

*Reprinted 4/87*

COMMERCE: Palmer, Chair; Mann, Welsh, Lind and Holden

*Amend (3546) & Do Pass 3/21/87 (p. 1006)  
Judiciary 4/1/87 Amend (3590) & Do Pass 4/2 (p. 1024)*

**FILED MAR 20 1987**

SENATE FILE 484  
BY COMMITTEE ON COMMERCE  
*Approved (p. 823)*

Passed Senate, Date 4-3-87 (p. 1088) Passed House, Date 4/6/88 (p. 1501)  
Vote: Ayes 39 Nays 7 Vote: Ayes 76 Nays 18  
Approved Retired 5/13/88

**A BILL FOR**

1 An Act relating to health care providers and patients and  
2 providing for the creation of an excess liability fund for  
3 health care providers, establishing a surcharge to be  
4 deposited in the fund, establishing a special surcharge,  
5 establishing qualifications for a health care provider or a  
6 patient to be protected by the fund, establishing a maximum  
7 limitation on the liability of the fund, creation of a  
8 compensation review board, authorization of the fund to  
9 procure reinsurance to protect the fund, authorization of the  
10 fund to provide primary insurance coverage to health care  
11 providers and providing for structured settlements.

12 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

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*SC 484*

1 Section 1. FINDINGS.

2 The general assembly finds that a critical situation exists  
3 in Iowa's health care provider industry impacting on the  
4 accessibility and affordability of high quality health care.  
5 Physicians in certain specialty and high-risk areas are  
6 choosing to no longer provide these services as a result of  
7 the potential liability. Physicians continuing to provide  
8 these services are increasingly practicing defensive medicine  
9 in an effort to protect themselves from potentially ruinous  
10 verdicts. The practice of defensive medicine results in  
11 increased cost to the public in need of medical services and  
12 rarely results in a corresponding medical benefit.

13 The general assembly further finds that it is in the public  
14 interest that high quality medical and hospital services be  
15 available to the citizens of Iowa at reasonable costs. It is  
16 in the public interest to encourage competent physicians to  
17 enter into and remain in the practice of medicine in this  
18 state. It is in the public interest to assure that funds are  
19 available to compensate an injured party while protecting  
20 health care providers from liabilities effectively preventing  
21 them from serving the best interests of society.

22 Sec. 2. NEW SECTION. 147B.1 SHORT TITLE. This Act shall  
23 be known as the "Health Care Provider and Patient Assistance  
24 Act".

25 Sec. 3. NEW SECTION. 147B.2 DEFINITIONS.

26 As used in this chapter, unless the context requires  
27 otherwise:

28 1. "Health care provider" means a person licensed or  
29 certified under chapter 147, 148, 148A, 148C, 149, 150, 150A,  
30 151, 152, 153, 154, 154B or 155 to provide in this state  
31 professional health care service to an individual during that  
32 individual's medical care, treatment, or confinement.

33 2. "Health services" means clinically related diagnostic,  
34 curative, or rehabilitative services, and includes alcoholism,  
35 drug abuse, and mental health services.

1 3. "Hospital" means the same as it is defined in section  
2 135B.1, subsection 1.

3 4. "Physician" shall mean a person licensed to practice  
4 medicine and surgery, osteopathy and surgery, osteopathy, or  
5 chiropractic under the laws of this state; however, a person  
6 licensed as a physician and surgeon shall be designated as a  
7 "physician" or "surgeon", a person licensed as an osteopath  
8 and surgeon shall be designated as an "osteopathic physician"  
9 or "osteopathic surgeon", a person licensed as an osteopath  
10 shall be designated as an "osteopathic physician", and a  
11 person licensed as a chiropractor shall be designated as a  
12 "chiropractor".

13 5. "Commissioner" means the commissioner of insurance.

14 Sec. 4. NEW SECTION. 147B.3 QUALIFIED PROVIDER --  
15 PATIENT.

16 1. A health care provider is qualified to participate  
17 under this chapter if the health care provider does the  
18 following:

19 a. Files with the commissioner proof of financial  
20 responsibility in an amount of one hundred thousand dollars  
21 per occurrence. The health care provider is qualified as long  
22 as the required proof of financial responsibility remains  
23 effective.

24 b. Pays a surcharge or special surcharge levied on health  
25 care providers pursuant to section 147B.8, subsection 2.

26 2. A hospital is qualified to participate under this  
27 chapter if the hospital does the following:

28 a. Files with the commissioner proof of financial  
29 responsibility in an amount of one million dollars for all  
30 occurrences or claims made in any policy year.

31 b. Pays a surcharge or special surcharge levied on  
32 hospitals pursuant to section 147B.8, subsection 2.

33 3. The commissioner may permit qualification of a health  
34 care provider who has retired or ceased doing business, if the  
35 health care provider files proof of financial responsibility

1 as required in subsection 1.

2 4. A claim or cause of action against a health care  
3 provider or hospital, for purposes of this chapter, is subject  
4 to the facts and circumstances relating to the health care  
5 provider's or hospital's qualification under this section at  
6 the time of the occurrence of the alleged wrongful act and is  
7 not affected by the fact that the health care provider or  
8 hospital is not qualified at the time the action is  
9 instituted. A health care provider or hospital who is not  
10 qualified at the time of the alleged occurrence is not  
11 eligible to qualify under this chapter by filing proof of  
12 financial responsibility and payment of the required surcharge  
13 subsequent to the occurrence giving rise to the claim.

14 Sec. 5. NEW SECTION. 147B.4 PATIENT ELECTION TO BE  
15 BOUND.

16 1. A patient's exclusive remedy against a health care  
17 provider or hospital qualifying under 147B.3 for alleged  
18 malpractice, professional negligence, failure to provide care,  
19 or claim based upon failure to obtain informed consent for an  
20 operation or treatment is the remedy provided for under this  
21 chapter unless the patient has elected not to be bound by the  
22 remedies provided for in this chapter. A patient may elect to  
23 not be bound under this chapter by filing the election with  
24 the commissioner, pursuant to rules adopted by the  
25 commissioner, in advance of a treatment, act or omission upon  
26 which a claim may be based, and notified the health care  
27 provider or hospital of the election within a reasonable time  
28 before any treatment begins. Failure to provide the required  
29 notice is conclusive evidence of the patient's election to be  
30 bound by the provisions of this chapter.

31 2. An election by a patient not to be bound by this  
32 chapter is effective for a period of two years after filing  
33 unless the election is withdrawn. The patient may withdraw  
34 the election in writing at any time by filing the withdrawal  
35 with the commissioner.

1 3. A health care provider or hospital must provide a  
2 patient with notice that the health care provider or hospital  
3 is qualified under this chapter prior to any treatment, and  
4 must inform the patient of the patient's right to elect not to  
5 be bound by the provisions of this chapter.

6 Sec. 6. NEW SECTION. 147B.5 SCOPE OF RECOVERY.

7 Actions arising under this chapter are subject to section  
8 147.136.

9 Sec. 7. NEW SECTION. 147B.6 LIMITATION ON RECOVERY.

10 1. The total amount recoverable from a health care  
11 provider or hospital and the excess liability fund for an  
12 occurrence resulting in an injury or death of a patient may  
13 not exceed one million dollars. However, if a verdict or  
14 judgment is issued for an amount greater than one million  
15 dollars, the court may order that payment of the verdict or  
16 award be structured so that the total payments made to the  
17 plaintiff are as close to the actual verdict or judgment as  
18 possible.

19 2. A health care provider or hospital qualified under this  
20 chapter is not liable to a patient or the patient's  
21 representative who has elected to be covered by this chapter  
22 for an amount in excess of one hundred thousand dollars for  
23 all claims or causes of action arising from an occurrence  
24 during the period of election. Subject to limits in this  
25 section, an amount due from a judgment or settlement which is  
26 in excess of the total liability of all liable health care  
27 providers shall be paid from the excess liability fund  
28 pursuant to section 147B.8.

29 Sec. 8. NEW SECTION. 147B.7 STATE COMPENSATION BOARD.

30 A state compensation board is created to review all  
31 malpractice claims against health care providers covered by  
32 this chapter.

33 Sec. 9. NEW SECTION. 147B.8 EXCESS LIABILITY FUND.

34 1. An excess liability fund is created for the purposes  
35 stated in this chapter. The fund and income from the fund

1 shall be deposited with the treasurer of state to be used for  
2 the payment of qualifying claims under this chapter, and the  
3 fund is appropriated for that purpose. Appropriations from  
4 the fund are not subject to reversion under section 8.33.

5 2. An annual surcharge shall be levied on all health care  
6 providers and hospitals qualifying under section 147B.3. The  
7 surcharge for a health care provider is determined by the  
8 commissioner subject to the following limitations:

9 a. The annual surcharge shall not exceed fifty percent of  
10 the annual premium paid by the health care provider for  
11 maintenance of current financial responsibility as provided in  
12 section 147B.3, subsection 1.

13 b. The charge shall not exceed the amount necessary to  
14 maintain the fund in accordance with section 147B.9.

15 3. The surcharge due under section 147B.3, subsection 1,  
16 is due and payable within thirty days after the health care  
17 provider has qualified pursuant to section 147B.3 and is  
18 payable annually thereafter in amounts as determined by the  
19 commissioner.

20 4. If the annual premium surcharge under section 147B.3 is  
21 not paid within the time specified in subsection 3, the  
22 qualification of the health care provider shall be suspended  
23 until the annual premium is paid. The suspension shall not be  
24 effective as to patients claiming against the health care pro-  
25 vider unless, at least thirty days before the effective date  
26 of the suspension, a written notice giving the date upon which  
27 the suspension becomes effective has been provided by the  
28 commissioner to the health care provider.

29 5. All expenses of collecting, protecting, and ad-  
30 ministering the funds shall be paid from the fund, including  
31 necessary costs of outside legal counsel.

32 Sec. 10. NEW SECTION. 147B.9 SPECIAL SURCHARGE -- RE-  
33 INSURANCE.

34 The commissioner may, at any time, analyze the fund to  
35 determine if the amount in the fund is inadequate to pay in

1 full all claims allowed or to be allowed during the calendar  
2 year. If the fund is determined to be inadequate, the  
3 commissioner may levy a special surcharge on all health care  
4 providers who have qualified under this chapter on the date of  
5 the special surcharge or at any time during the preceding  
6 twelve months and shall be in an amount proportionate to the  
7 surcharge each health care provider has paid to the fund. The  
8 special surcharge shall be an amount sufficient to permit full  
9 payment of all claims allowed against the fund during a  
10 calendar year. The special surcharge shall be levied against  
11 all health care providers who have qualified under this  
12 chapter. The special surcharge is due and payable within  
13 thirty days after the surcharge is levied.

14 The director may cause all or any part of the potential  
15 liability of the excess liability fund to be reinsured, if  
16 reinsurance is available on a fair and reasonable basis. The  
17 cost of the reinsurance shall be paid by the fund and the fact  
18 of the reinsurance shall be taken into account in determining  
19 the surcharge under section 147B.8, subsection 2, but in no  
20 event shall the surcharge exceed fifty percent of the annual  
21 premium paid by a health care provider for maintenance of  
22 current financial responsibility.

23

## EXPLANATION

24 This bill creates the Health Care Provider and Patient  
25 Assistance Act. The bill establishes a limitation on the  
26 liability of a health care provider or hospital qualified  
27 under the Act. An excess liability fund is created for the  
28 purpose of compensating injured parties for amounts awarded  
29 over that covered by the primary coverage provided by the  
30 health care provider or hospital. A surcharge is established  
31 to be assessed against all qualifying health care providers  
32 and hospitals which is to be deposited in the fund. A patient  
33 may elect to not be bound by the Act, but must provide notice  
34 to the health care provider or hospital of the election, as  
35 well as the insurance commissioner.

1 An amount recoverable under this Act by a plaintiff is  
2 limited to one million dollars. However, the court may order,  
3 in cases where a verdict or judgment is issued for a greater  
4 amount, that payments be structured so that the total payments  
5 to the plaintiff most closely approximate the actual verdict  
6 or award.

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SENATE FILE 484

S-3346

1 Amend Senate File 484 as follows:

2 1. Page 1, by striking lines 7 through 12 and  
3 inserting the following: "the unaffordability or  
4 unavailability of liability insurance."

5 2. Page 1, line 29, by striking the figure  
6 "147,".

7 3. Page 2, line 20, by striking the word "one"  
8 and inserting the word "two".

9 4. Page 4, line 22, by striking the word "one"  
10 and inserting the word "two".

11 5. Page 6, by inserting after line 22 the  
12 following:

13 "Sec. \_\_\_\_ . NEW SECTION. 147B.10 ANNUAL REPORT.

14 The state compensation board shall, pursuant to  
15 rules issued by the commissioner, on or before the  
16 first day of February of each year, provide to the  
17 chairs, vice chairs, and ranking members of the senate  
18 standing committees on judiciary and commerce, and the  
19 house of representatives standing committees on  
20 judiciary and law enforcement, and small business and  
21 commerce, a report regarding claims filed against the  
22 fund and claims closed involving the fund for the  
23 previous calendar year. The report shall contain the  
24 following information:

25 1. Parties to the claim.

26 2. Cause or causes of action.

27 3. Amounts reserved or paid per claim, including  
28 the present value for structured settlements or  
29 awards.

30 4. Legal fees, expert witness fees, court costs,  
31 or other associated costs of judgments or decrees per  
32 claim.

33 5. Other claims information as deemed necessary by  
34 the commissioner."

35 6. Page 6, by inserting after line 22 the  
36 following:

37 "Sec. \_\_\_\_ . NEW SECTION. 135B.40 INDEMNIFICATION  
38 AGREEMENT.

