, organization, partnership, or corporation
51 to provide, pay for, or reimburse the costs of hospital, medical, dental, or other health
52 care services; or

53 (D) Any contractual or voluntary wage continuation plan provided by employers or by
54 any other system intended to provide wages during a period of disability.

55 (5) 'Compensation schedule' means a schedule of damages for medical injuries.
56 (6) 'Department' means the Department of Community Health.
57 (7) 'Independent medical review panel,' or 'panel,' means a multidisciplinary panel
58 convened by the chief medical officer to review each application.
59 (8)(A) 'Medical injury' means a personal injury or wrongful death due to medical
60 treatment, including a missed diagnosis, which reasonably could have been avoided:
61 (i) With care provided by an individual provider, under the care of an experienced
62 specialist provider practicing in the same field of care under the same or similar
63 circumstances, or by an experienced general practitioner provider practicing under the
64 same circumstances; or
65 (ii) With care provided by a provider in a system of care, if rendered within an
66 optimal system of care under the same or similar circumstances.
67 (B) Consideration of whether a medical injury could have been avoided shall only
68 include consideration of an alternate course of treatment if the injury could have been
69 avoided through a different but equally effective manner with respect to the treatment
70 of the underlying condition. In addition, consideration of whether a medical injury
71 could have been avoided shall only include consideration of information that would
72 have been known to an experienced specialist or readily available to an optimal system
73 of care at the time of the medical treatment.
74 (C) 'Medical injury' shall not include an injury or wrongful death caused by a product
75 defect in a drug or device, as those terms are defined in Code Section 26-3-2.
76 (9) 'Panelist' means a hospital administrator, a person licensed under Chapter 9, 10A, 11,
77 11A, 26, 27, 28, 30, 33, 34, 35, 39, or 44 of Title 43, or any other person involved in the
78 management of a health care facility deemed appropriate by the board who serves on an
79 independent medical review panel.
80 (10) 'Provider' means a hospital or other health care facility licensed as such under
81 Chapter 7 of Title 31, including a nursing home or skilled nursing facility, or any person
82 licensed under Chapter 4 of Title 26 or Chapter 9, 10A, 11, 11A, 26, 27, 28, 30, 33, 34,
83 35, 39, or 44 of Title 43. The term shall also include any corporation, professional
84 corporation, partnership, limited liability company, limited liability partnership, authority,
85 or other entity composed of such providers. The term shall also include any unlicensed
86 facility or person that should be licensed in this state.
87 (11) 'System' means the Patient Compensation System created pursuant to Code
88 Section 51-13-4.

89 51-13-3.
90 (a) The rights and remedies granted by this chapter on account of a medical injury shall
91 exclude all other rights and remedies of the applicant and his or her personal representative,
92 parents, dependents, and next of kin, at common law or as provided in general law of this
93 state, against any provider directly involved in providing the medical treatment from which
94 such medical injury occurred; provided, however, that the provisions of this chapter shall
95 only apply to such applicant if he or she or his or her representative or legal guardian has
96 knowingly signed a waiver of his or her right to a jury or other access to court either prior
97 to or following the receipt of such medical treatment. Notwithstanding any other law to
98 the contrary, the provisions of this chapter shall apply exclusively to applications submitted
99 under this chapter. An applicant whose injury is excluded from coverage under this chapter
100 may file a claim for recovery of damages in accordance with the provisions of applicable
101 law.
102 (b) Nothing in this chapter shall be construed to prohibit a self-insured provider or an
103 insurer from providing an early offer of settlement in satisfaction of a medical injury. An
104 individual who accepts a settlement offer shall not file an application under this chapter for
105 the same medical injury. In addition, if an application has been filed prior to the offer of
106 settlement, the acceptance of the settlement offer by the applicant shall result in the
107 withdrawal of the application.

108 51-13-4.
109 (a) The Patient Compensation System is created and shall be assigned to the department
110 for administrative purposes only. The system shall be a separate budget entity responsible
111 for its administrative functions and shall not be subject to control, supervision, or direction
112 by the department in any manner. The system shall administer the provisions of this
113 chapter.
114 (b)(1) The Patient Compensation Board is established to govern the system.
115 (2) The board shall be composed of 11 members who shall represent the medical, legal,
116 patient, and business communities from diverse geographic areas throughout the state.
117 Members of the board shall be appointed as follows:
118 (A) Five of the members shall be appointed by and serve at the pleasure of the
119 Governor, one of whom shall be a licensed physician who actively practices in this
120 state, one of whom shall be an executive in the business community, one of whom shall
121 be a hospital administrator, one of whom shall be a certified public accountant who
122 actively practices in this state, and one of whom shall be an attorney;

123 (B) Three of the members shall be appointed by and serve at the pleasure of the
124 Lieutenant Governor, one of whom shall be a licensed physician who actively practices
125 in this state and one of whom shall be a patient advocate; and
126 (C) Three of the members shall be appointed by and serve at the pleasure of the
127 Speaker of the House of Representatives, one of whom shall be a licensed physician
128 who actively practices in this state and one of whom shall be a patient advocate.
129 (3) Each member shall be appointed for a four-year term. For the purpose of providing
130 staggered terms, of the initial appointments, the five members appointed by the Governor
131 shall be appointed to two-year terms and the remaining six members shall be appointed
132 to three-year terms. If a vacancy occurs on the board before the expiration of a term, the
133 original appointing authority shall appoint a successor to serve the unexpired portion of
134 the term.
135 (4) The board shall annually elect from its membership one member to serve as
136 chairperson and one member to serve as vice chairperson.
137 (5) The first meeting of the board shall be held no later than August 1, 2014. Thereafter,
138 the board shall meet at least quarterly upon the call of the chairperson. A majority of the
139 board members shall constitute a quorum. Meetings may be held by teleconference, web
140 conference, or other electronic means.
141 (6) Members of the board shall serve without compensation but shall be reimbursed for
142 their actual travel expenses necessarily incurred in the performance of their duties and,
143 for each day actually spent in the performance of their duties, shall receive the same per
144 diem as do members of the General Assembly for required attendance at board and other
145 meetings.
146 (7) The board shall have the following powers and duties:
147 (A) Ensuring the operation of the system in accordance with applicable federal and
148 state laws and regulations;
149 (B) Entering into contracts as necessary to administer this chapter;
150 (C) Employing an executive director and other staff as are necessary to perform the
151 functions of the system, except that the Governor shall appoint the initial executive
152 director;
153 (D) Approving the hiring of a chief compensation officer and chief medical officer, as
154 recommended by the executive director;
155 (E) Approving a compensation schedule for medical injuries, as recommended by the
156 compensation committee;
157 (F) Approving independent medical review panelists as recommended by the medical
158 review committee;
159 (G) Approving an annual budget; and

160 (H) Annually approving provider contribution amounts.
161 (8) The executive director shall oversee the operation of the system in accordance with
162 this chapter. The following staff shall report directly to and serve at the pleasure of the
163 executive director:
164 (A) The advocacy director shall ensure that each applicant is provided high quality
165 individual assistance throughout the process, from initial filing to disposition of the
166 application. The advocacy director shall assist each applicant in determining whether
167 to retain an attorney, including an explanation of possible fee arrangements and the
168 benefits and disadvantages of retaining an attorney. If the applicant seeks to file an
169 application without an attorney, the advocacy director shall assist the applicant in filing
170 the application. In addition, the advocacy director shall regularly provide status reports
171 to the applicant regarding his or her application;
172 (B) The chief compensation officer shall manage the office of compensation. The
173 chief compensation officer shall recommend to the compensation committee a
174 compensation schedule for each type of injury;
175 (C) The chief financial officer shall be responsible for overseeing the financial
176 operations of the system, including the annual development of a budget;
177 (D) The chief legal officer shall be an attorney licensed to practice law in this state and
178 represent the system in all contested applications, oversee the operation of the system
179 to ensure compliance with established procedures, and ensure adherence to all
180 applicable federal and state laws and regulations;
181 (E) The chief medical officer shall be a physician licensed under Chapter 34 of Title 43
182 who shall manage the office of medical review. The chief medical officer shall
183 recommend to the medical review committee a qualified list of multidisciplinary
184 panelists for independent medical review panels. In addition, the chief medical officer
185 shall convene independent medical review panels as necessary to review applications;
186 and
187 (F) The chief quality officer shall manage the office of quality improvement.
188 (c) The following offices are established within the system:
189 (1) The chief compensation officer shall manage the office of compensation. The office
190 of compensation shall allocate compensation for each application in accordance with the
191 compensation schedule;
192 (2) The chief medical officer shall manage the office of medical review. The office of
193 medical review shall evaluate and, as necessary, investigate all applications in accordance
194 with this chapter. For the purpose of an investigation of an application, the office of
195 medical review shall have the power to administer oaths, take depositions, issue
196 subpoenas, compel the attendance of witnesses and the production of papers, documents,