39 1. An agreement between a hospital and a health  
40 care provider may be entered into providing that the  
41 hospital shall indemnify the health care provider for  
42 any liability of the health care provider arising  
43 while the health care provider is providing services  
44 at the hospital with which the agreement is made. The  
45 agreement may provide that the hospital will indemnify  
46 the health care provider for liability arising from  
47 services provided outside of the hospital. The  
48 agreement shall not provide for indemnification of  
49 liability arising from services provided by the health  
50 care provider in another hospital.

S-3346 pg. 2

1 2. A hospital may, before entering into an  
2 agreement pursuant to this section require the health  
3 care provider to provide information regarding all  
4 claims filed against the health care provider and  
5 losses resulting from the claims.

6 Sec. \_\_\_\_ . NEW SECTION. 668.14 EVIDENCE OF  
7 PREVIOUS PAYMENT OR FUTURE RIGHT OF PAYMENT.

8 1. In an action brought pursuant to this chapter  
9 seeking damages for personal injury, the court shall  
10 permit evidence and argument as to the previous  
11 payment or future right of payment of actual economic  
12 losses incurred or to be incurred as a result of the  
13 personal injury for necessary medical care, rehabili-  
14 tation services, and custodial care except to the  
15 extent that the previous payment or future right of  
16 payment is pursuant to a state or federal program or  
17 from assets of the claimant or the members of the  
18 claimant's immediate family.

19 2. If evidence and argument regarding previous  
20 payments or future rights of payment is permitted  
21 pursuant to subsection 1, the court shall also permit  
22 evidence and argument as to the costs to the claimant  
23 of procuring the previous payments or future rights of  
24 payment and as to any existing rights of in-  
25 demnification or subrogation relating to the previous  
26 payments or future rights of payment.

27 3. If evidence or argument is permitted pursuant  
28 to subsection 1 or 2, the court shall, unless  
29 otherwise agreed to by all parties, instruct the jury  
30 to answer special interrogatories or, if there is no  
31 jury, shall make findings indicating the effect of  
32 such evidence or argument on the verdict."

33 7. By renumbering as necessary.

S-3346

Filed March 31, 1987

*B. Passed 10/86*

*A. Adopted 10/86*

*C. Adopted as amended by 3389 (10/86)*

BY COMMITTEE ON COMMERCE

WILLIAM D. PALMER, Chairperson

SENATE FILE 484

S-3410

1 Amend Senate File 484 as follows:  
2 1. Page 6, by inserting after line 22 the  
3 following:  
4 "Sec. \_\_\_\_ . NEW SECTION. 147B.10 MEDICAL  
5 LIABILITY INSURANCE PROFITS.  
6 The commissioner shall establish rules which shall  
7 limit the profits of an insurance company admitted to  
8 this state to not more than seven percent on all  
9 policies of medical liability insurance sold in this  
10 state."

S-3410

Filed April 3, 1987  
WITHDRAWN (p. 1025)

BY JOE J. WELSH  
JAMES R. RIORDAN

SENATE FILE 484

S-3411

1 Amend amendment, S-3390, to Senate File 484 as  
2 follows:  
3 1. Page 1, by striking lines 14 through 30.  
4 2. Page 2, by striking lines 4 through 23.

S-3411

Filed April 3, 1987  
RULED OUT OF ORDER (p. 1086)

BY JULIA GENTLEMAN  
RICHARD F. DRAKE

SENATE FILE 484

S-3393

1 Amend amendment, S-3390, to Senate File 484 as  
2 follows:

3 1. Page 1, by striking line 8 and inserting the  
4 following: A

5 " Page 4, by striking lines 29 through 32."

6 2. Page 1, by striking lines 14 through 30. B

7 3. Page 2, by striking lines 4 through 23. C

S-3393

Filed April 3, 1987

BY JULIA GENTLEMAN  
RICHARD F. DRAKE

A - WITHDRAWN (p. 1082)  
B & C - RULED OUT OF ORDER (p. 1086)

SENATE FILE 484

S-3396

1 Amend the Commerce Committee amendment S-3346, to  
2 Senate File 484 as follows:  
3 1. Page 2, by striking lines 6 through 32.

S-3396

Filed April 3, 1987  
LOST (p. 1087)

BY JULIA GENTLEMAN  
RICHARD F. DRAKE

SENATE FILE 484

S-3403

1 Amend Senate File 484 as follows:

2 1. Page 6, by inserting after line 22 the  
3 following:

4 "Sec. \_\_\_\_\_. 147B.10 COMPENSATION FUND  
5 ADMINISTRATOR.

6 The commissioner may appoint an administrator to  
7 perform all duties and responsibilities pursuant to  
8 this chapter. The administrator shall serve at the  
9 pleasure of the commissioner. The salary and expenses  
10 of the administrator shall be paid from the fund.

11 Sec. \_\_\_\_\_. 147B.11 ADMINISTRATION.

12 The commissioner shall either provide staff  
13 services necessary for the implementation and  
14 operation of this chapter or may contract with an  
15 insurance company licensed to do business in this  
16 state, or both, to perform any administrative duties  
17 and responsibilities of the commissioner pursuant to  
18 this chapter. The commissioner shall retain  
19 supervisory control over all services for which a  
20 contract is entered into. All reasonable costs and  
21 charges incurred in the administration of this chapter  
22 shall be paid from the fund.

23 Sec. \_\_\_\_\_. 147B.12 RULES.

24 The commissioner shall adopt rules for the  
25 administration and efficient operation of this chapter  
26 in accordance with its terms and intent.

27 Sec. \_\_\_\_\_. Section 147.136 is repealed."

28 2. Renumber as necessary.

S-3403

Filed April 3, 1987

BY TOM MANN, JR.

ADOPTED (p. 1088)

SENATE FILE 484

S-3390

1 Amend Senate File 484 as follows:

2 1. Page 1, line 4, by striking the word  
3 "accessibility" and inserting the word  
4 "unavailability".

5 2. Page 2, line 13, by inserting after the word  
6 "insurance" the following: "or the compensation fund  
7 administrator appointed pursuant to section 147B.10".

8 3. Page 4, by striking lines 6 through 32.

9 4. Page 6, line 14, by striking the word  
10 "director" and inserting the following:  
11 "commissioner".

12 5. Page 6, by inserting after line 22 the  
13 following:

14 "Sec. \_\_\_\_ . Section 147.136, Code 1987, is amended  
15 by striking the section and inserting in lieu thereof  
16 the following:

17 147.136 JOINT AND SEVERAL LIABILITY.

18 Notwithstanding section 668.4, the rule of joint  
19 and several liability shall apply to defendants in an  
20 action for damages for personal injury against a  
21 physician and surgeon, osteopath, osteopathic  
22 physician and surgeon, dentist, podiatrist,  
23 optometrist, pharmacist, chiropractor, or nurse  
24 licensed to practice that profession in this state, or  
25 against a hospital licensed for operation in this  
26 state, based on the alleged negligence of the  
27 practitioner in the practice of the profession or  
28 occupation, or upon the alleged negligence of the  
29 hospital in patient care, in which liability is  
30 admitted or established.

31 Sec. \_\_\_\_ . NEW SECTION. 147B.10 COMPENSATION FUND  
32 ADMINISTRATOR.

33 The commissioner may appoint an administrator to  
34 perform all duties and responsibilities pursuant to  
35 this chapter. The administrator shall serve at the  
36 pleasure of the commissioner. The salary and expenses  
37 of the administrator shall be paid from the fund.

38 Sec. \_\_\_\_ . NEW SECTION. 147B.11 ADMINISTRATION.

39 The commissioner shall either provide staff  
40 services necessary for the implementation and  
41 operation of this chapter or may contract with an  
42 insurance company licensed to do business in this  
43 state, or both, to perform any administrative duties  
44 and responsibilities of the commissioner pursuant to  
45 this chapter. The commissioner shall retain  
46 supervisory control over all services for which a  
47 contract is entered into. All reasonable costs and  
48 charges incurred in the administration of this chapter  
49 shall be paid from the fund.

50 Sec. \_\_\_\_ . NEW SECTION. 147B.12 RULES.

Ⓢ S-3390 pg. 2

1 The commissioner shall adopt rules for the  
2 administration and efficient operation of this chapter  
3 in accordance with its terms and intent.

4 Sec. \_\_\_\_ . Section 614.1, subsection 9, Code 1987,  
5 is amended to read as follows:

6 9. MALPRACTICE. Those founded on injuries to the  
7 person or wrongful death against any physician and  
8 surgeon, osteopath, osteopathic physician and surgeon,  
9 dentist, podiatrist, optometrist, pharmacist,  
10 chiropractor, or nurse, licensed under chapter 147, or  
11 a hospital licensed under chapter 135B, arising out of  
12 patient care, within two years after the date on which  
13 the claimant knew, or through the use of reasonable  
14 diligence should have known, or received notice in  
15 writing of the existence of, the injury or death for  
16 which damages are sought in the action, whichever of  
17 the dates occurs first, ~~but in no event shall any~~  
18 ~~action be brought more than six years after the date~~  
19 ~~on which occurred the act or omission or occurrence~~  
20 ~~alleged in the action to have been the cause of the~~  
21 ~~injury or death unless a foreign object~~  
22 ~~unintentionally left in the body caused the injury or~~  
23 death."

24 6. Renumber as necessary.

S-3390

Filed April 2, 1987

BY COMMITTEE ON JUDICIARY

*A. Adopted 4/3 (p. 1075)*

DONALD V. DOYLE, Chairperson

*B. Ltr. (p. 1076) Recommended & Adopted (p. 1086)*  
*C. H/D (p. 1086)*

SENATE FILE 484

S-3389

1 Amend the amendment, S-3346, to Senate File 484, as  
2 follows:

3 1. Page 1, by striking lines 14 and 15 and in-  
4 serting the following:

5 "The commissioner shall, on or before the".

S-3389

Filed April 2, 1987

BY COMMITTEE ON JUDICIARY

*Adopted 4/3 (p. 1086)*

DONALD V. DOYLE, Chairperson

*Has Conference 4/7/87*

*Re* Judiciary and Law Enforcement: Jay, Chair; Halvorson of Clayton, Hansen of Woodbury, Lageschulte and McKinney.

*Amended per 5925. To Senate 3/26 (p. 1127)*

SENATE FILE **484**  
BY COMMITTEE ON COMMERCE

(AS AMENDED AND PASSED BY THE SENATE APRIL 3, 1987)

\_\_\_\_\_ - New Language by the Senate  
\* - Language Stricken by the Senate

*Re* Passed Senate, Date 4/3/87 (p. 1323) Passed House, Date 4/6/87 (p. 1501)  
Vote: Ayes 35 Nays 10 Vote: Ayes 78 Nays 18  
Approved Vetoes 5/13/88

*Repassed House 4/12/87 (p. 1793)*

A BILL FOR

*62-57  
Motion to reconsider 4/13 (p. 1861)  
Failed 4/17*

1 An Act relating to health care providers and patients and  
2 providing for the creation of an excess liability fund for  
3 health care providers, establishing a surcharge to be  
4 deposited in the fund, establishing a special surcharge,  
5 establishing qualifications for a health care provider or a  
6 patient to be protected by the fund, establishing a maximum  
7 limitation on the liability of the fund, creation of a  
8 compensation review board, authorization of the fund to  
9 procure reinsurance to protect the fund, authorization of the  
10 fund to provide primary insurance coverage to health care  
11 providers and providing for structured settlements.

12 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

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484

1 Section 1. FINDINGS.

2 The general assembly finds that a critical situation exists  
3 in Iowa's health care provider industry impacting on the  
4 unavailability and affordability of high quality health care.  
5 Physicians in certain specialty and high-risk areas are  
6 choosing to no longer provide these services as a result of  
7 the unaffordability or unavailability of liability insurance.

8 The general assembly further finds that it is in the public  
9 interest that high quality medical and hospital services be  
10 available to the citizens of Iowa at reasonable costs. It is  
11 in the public interest to encourage competent physicians to  
12 enter into and remain in the practice of medicine in this  
13 state. It is in the public interest to assure that funds are  
14 available to compensate an injured party while protecting  
15 health care providers from liabilities effectively preventing  
16 them from serving the best interests of society.

17 Sec. 2. NEW SECTION. 147B.1 SHORT TITLE. This Act shall  
18 be known as the "Health Care Provider and Patient Assistance  
19 Act".

20 Sec. 3. NEW SECTION. 147B.2 DEFINITIONS.

21 As used in this chapter, unless the context requires  
22 otherwise:

23 1. "Health care provider" means a person licensed or  
\* 24 certified under chapter 148, 148A, 148C, 149, 150, 150A, 151,  
25 152, 153, 154, 154B or 155 to provide in this state  
26 professional health care service to an individual during that  
27 individual's medical care, treatment, or confinement.

28 2. "Health services" means clinically related diagnostic,  
29 curative, or rehabilitative services, and includes alcoholism,  
30 drug abuse, and mental health services.

31 3. "Hospital" means the same as it is defined in section  
32 135B.1, subsection 1.

33 4. "Physician" shall mean a person licensed to practice  
34 medicine and surgery, osteopathy and surgery, osteopathy, or  
35 chiropractic under the laws of this state; however, a person

1 licensed as a physician and surgeon shall be designated as a  
2 "physician" or "surgeon", a person licensed as an osteopath  
3 and surgeon shall be designated as an "osteopathic physician"  
4 or "osteopathic surgeon", a person licensed as an osteopath  
5 shall be designated as an "osteopathic physician", and a  
6 person licensed as a chiropractor shall be designated as a  
7 "chiropractor".

8 5. "Commissioner" means the commissioner of insurance or  
9 the compensation fund administrator appointed pursuant to  
10 section 147B.8.