197 and other evidence, and obtain patient records pursuant to the applicant's release of
198 protected health information; and
199 (3) The chief quality officer shall manage the office of quality improvement. The office
200 of quality improvement shall regularly review application data to conduct root cause
201 analyses in order to develop and disseminate best practices based on such reviews. In
202 addition, the office of quality improvement shall capture and record safety related data
203 obtained during an investigation conducted by the office of medical review, including the
204 cause of the medical injury, the contributing factors, and any interventions that may have
205 prevented the medical injury.
206 (d)(1) The board shall create a medical review committee and a compensation
207 committee. The board may create additional committees as necessary to assist in the
208 performance of its duties and responsibilities.
209 (2)(A) The medical review committee shall be composed of two physicians and one
210 other board member. The board shall designate one of the physician committee
211 members as chairperson of the committee.
212 (B) The compensation committee shall be composed of a certified public accountant
213 and two other board members. The certified public accountant shall serve as
214 chairperson of the committee.
215 (C) Additional committees shall be composed of three board members chosen by a
216 majority vote of the board.
217 (3) Members of each committee shall serve two-year terms, within their respective terms
218 as board members. If a vacancy occurs on a committee, the board shall appoint a
219 successor to serve the unexpired portion of the term. A committee member who is
220 removed or resigns from the board shall be removed from the committee.
221 (4) Each committee shall meet at least quarterly or at the specific direction of the board.
222 Meetings may be held by teleconference, web conference, or other electronic means.
223 (5)(A) The medical review committee shall recommend to the board a comprehensive,
224 multidisciplinary list of panelists to serve on the independent medical review panels as
225 needed.
226 (B) The compensation committee shall, in consultation with the chief compensation
227 officer, recommend to the board:
228 (i) A compensation schedule formulated such that the initial compensation schedule
229 plus the initial amount of contributions by providers shall not exceed the fiscal year
230 2013 aggregate cost of medical malpractice as determined by an independent actuary
231 at the request of the board. In addition, damage payments for each type of medical
232 injury shall be not less than the average indemnity payment in Georgia as reported by
233 the Physician Insurers Association of America or its successor organization for like

234 injuries with like severity for the fiscal year 2013. Thereafter, the compensation
235 committee shall annually review the compensation schedule, and, if necessary,
236 recommend a revised schedule, but the projected cost of the revised schedule shall not
237 exceed fiscal year 2013 aggregate cost of medical malpractice by more than the
238 percentage change in the medical care component of the consumer price index for all
239 urban consumers;
240 (ii) Guidelines for the payment of compensation awards through periodic payments;
241 and
242 (iii) Guidelines for the apportionment of compensation among multiple providers,
243 which shall be based on the historical apportionment among multiple providers for
244 like injuries with like severity.
245 (e) The chief medical officer shall convene an independent medical review panel to
246 evaluate whether an application constitutes a medical injury. Each panel shall be
247 composed of an odd number of at least three panelists chosen from the list of panelists
248 recommended by the medical review committee and approved by the board and shall be
249 convened upon the call of the chief medical officer. Each panelist shall be paid a stipend
250 as determined by the board for his or her service on the panel. In order to expedite the
251 review of applications, the chief medical officer may, whenever practicable, group related
252 applications together for consideration by a single panel.
253 (f) A board member, panelist, or employee of the system shall not engage in any conduct
254 that constitutes a conflict of interest. A board member, panelist, or employee shall
255 immediately disclose in writing the presence of a conflict of interest when the board
256 member, panelist, or employee knows or should have known that the factual circumstances
257 surrounding a particular application constitutes or constituted a conflict of interest. A
258 board member, panelist, or employee who violates this subsection shall be subject to
259 disciplinary action as determined by the board. For purposes of this subsection, the term
260 'conflict of interest' means a situation in which the private interest of a board member,
261 panelist, or employee could influence his or her judgment in the performance of his or her
262 duties under this chapter and includes, but is not limited to:
263 (1) Any conduct that would lead a reasonable person having knowledge of all of the
264 circumstances to conclude that a board member, panelist, or employee is biased against
265 or in favor of an applicant; and
266 (2) Participation in any application in which the board member, panelist, or employee,
267 or the parent, spouse, or child of a board member, panelist, or employee, has a financial
268 interest.
269 (g) The board shall promulgate rules to administer the provisions of this chapter, which
270 shall include rules addressing:

271 (1) The application process, including forms necessary to collect relevant information
272 from applicants;
273 (2) Disciplinary procedures for a board member, panelist, or employee who violates the
274 conflicts of interest provisions of this Code section;
275 (3) Stipends paid to panelists for their service on an independent medical review panel,
276 which may be scaled in accordance with the relative scarcity of the provider's specialty,
277 if applicable; and
278 (4) Payment of compensation awards through periodic payments and the apportionment
279 of compensation among multiple providers, as recommended by the compensation
280 committee.

281 51-13-5.
282 (a) In order to obtain compensation for a medical injury, a person, or his or her legal
283 representative, shall file an application with the Patient Compensation System. The
284 application shall include the following:
285 (1) The name and address of the applicant or his or her representative and the basis of
286 the representation;
287 (2) The name and address of any provider that provided medical treatment allegedly
288 resulting in the medical injury;
289 (3) A brief statement of the facts and circumstances surrounding the medical injury that
290 gave rise to the application;
291 (4) An authorization for release to the office of medical review all protected health
292 information that is potentially relevant to the application;
293 (5) Any other information that the applicant believes will be beneficial to the
294 investigatory process, including the names of potential witnesses; and
295 (6) Documentation of any applicable private or governmental source of services or
296 reimbursement relative to the medical injury.
297 (b) If an application is not complete, the system shall, within 30 days after the receipt of
298 the initial application, notify the applicant in writing of any errors or omissions. An
299 applicant shall have 30 days in which to correct the errors or omissions in the initial
300 application.
301 (c) An application shall be filed within the time frames specified in Code Section 9-3-71
302 for medical malpractice actions.
303 (d) After the filing of an application, the applicant may supplement the initial application
304 with additional information the applicant believes may be beneficial in the resolution of the
305 application.

306 (e) Nothing in this chapter shall be construed to prohibit an applicant or provider from
307 retaining an attorney for the purpose of representing the applicant or provider in the review
308 and resolution of an application.

309 51-13-6.
310 (a)(1) Individuals with relevant clinical expertise in the office of medical review shall,
311 within ten days of the receipt of a completed application, determine whether the
312 application, prima facie, constitutes a medical injury.
313 (2) If the office of medical review determines that the application, prima facie,
314 constitutes a medical injury, the office shall immediately notify, by registered or certified
315 mail, each provider named in the application and, for providers that are not self-insured,
316 the insurer that provides coverage for the provider. The notification shall inform the
317 provider that the provider may support the application to expedite the processing of the
318 application. A provider shall have 15 days from the receipt of notification of an
319 application to support the application. If the provider supports the application, the office
320 of medical review shall review the application in accordance with subsection (b) of this
321 Code section.
322 (3) If the office of medical review determines that the application does not, prima facie,
323 constitute a medical injury, the office shall send a rejection letter to the applicant by
324 registered or certified mail which shall inform the applicant of his or her right of appeal.
325 The applicant shall have 15 days from the date of the receipt of the letter in which to
326 appeal the determination of the office pursuant to Code Section 51-13-7.
327 (b) An application that is supported by a provider in accordance with subsection (a) of this
328 Code section shall be reviewed for validation by individuals with relevant clinical expertise
329 in the office of medical review within 30 days of the notification of the provider's support
330 of the application. If the office of medical review finds that the application is valid, the
331 office of compensation shall determine an award of compensation in accordance with
332 subsection (d) of this Code section. If the office of medical review finds that the
333 application is not valid, the office shall immediately notify the applicant of the rejection
334 of the application and, in the case of fraud, the office shall immediately notify relevant law
335 enforcement authorities.
336 (c)(1) If the office of medical review determines that the application, prima facie,
337 constitutes a medical injury, and the provider does not elect to support the application,
338 the office shall complete a thorough investigation of the application within 60 days after
339 the determination by the office. The investigation shall be conducted by a
340 multidisciplinary team with relevant clinical expertise and shall include a thorough
341 investigation of all available documentation, witnesses, and other information. Within