11 Sec. 4. NEW SECTION. 147B.3 QUALIFIED PROVIDER --  
12 PATIENT.

13 1. A health care provider is qualified to participate  
14 under this chapter if the health care provider does the  
15 following:

16 a. Files with the commissioner proof of financial  
17 responsibility in an amount of two hundred thousand dollars  
18 per occurrence. The health care provider is qualified as long  
19 as the required proof of financial responsibility remains  
20 effective.

21 b. Pays a surcharge or special surcharge levied on health  
22 care providers pursuant to section 147B.5, subsection 2.

23 2. A hospital is qualified to participate under this  
24 chapter if the hospital does the following:

25 a. Files with the commissioner proof of financial  
26 responsibility in an amount of one million dollars for all  
27 occurrences or claims made in any policy year.

28 b. Pays a surcharge or special surcharge levied on  
29 hospitals pursuant to section 147B.5, subsection 2.

30 3. The commissioner may permit qualification of a health  
31 care provider who has retired or ceased doing business, if the  
32 health care provider files proof of financial responsibility  
33 as required in subsection 1.

34 4. A claim or cause of action against a health care  
35 provider or hospital, for purposes of this chapter, is subject

1 to the facts and circumstances relating to the health care  
2 provider's or hospital's qualification under this section at  
3 the time of the occurrence of the alleged wrongful act and is  
4 not affected by the fact that the health care provider or  
5 hospital is not qualified at the time the action is  
6 instituted. A health care provider or hospital who is not  
7 qualified at the time of the alleged occurrence is not  
8 eligible to qualify under this chapter by filing proof of  
9 financial responsibility and payment of the required surcharge  
10 subsequent to the occurrence giving rise to the claim.

11 Sec. 5. NEW SECTION. 147B.4 PATIENT ELECTION TO BE  
12 BOUND.

13 1. A patient's exclusive remedy against a health care  
14 provider or hospital qualifying under 147B.3 for alleged  
15 malpractice, professional negligence, failure to provide care,  
16 or claim based upon failure to obtain informed consent for an  
17 operation or treatment is the remedy provided for under this  
18 chapter unless the patient has elected not to be bound by the  
19 remedies provided for in this chapter. A patient may elect to  
20 not be bound under this chapter by filing the election with  
21 the commissioner, pursuant to rules adopted by the  
22 commissioner, in advance of a treatment, act or omission upon  
23 which a claim may be based, and notified the health care  
24 provider or hospital of the election within a reasonable time  
25 before any treatment begins. Failure to provide the required  
26 notice is conclusive evidence of the patient's election to be  
27 bound by the provisions of this chapter.

28 2. An election by a patient not to be bound by this  
29 chapter is effective for a period of two years after filing  
30 unless the election is withdrawn. The patient may withdraw  
31 the election in writing at any time by filing the withdrawal  
32 with the commissioner.

33 3. A health care provider or hospital must provide a  
34 patient with notice that the health care provider or hospital  
35 is qualified under this chapter prior to any treatment, and

1 must inform the patient of the patient's right to elect not to  
2 be bound by the provisions of this chapter.

3 Sec. 6. NEW SECTION. 147B.5 EXCESS LIABILITY FUND.

4 1. An excess liability fund is created for the purposes  
5 stated in this chapter. The fund and income from the fund  
6 shall be deposited with the treasurer of state to be used for  
7 the payment of qualifying claims under this chapter, and the  
8 fund is appropriated for that purpose. Appropriations from  
9 the fund are not subject to reversion under section 8.33.

10 2. An annual surcharge shall be levied on all health care  
11 providers and hospitals qualifying under section 147B.3. The  
12 surcharge for a health care provider is determined by the  
13 commissioner subject to the following limitations:

14 a. The annual surcharge shall not exceed fifty percent of  
15 the annual premium paid by the health care provider for  
16 maintenance of current financial responsibility as provided in  
17 section 147B.3, subsection 1.

18 b. The charge shall not exceed the amount necessary to  
19 maintain the fund in accordance with section 147B.6.

20 3. The surcharge due under section 147B.3, subsection 1,  
21 is due and payable within thirty days after the health care  
22 provider has qualified pursuant to section 147B.3 and is  
23 payable annually thereafter in amounts as determined by the  
24 commissioner.

25 4. If the annual premium surcharge under section 147B.3 is  
26 not paid within the time specified in subsection 3, the  
27 qualification of the health care provider shall be suspended  
28 until the annual premium is paid. The suspension shall not be  
29 effective as to patients claiming against the health care pro-  
30 vider unless, at least thirty days before the effective date  
31 of the suspension, a written notice giving the date upon which  
32 the suspension becomes effective has been provided by the  
33 commissioner to the health care provider.

34 5. All expenses of collecting, protecting, and ad-  
35 ministering the funds shall be paid from the fund, including

1 necessary costs of outside legal counsel.

2 Sec. 7. NEW SECTION. 147B.6 SPECIAL SURCHARGE -- RE-  
3 INSURANCE.

4 The commissioner may, at any time, analyze the fund to  
5 determine if the amount in the fund is inadequate to pay in  
6 full all claims allowed or to be allowed during the calendar  
7 year. If the fund is determined to be inadequate, the  
8 commissioner may levy a special surcharge on all health care  
9 providers who have qualified under this chapter on the date of  
10 the special surcharge or at any time during the preceding  
11 twelve months and shall be in an amount proportionate to the  
12 surcharge each health care provider has paid to the fund. The  
13 special surcharge shall be an amount sufficient to permit full  
14 payment of all claims allowed against the fund during a  
15 calendar year. The special surcharge shall be levied against  
16 all health care providers who have qualified under this  
17 chapter. The special surcharge is due and payable within  
18 thirty days after the surcharge is levied.

19 The commissioner may cause all or any part of the potential  
20 liability of the excess liability fund to be reinsured, if  
21 reinsurance is available on a fair and reasonable basis. The  
22 cost of the reinsurance shall be paid by the fund and the fact  
23 of the reinsurance shall be taken into account in determining  
24 the surcharge under section 147B.5, subsection 2, but in no  
25 event shall the surcharge exceed fifty percent of the annual  
26 premium paid by a health care provider for maintenance of  
27 current financial responsibility.

28 Sec. 8. NEW SECTION. 147B.7 ANNUAL REPORT.

29 The commissioner shall, on or before the first day of  
30 February of each year, provide to the chairs, vice chairs, and  
31 ranking members of the senate standing committees on judiciary  
32 and commerce, and the house of representatives standing  
33 committees on judiciary and law enforcement, and small  
34 business and commerce, a report regarding claims filed against  
35 the fund and claims closed involving the fund for the previous

1 calendar year. The report shall contain the following  
2 information:

- 3 1. Parties to the claim.
- 4 2. Cause or causes of action.
- 5 3. Amounts reserved or paid per claim, including the  
6 present value for structured settlements or awards.
- 7 4. Legal fees, expert witness fees, court costs, or other  
8 associated costs of judgments or decrees per claim.
- 9 5. Other claims information as deemed necessary by the  
10 commissioner.

11 Sec. 9. 147B.8 COMPENSATION FUND ADMINISTRATOR.

12 The commissioner may appoint an administrator to perform  
13 all duties and responsibilities pursuant to this chapter. The  
14 administrator shall serve at the pleasure of the commissioner.  
15 The salary and expenses of the administrator shall be paid  
16 from the fund.

17 Sec. 10. 147B.9 ADMINISTRATION.

18 The commissioner shall either provide staff services  
19 necessary for the implementation and operation of this chapter  
20 or may contract with an insurance company licensed to do  
21 business in this state, or both, to perform any administrative  
22 duties and responsibilities of the commissioner pursuant to  
23 this chapter. The commissioner shall retain supervisory  
24 control over all services for which a contract is entered  
25 into. All reasonable costs and charges incurred in the  
26 administration of this chapter shall be paid from the fund.

27 Sec. 11. 147B.10 RULES.

28 The commissioner shall adopt rules for the administration  
29 and efficient operation of this chapter in accordance with its  
30 terms and intent.

31 Sec. 12. NEW SECTION. 135B.40 INDEMNIFICATION AGREEMENT.

32 1. An agreement between a hospital and a health care  
33 provider may be entered into providing that the hospital shall  
34 indemnify the health care provider for any liability of the  
35 health care provider arising while the health care provider is

1 providing services at the hospital with which the agreement is  
2 made. The agreement may provide that the hospital will  
3 indemnify the health care provider for liability arising from  
4 services provided outside of the hospital. The agreement  
5 shall not provide for indemnification of liability arising  
6 from services provided by the health care provider in another  
7 hospital.

8 2. A hospital may, before entering into an agreement  
9 pursuant to this section require the health care provider to  
10 provide information regarding all claims filed against the  
11 health care provider and losses resulting from the claims.

12 Sec. 13. NEW SECTION. 668.14 EVIDENCE OF PREVIOUS  
13 PAYMENT OR FUTURE RIGHT OF PAYMENT.

14 1. In an action brought pursuant to this chapter seeking  
15 damages for personal injury, the court shall permit evidence  
16 and argument as to the previous payment or future right of  
17 payment of actual economic losses incurred or to be incurred  
18 as a result of the personal injury for necessary medical care,  
19 rehabilitation services, and custodial care except to the  
20 extent that the previous payment or future right of payment is  
21 pursuant to a state or federal program or from assets of the  
22 claimant or the members of the claimant's immediate family.

23 2. If evidence and argument regarding previous payments or  
24 future rights of payment is permitted pursuant to subsection  
25 1, the court shall also permit evidence and argument as to the  
26 costs to the claimant of procuring the previous payments or  
27 future rights of payment and as to any existing rights of in-  
28 demnification or subrogation relating to the previous payments  
29 or future rights of payment.

30 3. If evidence or argument is permitted pursuant to  
31 subsection 1 or 2, the court shall, unless otherwise agreed to  
32 by all parties, instruct the jury to answer special  
33 interrogatories or, if there is no jury, shall make findings  
34 indicating the effect of such evidence or argument on the  
35 verdict.

1 Sec. 14. Section 147.136 is repealed.

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## SENATE FILE 484

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1 Amend Senate File 484 as follows:

2 1. By striking everything after the enacting  
3 clause and inserting the following:

4 "Section 1. FINDINGS. The general assembly finds  
5 and declares that it is in the public interest that  
6 high quality medical and hospital services be  
7 available to the citizens of Iowa at reasonable costs.  
8 It is essential to the public interest to assure  
9 continuing availability of medical care to encourage  
10 competent physicians to enter into and remain in the  
11 practice of medicine in this state. It is in the  
12 public interest to assure that funds are available to  
13 compensate an injured party while providing for the  
14 availability of medical liability insurance.

15 The general assembly further finds and declares  
16 that a critical situation exists impacting on the  
17 accessibility and affordability of quality health care  
18 for Iowa citizens because of the high cost and  
19 impending unavailability of medical malpractice  
20 insurance. Physicians in certain speciality and high-  
21 risk areas are increasingly choosing no longer to  
22 provide these services as a result of the potential  
23 liability and the high cost and uncertain availability  
24 of medical liability insurance.

25 The general assembly further finds that to assure  
26 the uninterrupted delivery of affordable health care  
27 services to the citizens of Iowa it is necessary to  
28 carefully balance the interest of persons who are  
29 damaged by medical accidents and the interest of all  
30 persons, who may be in need of future medical care, in  
31 keeping medical liability insurance affordable and  
32 available in this state. The general assembly further  
33 finds that without medical liability insurance,  
34 physicians, other health care providers, and hospitals  
35 cannot provide health care services to the public.

36 The general assembly further finds that the present  
37 critical situation has resulted in a decrease in the  
38 availability of certain health care services and that  
39 this problem of availability will become more severe  
40 unless addressed. Physicians are discontinuing their  
41 practices and leaving Iowa.

42 The general assembly further finds and declares it  
43 is necessary and essential that the provisions of this  
44 Act be enacted in order to provide for the health and  
45 welfare of the people of Iowa. It is the intent of  
46 this Act to protect the health and welfare of the  
47 people of this state by assuring the availability of  
48 health care services.

49 Sec. 2. NEW SECTION. 147B.1 SHORT TITLE.

50 This Act shall be known as the "Iowa Patient

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1 Compensation Fund Act".

2 Sec. 3. NEW SECTION. 147B.2 PUBLIC POLICY.

3 It is the policy of this state to assure the avail-  
4 ability of quality medical and hospital services to  
5 the citizens of Iowa, and to effectuate that policy it  
6 is essential to assure the availability of medical  
7 liability insurance so that competent physicians will  
8 enter into and remain in the practice of medicine in  
9 this state. This chapter shall be construed to carry  
10 out this policy.

11 Sec. 4. NEW SECTION. 147B.3 DEFINITIONS.

12 As used in this chapter, unless the context  
13 requires otherwise:

14 1. "Administrator" means the patient compensation  
15 fund administrator.

16 2. "Commissioner" means the commissioner of  
17 insurance.

18 3. "Fund" means the patient compensation fund.

19 4. "Health care practitioner" means a health care  
20 provider other than a hospital.

21 5. "Health care provider" means a physician and  
22 surgeon licensed pursuant to chapter 148; an osteopath  
23 licensed pursuant to chapter 150; an osteopathic  
24 physician and surgeon licensed pursuant to chapter  
25 150A; an association, partnership, or professional  
26 corporation composed of or owned by such persons; a  
27 hospital and an employee of such person, association,  
28 partnership, professional corporation, or hospital.

29 6. "Hospital" means a hospital licensed pursuant  
30 to chapter 135B.

31 7. "Medical malpractice" means acts or omissions  
32 of a health care practitioner in the practice of the  
33 practitioner's profession or occupation or acts or  
34 omissions of a hospital in patient treatment or care,  
35 including but not limited to negligence, failure to  
36 provide care, breach of contract relating to providing  
37 care, or claim based upon failure to obtain informed  
38 consent for an operation or treatment.