342 15 days after the completion of the investigation, the chief medical officer shall allow the
343 applicant and the provider to access records, statements, and other information obtained
344 in the course of the office's investigation, in accordance with relevant state and federal
345 laws. Within 30 days after the completion of the investigation, the chief medical officer
346 shall convene an independent medical review panel to determine whether the application
347 constitutes a medical injury. The independent medical review panel shall have access to
348 all redacted information obtained by the office in the course of its investigation of the
349 application and shall make a written determination within ten days after the convening
350 of the panel which shall be immediately provided to the applicant and the provider. The
351 standard of review shall be a preponderance of the evidence.
352 (2) If the independent medical review panel determines that the application constitutes
353 a medical injury, the office of medical review shall immediately notify the provider by
354 registered or certified mail of the right to appeal the determination of the panel. The
355 provider shall have 15 days from the receipt of the letter to appeal the determination of
356 the panel pursuant to Code Section 51-13-7.
357 (3) If the independent medical review panel determines that the application does not
358 constitute a medical injury, the office of medical review shall immediately notify the
359 applicant by registered or certified mail of the right to appeal the determination of the
360 panel. The applicant shall have 15 days from the receipt of the letter to appeal the
361 determination of the panel pursuant to Code Section 51-13-7.
362 (d) If an independent medical review panel finds that an application constitutes a medical
363 injury pursuant to subsection (c) of this Code section and all appeals of that finding have
364 been exhausted by the provider pursuant to Code Section 51-13-7, the office of
365 compensation shall, within 30 days after either the finding of the panel or the exhaustion
366 of all appeals of that finding, whichever occurs later, make a written determination of an
367 award of compensation in accordance with the compensation schedule and the findings of
368 the panel. The office shall notify the applicant and the provider by registered or certified
369 mail of the amount of compensation and shall explain to the applicant the process to appeal
370 the determination of the office. The applicant shall have 15 days from the receipt of the
371 letter to appeal the determination of the office pursuant to Code Section 51-13-7.
372 (e) Compensation for each application shall be offset by any past and future collateral
373 source payments. In addition, compensation may be paid by periodic payments as
374 determined by the office of compensation in accordance with rules adopted by the board.
375 (f) Within 15 days after either the acceptance of compensation by the applicant or the
376 conclusion of all appeals pursuant to Code Section 51-13-7, the provider, or for a provider
377 that has insurance coverage, the insurer, shall remit the compensation award to the system,
378 which shall immediately provide compensation to the applicant in accordance with the final

379 compensation award. Beginning 45 days after the acceptance of compensation by the
380 applicant or the conclusion of all appeals pursuant to Code Section 51-13-7, whichever
381 occurs later, an unpaid award shall begin to accrue interest at the rate of 18 percent per
382 annum. An applicant or the system may petition the Superior Court of Fulton County or
383 the superior court of the county in which he or she resides for enforcement of an award
384 under this chapter.
385 (g) A physician who is the subject of an application under this chapter shall not be found
386 to have committed medical malpractice and shall not automatically be reported to the
387 Georgia Composite Medical Board.
388 (h) The system shall provide the department and the Georgia Composite Medical Board
389 with electronic access to applications in which a medical injury was determined to exist
390 related to persons licensed under Chapter 9, 10A, 11, 11A, 26, 27, 28, 30, 33, 34, 35, 39,
391 or 44 of Title 43 if the provider represents an imminent risk of harm to the public. The
392 department shall review such applications to determine whether any of the incidents that
393 resulted in the application potentially involved conduct by the licensee that is subject to
394 disciplinary action.