39 Sec. 5. NEW SECTION. 147B.4 QUALIFIED PROVIDER.

40 1. A health care practitioner is qualified to  
41 participate under this chapter if the health care  
42 practitioner does both of the following:

43 a. Files with the commissioner proof that the  
44 health care practitioner is insured with an insurance  
45 company admitted to this state under a policy of  
46 medical liability insurance providing the following  
47 coverage for medical malpractice:

48 (1) Coverage pursuant to subparagraph part (a) or  
49 (b) per occurrence in an amount of one hundred percent  
50 for all sums required to be paid up to and including

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1 one hundred thousand dollars and ten percent of all  
2 sums required to be paid in excess of one hundred  
3 thousand dollars but not exceeding one million  
4 dollars:

5 (a) Under a claims-made form of medical  
6 malpractice insurance for each claim made during the  
7 term of the policy.

8 (b) Under an occurrence form of medical  
9 malpractice insurance for each claim arising out of an  
10 occurrence during the policy period.

11 (2) Coverage pursuant to subparagraph part (a) or  
12 (b) in the aggregate of three hundred thousand dollars  
13 for all occurrences:

14 (a) Under a claims-made form of medical  
15 malpractice liability insurance for all claims made  
16 during the term of the policy.

17 (b) Under an occurrence form of medical  
18 malpractice insurance for all claims arising out of  
19 all occurrences during the policy period.

20 b. Pays a surcharge or special surcharge levied on  
21 health care practitioners pursuant to section 147B.8,  
22 subsection 2, or section 147B.9.

23 2. A hospital is qualified to participate under  
24 this chapter if the hospital does both of the  
25 following:

26 a. Files with the commissioner proof that the  
27 hospital is insured with an insurance company admitted  
28 to this state under a policy of medical liability  
29 insurance providing the following coverage for medical  
30 malpractice:

31 (1) Coverage pursuant to subparagraph part (a) or  
32 (b) per occurrence in an amount of one hundred percent  
33 for all sums required to be paid up to and including  
34 one hundred thousand dollars and ten percent of all  
35 sums required to be paid in excess of one hundred  
36 thousand dollars but not exceeding one million  
37 dollars:

38 (a) Under a claims-made form of medical  
39 malpractice insurance for each claim made during the  
40 term of the policy.

41 (b) Under an occurrence form of medical  
42 malpractice insurance for each claim arising out of an  
43 occurrence during the policy period.

44 (2) Coverage pursuant to subparagraph part (a) or  
45 (b) in the aggregate of one million dollars for all  
46 occurrences:

47 (a) Under a claims-made form of medical  
48 malpractice liability insurance for all claims made  
49 during the term of the policy.

50 (b) Under an occurrence form of medical

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1 malpractice insurance for all claims arising out of  
2 all occurrences during the policy period.

3 b. Pays a surcharge or special surcharge levied on  
4 hospitals pursuant to section 147B.8, subsection 2, or  
5 section 147B.9.

6 3. Coverage required under subsections 1 and 2  
7 shall be adjusted in the same manner as provided in  
8 section 147B.7, subsection 3.

9 4. The commissioner may permit qualification of a  
10 health care practitioner who has retired or ceased  
11 practicing in this state, if the health care  
12 practitioner files proof of insurance and pays any  
13 surcharge or special surcharge levied as required in  
14 subsection 1.

15 5. A health care provider may qualify to  
16 participate under this chapter with respect to all  
17 medical malpractice claims made subsequent to the  
18 health care provider's qualification. A health care  
19 provider is not eligible to qualify under this chapter  
20 with respect to a medical malpractice claim made prior  
21 to the time of the health care provider's  
22 qualification.

23 6. If at any time prior to the health care  
24 provider's qualification under this section the health  
25 care provider was insured under an occurrence form of  
26 policy of medical liability insurance for all  
27 occurrences during the term of that policy, for an  
28 occurrence of alleged medical malpractice occurring  
29 during the time that policy was in effect, this  
30 chapter applies only to claims for alleged medical  
31 malpractice covered under the occurrence policy to the  
32 extent the judgment or settlement exceeds the limits  
33 of that policy.

34 <sup>3998</sup><sub>3984</sub> Sec. 6. NEW SECTION. 147B.5 PATIENT ELECTION TO  
35 BE BOUND.

36 1. This chapter applies to all occurrences of  
37 alleged medical malpractice occurring prior to the  
38 effective date of this Act for which a medical  
39 malpractice claim has not been made unless the patient  
40 elects not to be bound under this chapter for the  
41 prior occurrence. A patient may elect not to be bound  
42 under this chapter with respect to an occurrence of  
43 alleged medical malpractice occurring prior to the  
44 effective date of this Act by filing an election with  
45 the commissioner and providing notice to any health  
46 care provider alleged to be liable for the occurrence  
47 within one hundred eighty days of the effective date  
48 of this Act according to rules adopted by the  
49 commissioner. Failure to provide the required notice  
50 is deemed to be evidence of the patient's election to

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be bound by this chapter for a prior occurrence.

3946 2. A patient's exclusive remedy against a health  
3 care provider qualifying under section 147B.4 for  
4 medical malpractice occurring after the effective date  
5 of this Act is the remedy provided for under this  
6 chapter unless the patient has elected not to be bound  
7 by the remedies provided for in this chapter. A  
8 patient may elect not to be bound under this chapter  
9 by filing an election with the commissioner, pursuant  
10 to rules adopted by the commissioner, in advance of  
11 the treatment, act, or omission upon which a claim may  
12 be based, and notifying the health care provider of  
13 the election within a reasonable time before any  
14 treatment begins. Failure to provide the required  
15 notice is deemed to be evidence of the patient's  
16 election to be bound by this chapter. An election by  
17 a patient not to be bound by this chapter is effective  
18 for a period of two years after filing unless the  
19 election is withdrawn. The patient may withdraw the  
20 election in writing at any time by filing the  
21 withdrawal with the commissioner.

22 3. A qualified health care provider must provide a  
23 patient with notice that the health care provider is  
24 qualified under this chapter prior to any treatment,  
and must inform the patient of the patient's right to  
elect not to be bound by this chapter.

3952 27 Sec. 7. NEW SECTION. 147B.6 LIABILITY OF FUND.  
3954 28 Subject to section 147B.4, subsection 6, the fund  
3970 29 is liable on a following form basis for all sums  
30 required to be paid in excess of the coverage provided  
31 by the health care provider's medical liability  
32 insurance specified in section 147B.4, subsection 1 or  
33 2, in a medical malpractice action against a health  
34 care provider qualified to participate under this  
35 chapter by a patient who has elected to be bound under  
36 this chapter with respect to an occurrence within the  
37 state of Iowa to which this chapter applies, except as  
38 provided in section 147B.7.

3995 39 Sec. 8. NEW SECTION. 147B.7 LIMITATION ON  
3994 40 RECOVERY.

41 1. Except as provided in subsection 3, the total  
42 amount recoverable from all liable health care  
43 providers and the fund for an occurrence to which this  
44 chapter applies resulting in an injury or death of a  
45 patient arising out of medical malpractice shall not  
46 exceed one million dollars.

47 2. Except as provided in subsection 3, a health  
48 care provider qualified under this chapter is not  
49 liable to a patient who has elected to be covered by  
50 this chapter for an amount in excess of one hundred

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1 thousand dollars plus ten percent of all sums required  
2 to be paid in excess of one hundred thousand dollars  
3 but not exceeding one million dollars for all claims  
4 or causes of action for medical malpractice arising  
5 from an occurrence to which this chapter applies.  
6 Subject to limits in this section, an amount due from  
7 a judgment or settlement which is in excess of the  
8 liability of all liable health care providers shall be  
9 paid from the fund pursuant to section 147B.8.

10 3. a. The commissioner shall determine on or  
11 after July 1 but on or before December 31 of each year  
12 an amount by which the total amount recoverable under  
13 subsection 1 and an amount by which the maximum  
14 liability of a health care provider under subsection 2  
15 are adjusted for the calendar year beginning eighteen  
16 months after the July 1 date on which the adjusted  
17 amounts can first be determined. The amount of the  
18 adjustment is equal to the product of the amount  
19 determined for the previous calendar year and the  
20 percentage rate of change in the consumer price index  
21 for goods and services published by the United States  
22 department of labor for the fiscal year ending on June  
23 30 immediately preceding the July 1 date on which the  
24 adjusted amounts can first be determined. However, if  
25 the percentage rate of change in the consumer price  
26 index is less than five percent, adjustments shall not  
27 be made under this paragraph.

28 b. If adjustments are not made under paragraph "a"  
29 for one or more years, the commissioner shall  
30 determine a cumulative percentage rate of change and  
31 when that cumulative percentage rate of change is five  
32 percent or greater the commissioner shall determine  
33 the adjusted amounts for the next rate adjustment  
34 year.

35 c. The commissioner shall publish on or before  
36 December 31 preceding the next rate adjustment year  
37 any adjusted amounts which will apply to the next rate  
38 adjustment year.

39 Sec. 9. NEW SECTION. 147B.8 PATIENT COMPENSATION  
40 FUND.

41 1. A patient compensation fund is created for the  
42 purposes stated in this chapter. The fund and income  
43 from the fund shall be deposited with the treasurer of  
44 state to be used for the payment of qualifying claims  
45 under this chapter, and the fund is appropriated for  
46 that purpose. The fund shall not be used for purposes  
47 other than those of this chapter. Appropriations from  
48 the fund are not subject to reversion under section  
49 8.33.

50 2. An annual surcharge shall be levied on all

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1 qualified health care providers. The surcharge for a  
2 health care provider is determined by the commissioner  
3 subject to the following limitations:

4 a. The annual surcharge shall not exceed fifty  
5 percent of the annual premium paid by the health care  
6 provider for maintenance of current medical liability  
7 insurance as provided in section 147B.4, including the  
8 cost of reinsurance under section 147B.12.

9 b. The charge shall not exceed the amount  
10 necessary to maintain the fund in an amount determined  
11 by the commissioner to be actuarially adequate.

12 3. The surcharge due under this section is due and  
13 payable within thirty days after the surcharge has  
14 been levied on the qualified health care provider.

15 4. If the annual surcharge under this section is  
16 not paid within the time specified in subsection 3,  
17 the qualification of the health care provider shall be  
18 suspended until the annual surcharge is paid. The  
19 suspension is not effective as to patients claiming  
20 against the health care provider unless, at least  
21 thirty days before the effective date of the  
22 suspension, a written notice giving the date upon  
23 which the suspension becomes effective has been  
24 provided by the commissioner to the health care  
25 provider and notice of the suspension has been given  
26 to a patient prior to any treatment.

27 5. All actual expenses of collecting, protecting,  
28 and administering the fund shall be paid from the  
29 fund, including necessary costs of outside legal  
30 counsel. The attorney general is not responsible for  
31 legal defense of the fund.

32 Sec. 10. NEW SECTION. 147B.9 SPECIAL SURCHARGE.

33 The commissioner may, at any time, analyze the fund  
34 to determine if the amount in the fund is inadequate  
35 to pay in full all claims allowed or to be allowed  
36 during the calendar year. If the fund is determined  
37 to be inadequate, the commissioner may levy a special  
38 surcharge on all health care providers who have  
39 qualified under this chapter on the date of the  
40 special surcharge or at any time during the preceding  
41 twelve months and the special surcharge shall be in an  
42 amount proportionate to the surcharge each health care  
43 provider has paid to the fund. The special surcharge  
44 shall be an amount sufficient to permit full payment  
45 of all claims allowed against the fund during a  
46 calendar year, but shall not exceed fifty percent of  
47 the annual premium paid by the health care provider  
48 for maintenance of current medical liability insurance  
49 as provided in section 147B.4. The special surcharge  
50 shall be levied against all health care providers who

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1 have qualified under this chapter. The special sur-  
2 charge is due and payable within thirty days after the  
3 special surcharge is levied.

4 If the special surcharge under this section is not  
5 paid within the time specified, the qualification of  
6 the health care provider shall be suspended until the  
7 special surcharge is paid. The suspension is not  
8 effective as to patients claiming against the health  
9 care provider unless, at least thirty days before the  
10 effective date of the suspension, a written notice  
11 giving the date upon which the suspension becomes  
12 effective has been provided by the commissioner to the  
13 health care provider and notice of the suspension has  
14 been given to a patient prior to any treatment.

15 <sup>3948</sup>  
<sup>4013</sup> Sec. 11. NEW SECTION. 147B.10 STRUCTURED  
16 JUDGMENTS.

17 1. As used in this section, unless the context  
18 requires otherwise:

19 a. "Future injuries" means all legal harm relating  
20 to an injury which the trier of fact determines will  
21 be incurred by the injured party subsequent to the  
22 entry of judgment.

23 b. "Injured person" means the person during whose  
24 medical treatment or care the acts or omissions of  
25 medical malpractice are determined to have occurred.

26 c. "Injured party" means a party plaintiff to a  
27 medical malpractice action, and includes the injured  
28 person if that person is a party to the action.

29 d. "Injury" means a legal harm for which damages  
30 are recoverable in an action arising under this  
31 chapter.

32 2. In a medical malpractice action against a  
33 health care provider arising under this chapter, the  
34 verdict shall be itemized to distribute the monetary  
35 damages, if any, between past loss and future loss.  
36 In a trial to the court, the court shall itemize its  
37 findings in accordance with this section.