395 51-13-7.
396 (a) An administrative law judge shall hear and determine appeals filed by applicants or
397 providers pursuant to Code Section 51-13-6 and shall exercise the full power and authority
398 granted to him or her, as necessary, to carry out the purposes of such Code section. The
399 administrative law judge shall be limited in his or her review to determining whether the
400 office of medical review, the independent medical review panel, or office of compensation,
401 as appropriate, has faithfully followed the requirements of this chapter and rules adopted
402 pursuant to this chapter in reviewing applications. If the administrative law judge
403 determines that such requirements were not followed in reviewing an application, he or she
404 shall either require the chief medical officer to reconvene the original panel or convene a
405 new panel or require the office of compensation to redetermine the compensation amount,
406 in accordance with the determination of the administrative law judge.
407 (b) A determination by an administrative law judge under this Code section regarding the
408 faithful following of the requirements and rules under this chapter shall be conclusive and
409 binding as to all questions of fact. Such determination with findings of fact and
410 conclusions of law shall be sent to the applicant and provider in question. An applicant or
411 provider may obtain judicial review of such determination pursuant to Code Section
412 50-13-19.

413 (c) Upon a written petition by either the applicant or the provider, an administrative law
414 judge may grant, for good cause, an extension of any of the time periods specified in this
415 chapter.

416 51-13-8.
417 (a) The board shall annually determine a contribution that shall be paid by each provider
418 for the expense of the administration of this chapter. The contribution amount shall be
419 determined by January 1 of each year and shall be based on the anticipated expenses of the
420 administration of this chapter for the next state fiscal year.
421 (b) The contribution rate shall not exceed the following amounts:
422 (1) For an individual licensed under Chapter 11 or 26 of Title 43, with the exception of
423 a certified registered nurse anesthetist, $100.00 per licensee;
424 (2) For a hospital or ambulatory surgery center licensed under Chapter 7 of Title 31,
425 $200.00 per bed. The contribution for the initial fiscal year shall be $100.00 per bed;
426 (3) For a physician assistant licensed under Chapter 34 of Title 43 or a certified
427 registered nurse anesthetist certified under Chapter 26 of Title 43, $250.00 per licensee;
428 (4) For a chiropractor licensed under Chapter 9 of Title 43 or a physician licensed under
429 Chapter 34 of Title 43, $500.00 per licensee. The contribution for the initial fiscal year
430 shall be $500.00 per licensee; and
431 (5) For any other provider not otherwise described in this subsection, $2,500.00 per
432 registrant or licensee.
433 (c) The contribution determined under this Code section shall be payable by each provider
434 on July 1 of the next state fiscal year. Each provider shall pay the contribution amount
435 within 30 days from the date that notice is delivered to the provider. If any provider fails
436 to pay the contribution determined under this Code section within 30 days, the board shall
437 notify such provider by certified or registered mail that such provider's license shall be
438 subject to revocation if the contribution is not paid within 60 days from the date of the
439 original notice.
440 (d) A provider that fails to pay the contribution amount determined under this Code section
441 within 60 days from the date of the receipt of the original notice shall be subject to a
442 licensure revocation action by the Department of Community Health or the relevant
443 regulatory board.
444 (e) All amounts collected under the provisions of this Code section shall be paid into the
445 state treasury and are intended to be used for the expenses of administration of this chapter.

446 51-13-9.
447 The board shall annually submit, beginning on October 1, 2015, a report that describes the
448 filing and disposition of applications in the prior state fiscal year. The report shall include,
449 in the aggregate, the number of applications, the disposition of such applications, and
450 compensation awarded. The report shall also provide recommendations, if any, regarding
451 legislative changes that would improve the efficiency of the functions of the system. The
452 report shall be provided to the Governor, the Lieutenant Governor, and the Speaker of the
453 House of Representatives.″

454 **SECTION 3.**

455 This Act shall become effective upon its approval by the Governor or upon its becoming law
456 without such approval and shall apply to claims arising on or after such date.

457 **SECTION 4.**

458 All laws and parts of laws in conflict with this Act are repealed.