38 3. The court, in a medical malpractice action  
39 arising under this chapter in which a damage award for  
40 future injuries to a party exceeds one hundred  
41 thousand dollars, shall enter a judgment ordering the  
42 award to the party to be paid in periodic payments,  
43 subject to the limitations contained in this section.  
44 The court shall make a specified finding as to the  
45 dollar amount of regular payments which will be  
46 required to compensate the party periodically for loss  
47 of future income and future noneconomic harm, based  
48 upon the life expectancy of the party and the damages  
49 awarded. The periodic payments shall reflect interest  
50 in accordance with annuity principles. The judgment

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1 shall specify the recipient of the periodic payments,  
2 the dollar amount of each payment, the interval  
3 between payments, and the number of payments required  
4 to be made. The judgment shall specify the amount of  
5 and the purposes for which the balance of the judgment  
6 awarded for the future care and treatment of the party  
7 may be used.

8 4. Attorney fees of the party receiving an award,  
9 if payable out of the judgment, shall be assessed by  
10 the court and applied pro rata against amounts awarded  
11 for past injuries and for future injuries. The amount  
12 determined by the court to be payable out of damages  
13 for future injuries shall be deducted by the court  
14 from the amount to be ordered paid as provided in this  
15 subsection, and shall be deducted pro rata from those  
16 amounts awarded, if any, for loss of future income,  
17 future expenses for care and treatment, and future  
18 noneconomic harm. The amount of attorney fees  
19 attributable to the award for future injuries shall be  
20 payable upon entry of judgment.

21 5. If a judgment has been entered ordering  
22 periodic payments pursuant to this section, the health  
23 care provider's insurer shall pay to the fund the  
24 amount for which the insurer is liable under this  
25 chapter, after apportionment of costs of defense, for  
26 distribution by the fund to the party receiving the  
27 award.

28 6. If a judgment has been entered ordering  
29 periodic payments pursuant to this section, the fund  
30 shall make the payments as ordered or, alternatively,  
31 the fund may purchase an annuity from an insurance  
32 company admitted to Iowa sufficient to make the  
33 periodic payments.

34 7. If the party receiving the award dies, amounts  
35 to be paid for loss of future income are payable to  
36 those persons to whom the party receiving the award  
37 owed a duty of support. If the party receiving the  
38 award dies prior to payment of the amounts for other  
39 than loss of future income, the judgment is satisfied  
40 upon the payment of all obligations incurred up to the  
41 time of death and of the expenses of final illness and  
42 reasonable burial expenses.

43 8. Except with respect to amounts representing  
44 loss of future income, a judgment for future injuries  
45 is a contingent award, and the right to payment vests  
46 only at such times and in such amounts as accrue  
47 pursuant to the order specifying the amount of  
48 periodic payments and the interval of those payments.

49 9. The district court shall retain jurisdiction of  
50 a medical malpractice action in which the judgment in

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1 the action orders periodic payments, and upon the  
2 death of the party receiving the award in the case of  
3 an award for loss of future income, the dependents of  
4 the decedent or any other interested party to the  
5 action or a representative of an interested party, may  
6 petition the court for a modification of the judgment  
7 for a redesignation of the recipient of the payments,  
8 in accordance with the rights of persons established  
9 by this section. Unless otherwise ordered, the  
10 redesignated recipients of payments for loss of future  
11 income shall be paid in those amounts and at those  
12 intervals specified in the original judgment.  
13 Payments shall continue until the remaining amounts  
14 designated for that purpose have been paid, or until  
15 the death of those dependents, whichever occurs first.  
16 If the last surviving dependent dies prior to  
17 depletion of the amount specified for loss of future  
18 income, the judgment is deemed satisfied upon payment  
19 of amounts accrued up to the time of death.

20 Sec. 12. NEW SECTION. 147B.11 COSTS OF DEFENSE.

21 1. The fund may employ the services of outside  
22 legal counsel to defend the fund against claims and to  
23 assist the health care provider's insurer in defending  
24 the claim.

25 2. The fund may by agreement with the health care  
26 provider's insurer, allow the health care provider's  
27 insurer to provide a defense for a claim against the  
28 health care provider and the fund. The fund and the  
29 health care provider's insurer may agree to any  
30 apportionment of the costs of defense.

31 Sec. 13. NEW SECTION. 147B.12 REINSURANCE.

32 The commissioner may cause all or any part of the  
33 potential liability of the fund to be reinsured, if  
34 reinsurance is available on a fair and reasonable  
35 basis. The cost of the reinsurance shall be paid by  
36 the fund and the fact of the reinsurance shall be  
37 taken into account in determining the surcharge under  
38 section 147B.8, subsection 2, or the special surcharge  
39 under section 147B.9.

40 Sec. 14. NEW SECTION. 147B.13 NOTICE --

41 APPLICATION FEE.

42 1. Prior to consideration for coverage pursuant to  
43 this chapter, a health care provider shall first give  
44 notice to the commissioner of the provider's intention  
45 to apply for coverage. The notice of intention shall  
46 be accompanied by a one-time application fee of fifty  
47 dollars for health care providers and five hundred  
48 dollars for hospitals.

49 2. Funds received by the commissioner pursuant to  
50 subsection 1 shall only be expended for purposes of

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1 payment of the reasonable expenses incurred or to be  
2 incurred in the implementation of this chapter.

3 3. To the extent that funds received pursuant to  
4 subsection 1 are in excess of the expenses of  
5 implementation of this chapter, the commissioner shall  
6 transfer such excess funds to the fund.

7 4. Notice and application fees received subsequent  
8 to the implementation of this chapter shall be placed  
9 in the fund upon receipt.

10 Sec. 15. NEW SECTION. 147B.14 PATIENT  
11 COMPENSATION FUND ADMINISTRATOR.

12 The commissioner may appoint an administrator to  
13 perform all duties and responsibilities pursuant to  
14 this chapter. The administrator shall serve as  
15 administrator at the pleasure of the commissioner.  
16 The salary and expenses of the administrator shall be  
17 paid from the fund.

18 Sec. 16. NEW SECTION. 147B.15 ADMINISTRATION.

19 The commissioner shall either provide staff  
20 services necessary for the operation of this chapter  
21 or may contract with an insurance company licensed to  
22 do business in this state, or both, to perform any  
23 administrative duties and responsibilities of the  
24 commissioner pursuant to this chapter. The  
25 commissioner shall retain supervisory control over all  
26 matters for which a contract is entered into. All  
27 reasonable costs and charges incurred in the  
28 administration of this chapter shall be paid from the  
29 fund.

30 The administrator and all persons employed or  
31 contracted with to provide staff services necessary  
32 for the operation of this chapter shall not be  
33 considered employees of the state except for purposes  
34 of chapter 25A.

35 Sec. 17. NEW SECTION. 147B.16 RECIPROCITY.

36 The commissioner may enter into reciprocity  
37 agreements with the authorized representatives of any  
38 jurisdiction to allow health care providers from that  
39 jurisdiction to become qualified health care providers  
40 for purposes of the fund and to the extent that a  
41 claim against the health care provider arises in this  
42 state.

43 An agreement shall only be entered into with a  
44 jurisdiction to the same extent as the other  
45 jurisdiction allows Iowa health care providers to  
46 participate in a similar program in the other  
47 jurisdiction. The agreement shall include any  
48 conditions, restrictions, and privileges the  
49 commissioner deems necessary.

50 Sec. 18. NEW SECTION. 147B.17 ANNUAL REPORT.

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1 The commissioner shall, pursuant to rules issued by  
2 the commissioner, on or before the first day of  
3 February of each year, provide to the chairs, vice  
4 chairs, and ranking members of the senate standing  
5 committees on judiciary and commerce, and the house of  
6 representatives standing committees on judiciary and  
7 law enforcement, and small business and commerce, a  
8 report regarding claims filed against the fund and  
9 claims closed involving the fund for the previous  
10 calendar year. The report shall contain to the extent  
11 the information is available the following  
12 information:

- 13 1. Parties to the claims.
- 14 2. Cause or causes of action.
- 15 3. Amounts reserved or paid per claim, including  
16 the present value for structured settlements or  
17 awards.
- 18 4. Legal fees, expert witness fees, court costs,  
19 or other associated costs of judgments or decrees per  
20 claim.
- 21 5. Other claims information as deemed necessary by  
22 the commissioner.

23 Sec. 19. NEW SECTION. 147B.18 RULES.

24 The commissioner shall establish rules relating to  
25 the administration of this chapter as deemed necessary  
26 by the commissioner to promote the efficient operation  
27 of this chapter in accordance with its terms and  
28 intent.

29 Sec. 20. Notwithstanding section 4.12, if any pro-  
30 vision of this Act is held invalid, the whole Act is  
31 invalid, and to this end the provisions of the Act are  
32 not severable.

33 Sec. 21. This Act takes effect upon enactment, and  
34 the commissioner shall take all actions necessary to  
35 implement the provisions of this Act on or before  
36 January 1, 1988."

BY GRONINGA of Cerro Gordo  
HARBOR of Mills  
SKOW of Guthrie  
ROYER of Page  
H-3905 FILED APRIL 22, 1987

OLLIE of Clinton  
SCHNEKLOTH of Scott  
SHOULTZ of Black Hawk  
CHAPMAN of Linn  
RUNNING of Linn

*Cloned copy of 147B.18 (1988)*

SENATE FILE 484

H-3919

1 Amend Senate File 484 as amended, passed, and  
2 reprinted by the Senate as follows:  
3 1. Page 4, by inserting after line 2 the  
4 following:  
5 "4. A patient's election not to be bound shall not  
6 justify denial of treatment. Denial of treatment to a  
7 patient making an election not to be bound is presumed  
8 to be due to the patient's election."

H-3919 FILED APRIL 23, 1987 BY MCKINNEY of Dallas

SENATE FILE 484

H-3921

1 Amend Senate File 484 as amended, passed, and  
2 reprinted by the Senate as follows:  
3 1. Page 2, by inserting after line 22 the fol-  
4 lowing:  
5 "c. Files with the commissioner an agreement to  
6 accept the rates established by the federal Medicare  
7 program pursuant to Title XVIII of the federal Social  
8 Security Act as one hundred percent of the fee for the  
9 health care provider's services provided to Medicare-  
10 eligible patients."

H-3921 FILED APRIL 23, 1987 BY JAY of Appanoose

SENATE FILE 484

H-3927

1 Amend Senate File 484, as amended, passed, and  
2 reprinted by the Senate, as follows:  
3 1. Page 1, line 7, by inserting after the word  
4 "insurance." the following: "The general assembly  
5 further finds that it is in the public interest that  
6 statistical data be obtained so that an analysis of  
7 the cause of unavailability and unaffordability of  
8 liability insurance be undertaken in an attempt to  
9 determine the cause of such problems so that a long-  
10 term solution can be found."

H-3927 FILED APRIL 23, 1987 BY JAY of Appanoose

SENATE FILE 484

H-3928

1 Amend Senate File 484, as amended, passed, and re-  
2 printed by the Senate, as follows:  
3 1. By striking page 1, line 33 through page 2,  
4 line 7.  
5 2. Renumber as necessary.

H-3928 FILED APRIL 23, 1987 BY JAY of Appanoose

SENATE FILE 484

H-3700

1 Amend Senate File 484, as amended, passed, and re-  
2 printed by the Senate, as follows:  
3 1. Title page, by striking lines 6 through 11 and  
4 inserting the following: "patient to be protected by  
5 the fund, authorization of the fund to procure  
6 reinsurance to protect the fund, providing for the  
7 appointment of a compensation fund administrator,  
8 requiring certain claims information to be collected  
9 and reported to the legislature, authorizing an  
10 indemnification option to the fund, and repealing the  
11 collateral source rule as applied to medical  
12 malpractice cases and enacting a general collateral  
13 source rule."

BY COMMITTEE ON JUDICIARY  
AND LAW ENFORCEMENT

H-3700 FILED APRIL 10, 1987

*a/o*

SENATE FILE 484

H-3917

1 Amend Senate File 484 as amended, passed, and  
2 reprinted by the Senate as follows:  
3 1. Page 3, by inserting after line 10 the  
4 following:  
5 "5. Any health care provider having two successful  
6 medical malpractice claims made against the health  
7 care provider in a five-year period, and paid in part  
8 by the fund, shall immediately be placed on probation  
9 by the board of medical examiners for a period of two  
10 years."

H-3917 FILED APRIL 23, 1987 BY JAY of Appanoose

*a/o*

SENATE FILE 484

H-3918

1 Amend Senate File 484 as amended, passed, and  
2 reprinted by the Senate as follows:  
3 1. Page 2, by inserting after line 22 the  
4 following:  
5 "c. Files with the commissioner an agreement to  
6 reduce fees to patients by the same percentage that  
7 the health care provider realizes as a reduction in  
8 the cost of liability insurance coverage."

H-3918 FILED APRIL 23, 1987 BY BRAMMER of Linn

*a/o*

SENATE FILE 484

H-3920

1 Amend Senate File 484 as amended, passed and  
2 reprinted by the Senate as follows:  
3 1. Page 6, by inserting after line 30 the  
4 following:  
5 "Sec. \_\_\_\_ . NEW SECTION. 147B.11 MEDICAL  
6 LIABILITY INSURANCE PROFITS.  
7 The commissioner shall establish rules which shall  
8 limit the profits of an insurance company admitted to  
9 this state to not more than seven percent on all  
10 policies of medical liability insurance sold in this  
11 state."

H-3920 FILED APRIL 23, 1987 BY ROSENBERG of Story

*a/o*

SENATE FILE 484

H-3933

1 Amend amendment, H-3905, to Senate File 484 as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 2, by striking lines 31 through 38 and  
5 inserting the following:

6 "7. "Malpractice" or "professional negligence"  
7 means the failure of a health care provider, in  
8 rendering professional services, to perform according  
9 to standards of due care recognized generally in the  
10 medical community. Each term includes the failure to  
11 use ordinary and reasonable care, skill, and knowledge  
12 ordinarily possessed and used under like circumstances  
13 by members of the profession engaged in a similar  
14 practice."

15 2. Renumber as necessary.

H-3933 FILED APRIL 23, 1987

BY JAY of Appanoose

SENATE FILE 484

H-3934

1 Amend the amendment, H-3905, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 10, by inserting after line 19 the  
5 following:

6 "Sec. NEW SECTION. 147B.10A SETTLEMENT BY  
7 HEALTH CARE PROVIDER, HOSPITAL, OR FUND.

8 If at any time the health care provider, hospital,  
9 the health care provider's or hospital's insurance  
10 carrier, or the fund tenders payment to the plaintiff  
11 of any sum for the purpose of settlement, the act of  
12 payment is considered to be the admission of liability  
13 by the health care provider."

14 2. Renumber as necessary.

H-3934 FILED APRIL 23, 1987

BY JAY of Appanoose

SENATE FILE 484

H-3935

1 Amend the amendment, H-3905, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 5, by inserting after line 26 the follow-  
5 ing:

6 "4. An election under this chapter does not apply  
7 to any action brought by a patient based upon an  
8 expressed or implied contract assuring results."

H-3935 FILED APRIL 23, 1987

BY JAY of Appanoose

## SENATE FILE 484

H-3930

1 Amend the amendment, H-3905, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 12, by inserting after line 28 the  
5 following:

6 "Sec. \_\_\_\_ . NEW SECTION. 147B.19 DISCIPLINARY  
7 PROCEDURES.

8 1. A health care provider participating under this  
9 plan who has two claims paid under the fund in a five-  
10 year period shall be placed on probation by the board  
11 of medical examiners, and shall be required to attend  
12 not less than fifteen hours of continuing education in  
13 the area of care that caused the claims. No provider  
14 shall, during this probationary period, practice the  
15 area of medicine which was the subject of the claims  
16 without the supervision of a medical specialist in  
17 that area.

18 2. Any health care provider participating in this  
19 plan who has a total of five claims paid by the fund  
20 shall be barred from practicing in this state."

21 2. Renumber as necessary.

H-3930 FILED APRIL 23, 1987 BY JAY of Appanoose

## SENATE FILE 484

H-3929

1 Amend the amendment, H-3905, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 2, line 15, by inserting after the word  
5 "administrator" the following: "appointed pursuant to  
6 section 147B.8".

H-3929 FILED APRIL 23, 1987

BY JAY of Appanoose

## SENATE FILE 484

H-3932

1 Amend amendment, H-3905, to Senate File 484 as  
2 amended, passed and reprinted by the Senate as  
3 follows:

4 1. Page 2, line 42, by striking the word "both"  
5 and inserting the following: "all".

6 2. Page 3, by inserting after line 22 the  
7 following:

8 "c. Agrees to treat victims of medical negligence  
9 at the current rate paid in this state pursuant to  
10 Title XIX of the federal Social Security Act."

H-3932 FILED APRIL 23, 1987

BY JAY of Appanoose

## SENATE FILE 484

H-3939

1 Amend Senate File 484 as amended, passed, and  
2 reprinted by the Senate, as follows:

3 1. Page 2, by inserting after line 10 the  
4 following:

5 "6. "Malpractice" or "professional negligence"  
6 means the failure of a health care provider, in  
7 rendering professional services, to perform according  
8 to standards of due care recognized generally in the  
9 medical community. Each term includes the failure to  
10 use ordinary and reasonable care, skill, and knowledge  
11 ordinarily possessed and used under like circumstances  
12 by members of the profession engaged in a similar  
13 practice."

14 2. Renumber as necessary.

H-3939 FILED APRIL 23, 1987

BY JAY of Appanoose

## SENATE FILE 484

H-3940

1 Amend Senate File 484, as amended, passed, and  
2 reprinted by the Senate, as follows:

3 1. Page 1, by striking lines 23 through 27 and  
4 inserting the following:

5 "1. "Health care provider" means a person licensed  
6 or certified under chapter 148, 150A, or 152 to  
7 provide in this state professional health care  
8 services to an individual during that individual's  
9 medical care, treatment, or confinement."

10 2. Renumber as necessary.

H-3940 FILED APRIL 23, 1987

BY JAY of Appanoose

## SENATE FILE 484

H-3942

1 Amend Senate File 484, as amended, passed, and  
2 reprinted by the Senate, as follows:

3 1. Page 5, by inserting after line 27 the  
4 following:

5 "Sec. \_\_\_\_ . NEW SECTION. 147B.6A SETTLEMENT BY  
6 HEALTH CARE PROVIDER, HOSPITAL, OR FUND.  
7 If at any time the health care provider, hospital,  
8 the health care provider's or hospital's insurance  
9 carrier, or the fund tenders payment to the plaintiff  
10 of any sum for the purpose of settlement, the act of  
11 payment is considered to be the admission of liability  
12 by the health care provider."

13 2. Renumber as necessary.

H-3942 FILED APRIL 23, 1987

BY JAY of Appanoose

## SENATE FILE 484

H-3936

- 1 Amend the amendment, H-3905, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:  
4 1. Page 2, by striking lines 19 through 28 and  
5 inserting the following:  
6 " \_\_\_\_\_. "Health care provider" means a person  
7 licensed or certified under chapter 148, 150A, or 152  
8 to provide in this state professional health care  
9 services to an individual during that individual's  
10 medical care, treatment, or confinement."  
11 2. Renumber as necessary.

H-3936 FILED APRIL 23, 1987

BY JAY of Appanoose

w/b

## SENATE FILE 484

H-3937

- 1 Amend Senate File 484 as amended, passed, and  
2 reprinted by the Senate, as follows:  
3 1. By striking page 8, line 1.

H-3937 FILED APRIL 23, 1987

BY JAY of Appanoose

w/b

## SENATE FILE 484

H-3938

- 1 Amend the amendment, H-3905, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:  
4 1. Page 1, line 24, by inserting after the word  
5 "insurance." the following: "The general assembly  
6 further finds that it is in the public interest that  
7 statistical data be obtained so that an analysis of  
8 the cause of unavailability and unaffordability of  
9 liability insurance be undertaken in an attempt to  
10 determine the cause of such problems so that a long-  
11 term solution can be found."

H-3938 FILED APRIL 23, 1987

BY JAY of Appanoose

w/b

## SENATE FILE 484

H-3941

- 1 Amend Senate File 484, as amended, passed, and re-  
2 printed by the Senate, as follows:  
3 1. Page 4, by inserting after line 2 the follow-  
4 ing:  
5 "4. An election under this chapter does not apply  
6 to any action brought by a patient based upon an  
7 expressed or implied contract assuring results."

H-3941 FILED APRIL 23, 1987

BY JAY of Appanoose

w/b

SENATE FILE 484

H-3943

1 Amend the amendment, H-3905, to Senate File 484 as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 5, by inserting after line 1 the  
5 following:

6 "An election to be bound under this section shall  
7 not affect an action against a health care provider or  
8 hospital which is based upon res ipsa loquitur."

H-3943 FILED APRIL 23, 1987 BY JAY of Appanoose

SENATE FILE 484

H-3947

1 Amend Senate File 484, as amended, passed, and re-  
2 printed by the Senate, as follows:

3 1. Page 2, by striking lines 8 through 10 and in-  
4 serting the following:

5 "5. "Commissioner" means the commissioner of in-  
6 surance.

7 6. "Administrator" means the compensation fund  
8 administrator appointed pursuant to section 147B.8."

9 2. Renumber as necessary.

H-3947 FILED APRIL 23, 1987 BY JAY of Appanoose

SENATE FILE 484

H-3946

1 Amend Senate File 484 as amended, passed and  
2 reprinted by the Senate as follows:

3 1. Page 2, line 14, by inserting after the word  
4 "does" the following: "all of".

5 2. Page 2, by inserting after line 22 the  
6 following:

7 "c. Agrees to treat victims of medical negligence  
8 at the current rate paid in this state pursuant to  
9 Title XIX of the federal Social Security Act."

H-3946 FILED APRIL 23, 1987 BY JAY of Appanoose

SENATE FILE 484

H-3949

1 Amend Senate File 484 as amended, passed, and  
2 reprinted by the Senate, as follows:

3 1. Page 3, by inserting after line 27 the  
4 following:

5 "An election to be bound under this section shall  
6 not affect an action against a health care provider or  
7 hospital which is based upon res ipsa loquitur."

H-3949 FILED APRIL 23, 1987 BY JAY of Appanoose

## SENATE FILE 484

H-3944

1 Amend Senate File 484, as amended, passed, and  
2 reprinted by the Senate, as follows:

3 1. Page 5, by inserting after line 27 the  
4 following:

5 "Sec. \_\_\_\_ . NEW SECTION. 147B.6A EVIDENCE OF  
6 ADVANCE PAYMENT NOT CONSTRUED AS ADMISSION TO  
7 LIABILITY.

8 A payment made by a health care provider or the  
9 health care provider's insurer to or for the patient  
10 or any other person on the patient's behalf in advance  
11 of a final determination of liability shall not be  
12 construed as an admission of liability for injuries or  
13 damages suffered in an action brought pursuant to this  
14 chapter. In the event of any advance payment, the  
15 court shall reduce the judgment to the plaintiff by an  
16 amount equal to the advance payment. If the advance  
17 payment exceeds the liability of the defendant, the  
18 court shall order any adjustment necessary to equalize  
19 the amount under which each defendant is obligated to  
20 pay but in no case shall an advance in excess of the  
21 amount found to be due be repayable to the health care  
22 provider making the advance."

23 2. Renumber as necessary.

H-3944 FILED APRIL 23, 1987 BY JAY of Appanoose

## SENATE FILE 484

H-3945

1 Amend Senate File 484, as amended, passed, and re-  
2 printed by the Senate, as follows:

3 1. Page 6, by inserting after line 30 the  
4 following:

5 "Sec. \_\_\_\_ . NEW SECTION. 147B.11 DISCIPLINARY  
6 PROCEDURES.

7 1. A health care provider participating under this  
8 plan who has two claims paid under the fund in a five-  
9 year period shall be placed on probation by the board  
10 of medical examiners, and shall be required to attend  
11 not less than fifteen hours of continuing education in  
12 the area of care that caused the claims. No provider  
13 shall, during this probationary period, practice the  
14 area of medicine which was the subject of the claims  
15 without the supervision of a medical specialist in  
16 that area.

17 2. Any health care provider participating in this  
18 plan who has a total of five claims paid by the fund  
19 shall be barred from practicing in this state."

20 2. Renumber as necessary.

H-3945 FILED APRIL 23, 1987 BY JAY of Appanoose

SENATE FILE 484

H-3955

1 Amend amendment, H-3905, to Senate File 484 as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 10, by inserting after line 19 the  
5 following:

6 "Sec. \_\_\_\_ . NEW SECTION. 147B.10A ATTORNEY FEES -  
7 - DEFENSE COSTS.

8 Coverage for medical malpractice under the fund and  
9 liability policies posted for proof of financial  
10 responsibility shall include defense costs and  
11 allocation for loss adjustment expense if such  
12 benefits in any way reduce the coverage available to  
13 provide for payment of judgments by an insured party."

14 2. Renumber as necessary.

H-3955 FILED APRIL 24, 1987 BY HANSEN of Woodbury

*o/c*

SENATE FILE 484

H-3953

1 Amend amendment, H-3905, to Senate File 484 as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 10, by inserting after line 19 the  
5 following:

6 "Sec. \_\_\_\_ . NEW SECTION. 147B.10A FRIVOLOUS  
7 ACTIONS.

8 In all cases against a health care provider or  
9 hospital for malpractice or professional negligence,  
10 the court may, upon application by the prevailing  
11 party, in its discretion and in an amount determined  
12 in its discretion, tax as costs payable to the  
13 prevailing party, the reasonable costs of preparation  
14 and trial, including reasonable attorney fees and the  
15 reasonable loss of earnings by the prevailing party  
16 occasioned by the trial, if the court finds that the  
17 losing party did not have a reasonable chance of  
18 recovery or a reasonable chance of a successful  
19 defense. The taxation of any cost under this section  
20 is the sole responsibility of the named parties and is  
21 not to be considered a cost of defense or a portion of  
22 the insurance coverage provided to either party which  
23 thereby reduces the amount of coverage available for  
24 the payment of any judgment rendered against that  
25 party."

26 2. Renumber as necessary.

H-3953 FILED APRIL 24, 1987 BY HANSEN of Woodbury

*o/c*

SENATE FILE 484

H-3948

1 Amend the amendment, H-3905, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 8, by inserting after line 14 the  
5 following:

6 "Sec. \_\_\_\_ . NEW SECTION. 147B.9A EVIDENCE OF  
7 ADVANCE PAYMENT NOT CONSTRUED AS ADMISSION TO  
8 LIABILITY.

9 A payment made by a health care provider or the  
10 health care provider's insurer to or for the patient  
11 or any other person on the patient's behalf in advance  
12 of a final determination of liability shall not be  
13 construed as an admission of liability for injuries or  
14 damages suffered in an action brought pursuant to this  
15 chapter. In the event of any advance payment, the  
16 court shall reduce the judgment to the plaintiff by an  
17 amount of the advance payment. If the advance payment  
18 exceeds the liability of the defendant, the court  
19 shall order any adjustment necessary to equalize the  
20 amount under which each defendant is obligated to pay  
21 but in no case shall an advance in excess of the  
22 amount found to be due be repayable to the health care  
23 provider making the advance."

24 2. Renumber as necessary.

H-3948 FILED APRIL 23, 1987 BY JAY of Appanoose

*do slightly more*

SENATE FILE 484

H-3959

1 Amend Senate File 484 as amended, passed, and  
2 reprinted by the Senate, as follows:  
3 1. Page 5, by inserting after line 27 the  
4 following:  
5 "Sec. \_\_\_\_ . NEW SECTION. 147B.6A ATTORNEY FEES --  
6 DEFENSE COSTS.  
7 Coverage for medical malpractice under the fund and  
8 liability policies posted for proof of financial  
9 responsibility shall include defense costs and  
10 allocation for loss adjustment expense if such  
11 benefits in any way reduce the coverage available to  
12 provide for payment of judgments by an insured party."  
13 2. Renumber as necessary.

H-3959 FILED APRIL 24, 1987 BY DODERER of Johnson  
*o/s*

SENATE FILE 484

H-3960

1 Amend the amendment, H-3905, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:  
4 1. By striking page 3, line 23 through page 4,  
5 line 5, and inserting the following:  
6 "2. A hospital is qualified to participate under  
7 this chapter if the hospital files with the  
8 commissioner proof of financial responsibility in the  
9 same manner as is provided for a health care  
0 provider."

H-3960 FILED APRIL 24, 1987 BY MCKINNEY of Dallas  
*o/s*

SENATE FILE 484

H-3964

1 Amend Senate File 484, as amended, passed, and  
2 reprinted by the Senate, as follows:  
3 1. Page 2, by striking lines 23 through 29 and  
4 inserting the following:  
5 "2. A hospital is qualified to participate under  
6 this chapter if the hospital files with the  
7 commissioner proof of financial responsibility in the  
8 same manner as is provided for a health care  
9 provider."

H-3964 FILED APRIL 24, 1987 BY MCKINNEY of Dallas  
*o/s*

SENATE FILE 484

H-3954

1 Amend the amendment, H-3905, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 5, by inserting after line 26 the fol-  
5 lowing:

6 "4. A copy of any notice provided for under this  
7 section must be provided to the patient or the  
8 patient's guardian and signed, receipted for, and  
9 witnessed by an employee of a health care provider or  
10 hospital after the notice is explained to the patient  
11 by the employee. If the patient is not provided a  
12 copy of the notice, the election is invalid."

H-3954 FILED APRIL 24, 1987 BY HANSEN of Woodbury

*etc*

SENATE FILE 484

H-3957

1 Amend Senate File 484 as amended, passed and  
2 reprinted by the Senate, as follows:

3 1. Page 7, by striking lines 12 through 35.  
4 2. Renumber as necessary.

H-3957 FILED APRIL 24, 1987 BY DODERER of Johnson

*etc*

SENATE FILE 484

H-3956

1 Amend Senate File 484, as amended, passed, and  
2 reprinted by the Senate, as follows:

3 1. Page 2, line 20, by inserting after the word  
4 "effective." the following: "Financial responsibility  
5 may be proven by providing a certified copy of a  
6 professional liability insurance policy currently in  
7 force with annual proof of renewal, the posting of a  
8 bond, or the payment of cash."

H-3956 FILED APRIL 24, 1987 BY DODERER of Johnson

*etc*

SENATE FILE 484

H-3958

1 Amend Senate File 484, as amended, passed, and re-  
2 printed by the Senate, as follows:

3 1. Page 4, by inserting after line 2 the fol-  
4 lowing:

5 "4. A copy of any notice provided for under this  
6 section must be provided to the patient or the  
7 patient's guardian and signed, receipted for, and  
8 witnessed by an employee of a health care provider or  
9 hospital after the notice is explained to the patient  
10 by the employee. If the patient is not provided a  
11 copy of the notice, the election is invalid."

H-3958 FILED APRIL 24, 1987 BY DODERER of Johnson

*etc*

SENATE FILE 484

H-3965

1 Amend the amendment, H-3905, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:  
4 1. Page 1, by inserting after line 48 the fol-  
5 lowing:  
6 "The general assembly further finds the situation  
7 of availability and affordability of medical  
8 malpractice insurance to be so critical that this Act  
9 is specifically designed to make insurance more  
10 available and affordable and therefore to make health  
11 care services more available and affordable to Iowa  
12 consumers."

H-3965 FILED APRIL 24, 1987 BY DODERER of Johnson

SENATE FILE 484

H-3966

1 Amend Senate File 484 as amended, passed, and  
2 reprinted by the Senate, as follows:  
3 1. Page 5, by striking line 5 and inserting the  
4 following: "determine if the amount of the fund is  
5 adequate to pay in".

H-3966 FILED APRIL 24, 1987 BY HANSEN of Woodbury

SENATE FILE 484

H-3967

1 Amend the amendment, H-3905, to Senate File 484 as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:  
4 1. Page 12, by inserting after line 36 the  
5 following:  
6 "Sec. \_\_\_\_ . It is deemed that this Act should  
7 reduce medical liability insurance premiums by fifty  
8 percent and substantially reduce the need for  
9 defensive medicine practices. On the effective date  
10 of this Act all health care providers participating  
11 under this Act shall reduce their charges to their  
12 patients ~~by~~ no less than twenty percent."  
13 2. Renumber as necessary.

H-3967 FILED APRIL 24, 1987 BY MCKINNEY of Dallas

SENATE FILE 484

H-3968

1 Amend Senate File 484 as amended, passed and  
2 reprinted by the Senate as follows:  
3 1. Page 4, by inserting after line 2 the  
4 following:  
5 "4. An election under this chapter shall not apply  
6 to any action brought by a patient based upon an  
7 expressed or implied contract assuring results."

H-3968 FILED APRIL 24, 1987 BY HANSEN of Woodbury

## SENATE FILE 484

H-3963

1 Amend amendment, H-3905, to Senate File 484 as  
2 amended, passed and reprinted by the Senate, as  
3 follows:

4 1. Page 12, by inserting after line 28 the  
5 following:

6 "Sec. \_\_\_\_ . NEW SECTION. 147B.19 LIMITATION ON  
7 APPLICABILITY.

8 Section 147.136, section 614.1, subsection 9, and  
9 section 668.4 shall not apply to any health care  
10 provider not participating under this chapter."

11 2. By renumbering as necessary.

H-3963 FILED APRIL 24, 1987 BY MCKINNEY of Dallas

## SENATE FILE 484

H-3962

1 Amend the amendment, H-3905, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. By striking page 2, line 43, through page 3,  
5 line 19 and inserting the following:

6 "a. Files with the commissioner proof of financial  
7 responsibility in an amount of two hundred thousand  
8 dollars per occurrence. The health care provider is  
9 qualified as long as the required proof of financial  
10 responsibility remains effective. Financial  
11 responsibility may be proven by providing a certified  
12 copy of a professional liability insurance policy  
13 currently in force with annual proof of renewal, the  
14 posting of a bond, or the payment of cash."

H-3962 FILED APRIL 24, 1987 BY MCKINNEY of Dallas

## SENATE FILE 484

H-3961

1 Amend Senate File 484 as amended, passed and  
2 reprinted by the Senate, as follows:

3 1. Page 6, by inserting after line 30 the  
4 following:

5 "Sec. \_\_\_\_ . NEW SECTION. 147B.11 LIMITATION ON  
6 APPLICABILITY.

7 Section 147.136, section 614.1, subsection 9, and  
8 section 668.4 shall not apply to any health care  
9 provider not participating under this chapter."

10 2. By renumbering as necessary.

H-3961 FILED APRIL 24, 1987 BY MCKINNEY of Dallas

SENATE FILE 484

H-3979

1 Amend Senate File 484 as amended, passed and  
2 reprinted by the Senate as follows:

3 1. Page 6, by inserting after line 10 the  
4 following:

5 "6. The report shall be a public record."

H-3979 FILED APRIL 24, 1987 BY HANSEN of Woodbury

SENATE FILE 484

H-3978

1 Amend amendment, H-3905, to Senate File 484 as  
2 amended, passed and reprinted by the Senate as  
3 follows:

4 1. Page 12, by inserting after line 22 the  
5 following:

6 "6. The report shall be a public record."

H-3978 FILED APRIL 24, 1987 BY MCKINNEY of Dallas

SENATE FILE 484

H-3980

1 Amend amendment, H-3905, to Senate File 484 as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 12, by inserting after line 22 the  
5 following:

6 "Sec.           . NEW SECTION. 147B.17A REPORT TO  
7 HEALTH DATA COMMISSION.

8 1. A health care provider, when giving notice to  
9 the commissioner of the provider's intention to apply  
10 for coverage under the fund, shall provide to the  
11 health data commission and the commissioner, before  
12 coverage under the fund is effective, information  
13 concerning both of the following:

14 a. Proof and amount of medical liability insurance  
15 premiums paid by the health care provider for the  
16 three years prior to the year for which application  
17 for coverage has been made, and the coverage provided.

18 b. A schedule of fees charged by the health care  
19 provider for the three years prior to the year for  
20 which application for coverage has been made.

21 2. A qualified health care provider shall provide  
22 to the health data commission and the commissioner  
23 after January 1 but before March 1 of each year  
24 information required to be reported in subsection 1.  
25 The information in this report shall be for the  
26 preceding calendar year.

27 3. The commissioner shall certify to the  
28 administrator the names of those health care providers  
29 complying with subsections 1 and 2.

30 4. Health care providers shall reduce fees charged  
31 to patients by an amount equal to the reduced cost of  
32 medical liability insurance, including any surcharge  
33 or special surcharge, as evidenced by the reports  
34 filed pursuant to subsections 1 and 2."

35 2. Renumber as necessary.

H-3980 FILED APRIL 24, 1987 BY SWARTZ of Marshall

SENATE FILE 484

H-3969

1 Amend Senate File 484 as amended, passed, and  
2 reprinted by the Senate, as follows:

3 1. Page 5, by inserting after line 27 the  
4 following:

5 "Sec. \_\_\_\_ . NEW SECTION. 147B.6A FRIVOLOUS  
6 ACTIONS.

7 In all cases against a health care provider or  
8 hospital for malpractice or professional negligence,  
9 the court may, upon application by the prevailing  
10 party, in its discretion and in an amount determined  
11 in its discretion, tax as costs payable to the  
12 prevailing party, the reasonable costs of preparation  
13 and trial, including reasonable attorney fees and the  
14 reasonable loss of earnings by the prevailing party  
15 occasioned by the trial, if the court finds that the  
16 losing party did not have a reasonable chance of  
17 recovery or a reasonable chance of a successful  
18 defense. The taxation of any cost under this section  
19 is the sole responsibility of the named parties and is  
20 not to be considered a cost of defense or a portion of  
21 the insurance coverage provided to either party which  
22 thereby reduces the amount of coverage available for  
23 the payment of any judgment rendered against that  
24 party."

25 2. Renumber as necessary.

H-3969 FILED APRIL 24, 1987 BY HANSEN of Woodbury

SENATE FILE 484

H-3970

1 Amend amendment, H-3905, to Senate File 484 as  
2 amended, passed and reprinted by the Senate as  
3 follows:

4 1. Page 7, line 34, by striking the word  
5 "inadequate" and inserting the following: "adequate".

H-3970 FILED APRIL 24, 1987 BY MCKINNEY of Dallas

SENATE FILE 484

H-3971

1 Amend amendment, H-3905, to Senate File 484 as  
2 amended, passed and reprinted by the Senate as  
3 follows:

4 1. Page 5, by inserting after line 26 the  
5 following:

6 "4. An election under this chapter shall not apply  
7 to any action brought by a patient based upon an  
8 expressed or implied contract assuring results."

H-3971 FILED APRIL 24, 1987 BY MCKINNEY of Dallas

## SENATE FILE 484

H-3981

Amend the amendment, H-3905, to Senate File 484 as amended, passed, and reprinted by the Senate, as follows:

1. Page 6, by inserting after line 38 the following:

"4. If a judgment has been entered for an injured person, as defined in section 147B.10, which exceeds the amount recoverable as determined under this section, the injured person may file a claim pursuant to chapter 25 for the amount in excess of the amount recoverable."

2. Page 12, by inserting after line 28 the following:

"Sec. \_\_\_\_ . Section 25.1, Code 1987, is amended to read as follows:

25.1 RECEIPT, INVESTIGATION, AND REPORT.

When a claim is filed or made against the state, on which in the judgment of the director of management the state would be liable except for the fact of its sovereignty or which has no appropriation available for its payment, the director of management shall deliver said claim to the state appeal board. The state appeal board shall make a record of the receipt of said claim and forthwith deliver same to the special assistant attorney general for claims who shall, with a view to determining the merits and legality thereof, fully investigate said claim, including the facts upon which it is based and report in duplicate findings and conclusions of law to the state appeal board. Notwithstanding this section, any claim made for an amount recoverable pursuant to section 147B.7, subsection 4, shall be delivered directly to the state appeal board.

Sec. \_\_\_\_ . Section 25.2, Code 1987, is amended to read as follows:

25.2 EXAMINATION OF REPORT -- APPROVAL OR REJECTION -- PAYMENT.

The state appeal board with the recommendation of the special assistant attorney general for claims may approve or reject claims against the state of less than ten years covering the following: Outdated warrants; outdated sales and use tax refunds; license refunds; additional agricultural land tax credits; outdated invoices; fuel and gas tax refunds; outdated homestead and veterans' exemptions; outdated funeral service claims; tractor fees; registration permits; outdated bills for merchandise; services furnished to the state; claims by any county or county official relating to the personal property tax credit; and refunds of fees collected by the state; and amounts

1 recoverable pursuant to section 147B.7, subsection 4.  
2 Payments authorized by the state appeal board shall be  
3 paid from the appropriation or fund of original  
4 certification of the claim, except, that if such  
5 appropriation or fund has since reverted under section  
6 8.33 or the claim is made for an amount recoverable  
7 pursuant to section 147B.7, subsection 4, then such  
8 payment authorized by the state appeal board shall be  
9 out of any money in the state treasury not otherwise  
10 appropriated. Notwithstanding the provisions of this  
11 section, the state comptroller may reissue outdated  
12 warrants."

H-3981 FILED APRIL 24, 1987 BY SWARTZ of Marshall

*Wm. H. Swartz*

SENATE FILE 484

H-3984

1 Amend the amendment, H-3905, to Senate File 484 as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. By striking page 4, line 34, through page 5,  
5 line 26, and inserting the following:

6 "Sec. \_\_\_\_ . NEW SECTION. 147B.5 PATIENT ELECTION  
7 TO BE BOUND.

8 1. A patient's exclusive remedy against a health  
9 care provider qualifying under section 147B.4 for  
10 medical malpractice occurring after the effective date  
11 of this Act is the remedy provided for under this  
12 chapter unless the patient has elected not to be bound  
13 by the remedies provided for in this chapter. A  
14 patient may elect not to be bound under this chapter  
15 by filing an election with the commissioner, pursuant  
16 to rules adopted by the commissioner, in advance of  
17 the treatment, act, or omission upon which a claim may  
18 be based, and notifying the health care provider of  
19 the election within a reasonable time before any  
20 treatment begins. Failure to provide the required  
21 notice is deemed to be evidence of the patient's  
22 election to be bound by this chapter. The patient may  
23 withdraw the election in writing at any time by filing  
24 the withdrawal with the commissioner.

25 2. A qualified health care provider must provide a  
26 patient with notice that the health care provider is  
27 qualified under this chapter prior to any treatment,  
28 and must inform the patient of the patient's right to  
29 elect not to be bound by this chapter.

30 3. If any health care provider refuses to treat a  
31 patient electing not to be bound under this section,  
32 any injury or damage sustained by that patient shall  
33 be presumed to be caused by the health care provider's  
34 refusal to treat."

35 2. Renumber as necessary.

H-3984 FILED APRIL 24, 1987 BY ROSENBERG of Story

*1/2 4/22/87 (1500)*

## SENATE FILE 484

H-3985

1 Amend Senate File 484 as amended, passed and  
2 reprinted by the Senate as follows:

3 1. Page 4, by inserting after line 2 the  
4 following:

5 "Sec. \_\_\_\_ . NEW SECTION. 147B.4A VICTIM  
6 QUALIFICATION FOR ASSISTANCE.

7 Any victim of medical negligence deemed to have  
8 been damaged in excess of the limits of liability as  
9 provided in section 147B.7 shall immediately be  
10 qualified for state assistance through the department  
11 of human services."

12 2. By renumbering as necessary.

H-3985 FILED APRIL 24, 1987 BY JAY of Appanoose  
e/s

## SENATE FILE 484

H-3983

1 Amend Senate File 484 as amended, passed, and  
2 reprinted by the Senate, as follows:

3 1. By striking page 3, line 11, through page 4,  
4 line 2, and inserting the following:

5 "Sec. \_\_\_\_ . NEW SECTION. 147B.4 PATIENT ELECTION  
6 TO BE BOUND.

7 1. A patient's exclusive remedy against a health  
8 care provider qualifying under section 147B.4 for  
9 medical malpractice occurring after the effective date  
10 of this Act is the remedy provided for under this  
11 chapter unless the patient has elected not to be bound  
12 by the remedies provided for in this chapter. A  
13 patient may elect not to be bound under this chapter  
14 by filing an election with the commissioner, pursuant  
15 to rules adopted by the commissioner, in advance of  
16 the treatment, act, or omission upon which a claim may  
17 be based, and notifying the health care provider of  
18 the election within a reasonable time before any  
19 treatment begins. Failure to provide the required  
20 notice is deemed to be evidence of the patient's  
21 election to be bound by this chapter. The patient may  
22 withdraw the election in writing at any time by filing  
23 the withdrawal with the commissioner.

24 2. A qualified health care provider must provide a  
25 patient with notice that the health care provider is  
26 qualified under this chapter prior to any treatment,  
27 and must inform the patient of the patient's right to  
28 elect not to be bound by this chapter.

29 3. If any health care provider refuses to treat a  
30 patient electing not to be bound under this section,  
31 any injury or damage sustained by that patient shall  
32 be presumed to be caused by the health care provider's  
33 refusal to treat."

34 2. Renumber as necessary.

H-3983 FILED APRIL 24, 1987 BY JAY of Appanoose  
e/s

## SENATE FILE 484

H-3990

1 Amend Senate File 484 as amended, passed, and  
 2 reprinted by the Senate, as follows:  
 3 1. Page 2, by inserting after line 10 the  
 4 following:  
 5 "6. A "claim is made" when a patient informs a  
 6 health care provider in person orally, in writing, or  
 7 by the patient's attorney that the patient believes  
 8 the health care provider is liable for an act of  
 9 medical malpractice. A claim is also made when a  
 10 patient brings a legal action against a health care  
 11 provider or providers."

H-3990 FILED APRIL 24, 1987 BY ROSENBERG of Story

*Am. 20h. 4/27/87 (p. 1500)*

## SENATE FILE 484

H-3991

1 Amend the amendment, H-3905, to Senate File 484 as  
 2 amended, passed, and reprinted by the Senate, as  
 3 follows:  
 4 1. Page 12, by inserting after line 22 the  
 5 following:  
 6 "Sec. \_\_\_\_ . NEW SECTION. 147B.17A HEALTH CARE  
 7 PROVIDER INFORMATION.  
 8 The administrator, upon the request of any person,  
 9 shall provide the person without charge with the  
 10 following information regarding any health care  
 11 provider who has qualified under this Act:  
 12 a. The name of all insurance carriers which  
 13 currently insure the health care provider or which  
 14 have insured the health care provider, whether by  
 15 claims-made or occurrence-type coverage.  
 16 b. The term of each policy.  
 17 c. The limits of each policy."  
 18 2. Renumber as necessary.

H-3991 FILED APRIL 24, 1987 BY ROSENBERG of Story

*Am. 20h. 4/27/87*

## SENATE FILE 484

H-3989

1 Amend Senate File 484 as amended, passed and  
 2 reprinted by the Senate as follows:  
 3 1. Page 8, by inserting after line 1 the  
 4 following:  
 5 "Sec. \_\_\_\_ . The provisions of this Act shall not  
 6 apply to any occurrence before January 1, 1988."  
 7 2. Renumber as necessary.

H-3989 FILED APRIL 24, 1987 BY ROSENBERG of Story

*4/27*

## SENATE FILE 484

H-3988

1 Amend Senate File 484 as amended, passed, and  
2 reprinted by the Senate, as follows:

3 1. Page 6, by inserting after line 10 the  
4 following:

5 "Sec. \_\_\_\_ . NEW SECTION. 147B.7A HEALTH CARE  
6 PROVIDER INFORMATION.

7 The administrator, upon the request of any person,  
8 shall provide the person without charge with the  
9 following information regarding any health care  
10 provider who has qualified under this Act:

11 a. The name of all insurance carriers which  
12 currently insure the health care provider or which  
13 have insured the health care provider, whether by  
14 claims-made or occurrence-type coverage.

15 b. The term of each policy.

16 c. The limits of each policy."

17 2. Renumber as necessary.

H-3988 FILED APRIL 24, 1987 BY BRAMMER of Linn

*etc*

## SENATE FILE 484

H-3987

1 Amend the amendment, H-3905, to Senate File 484 as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 2, by inserting after line 38 the  
5 following:

6 "8. A "claim is made" when a patient informs a  
7 health care provider in person orally, in writing, or  
8 by the patient's attorney that the patient believes  
9 the health care provider is liable for an act of  
10 medical malpractice. A claim is also made when a  
11 patient brings a legal action against a health care  
12 provider or providers."

H-3987 FILED APRIL 24, 1987 BY JAV of Appanoose

*etc*

## SENATE FILE 484

H-3986

1 Amend amendment, H-3905, to Senate File 484 as  
2 amended, passed and reprinted by the Senate as  
3 follows:

4 1. Page 12, by inserting after line 36 the  
5 following:

6 "Sec. \_\_\_\_ . The provisions of this Act shall not  
7 apply to any occurrence before January 1, 1988."

8 2. Renumber as necessary.

H-3986 FILED APRIL 24, 1987 BY JAY of Appanoose

*etc*

## SENATE FILE 484

H-3996

1 Amend the amendment, H-3905, to Senate File 484 as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 5, by inserting after line 1 the  
5 following:

6 "The one hundred eighty days during which a patient  
7 may file an election with the commissioner and notify  
8 the health care provider is tolled until the health  
9 care provider has notified all patients treated in the  
10 last ten years in writing of the patients' rights not  
11 to be bound. The notice shall be sent by certified  
12 mail, restricted delivery to the addressee only, to  
13 the patient's last known address as shown by the  
14 health care provider's records.

15 The notice shall include verbatim the definition of  
16 medical malpractice as defined in this chapter and  
17 shall inform the patient that if the patient believes  
18 a claim of medical malpractice exists against the  
19 health care provider that the patient has one hundred  
20 eighty days to elect not to be bound by this chapter.  
21 The notice shall include verbatim the provisions of  
22 section 147B.5."

H-3996 FILED APRIL 24, 1987 BY ROSENBERG of Story

*Passed 4/24/87 by 180-1500*

## SENATE FILE 484

H-3995

1 Amend amendment, H-3905, to Senate File 484 as  
2 amended, passed and reprinted by the Senate as  
3 follows:

4 1. By striking page 5, line 39, through page 6,  
5 line 38.

6 2. By striking page 8, line 17 through page 10,  
7 line 19 and inserting the following:

8 "Any judgment rendered against a health care  
9 provider or hospital participating under this chapter  
10 which exceeds one million dollars shall be paid as  
11 follows:

12 1. The first one million dollars shall be paid at  
13 the time of judgment unless appeal is taken.

14 2. Any amount awarded in excess of one million  
15 dollars shall be structured under terms agreeable to  
16 all parties to the action after payment of attorney  
17 fees and court costs."

18 3. By renumbering as necessary.

H-3995 FILED APRIL 24, 1987 BY ROSENBERG of Story

*Passed 4/24/87*

SENATE FILE 484

H-3994

1 Amend amendment, H-3905, to Senate File 484 as  
2 amended, passed and reprinted by the Senate as  
3 follows:

4 1. Page 5, line 50, by striking the word "one"  
5 and inserting the following: "two".

6 2. Page 6, by striking lines 1 through 5 and  
7 inserting the following: "thousand dollars."

8 3. Page 6, by inserting after line 38 the  
9 following:

10 "4. Payment by the primary insurance provider of  
11 the limit of its liability constitutes conclusive  
12 proof of liability."

H-3994 FILED APRIL 24, 1987 BY JAY of Appanoose

*Placed in Senate file 484*

SENATE FILE 484

H-3993

1 Amend amendment, H-3905, to Senate File 484 as  
2 amended, passed and reprinted by the Senate as  
3 follows:

4 1. Page 6, by inserting after line 38 the  
5 following:

6 "4. This chapter shall not be construed to prevent  
7 a claimant from recovering full policy limits from any  
8 health care providers' insurance carrier or carriers  
9 which have issued policies and collected premiums  
10 permitting full recovery."

11 2. Renumber as necessary.

H-3993 FILED APRIL 24, 1987 BY JAY of Appanoose

*Placed in*

SENATE FILE 484

H-3992

1 Amend amendment, H-3905, to Senate File 484 as  
2 amended, passed and reprinted by the Senate as  
3 follows:

4 1. Page 6, by inserting after line 38 the  
5 following:

6 "Sec. . . . NEW SECTION. 147B.7A VICTIM  
7 QUALIFICATION FOR ASSISTANCE.

8 Any victim of medical negligence deemed to have  
9 been damaged in excess of the limits of liability as  
10 provided in section 147B.7 shall immediately be  
11 qualified for state assistance through the department  
12 of human services."

13 2. By renumbering as necessary.

H-3992 FILED APRIL 24, 1987 BY ROSENBERG of Story

*Placed in*

SENATE FILE 484

H-4010

1 Amend the amendment, H-3905, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 12, by inserting after line 28 the  
5 following:

6 "Sec. \_\_\_\_\_. The commissioner shall make a  
7 determination after January 1, 1989 but no later than  
8 July 1, 1989 as to whether the enactment of this Act  
9 impacts factors which affect the cost of medical  
10 liability insurance such that a mandatory rollback of  
11 premium rates is warranted.

12 The commissioner shall also require an immediate  
13 fifteen percent rollback of workers' compensation  
14 premium rates pursuant to the commissioner's denial of  
15 a rate increase request, issued April 16, 1987."

16 2. Renumber as necessary.

H-4010 FILED APRIL 27, 1987 BY HANSEN of Woodbury

*Sub. 2010 4/27/87 (p. 1501)*

SENATE FILE 484

H-4011

1 Amend Senate File 484 as amended, passed and  
2 reprinted by the Senate as follows:

3 1. Page 8, by inserting after line 1 the  
4 following:

5 "Sec. \_\_\_\_\_. Notwithstanding section 4.12, if any  
6 provision of this Act is held invalid, the whole Act  
7 is invalid, and to this end the provisions of the Act  
8 are not severable.

9 Sec. \_\_\_\_\_. This Act takes effect upon enactment,  
10 and the commissioner shall take all actions necessary  
11 to implement the provisions of this Act on or before  
12 January 1, 1988."

13 2. Renumber as necessary.

H-4011 FILED APRIL 27, 1987 BY HANSEN of Woodbury

*Sub. 2010*

SENATE FILE 484

H-3997

1 Amend Senate File 484 as amended, passed, and  
2 reprinted by the Senate, as follows:

3 1. Page 8, by inserting after line 1 the  
4 following:

5 "Sec. \_\_\_\_ . It is deemed that this Act should  
6 reduce medical liability insurance premiums by fifty  
7 percent and substantially reduce the need for  
8 defensive medicine practices. On the effective date  
9 of this Act all health care providers participating  
10 under this Act shall reduce their charges to their  
11 patients by no less than twenty percent."

12 2. Renumber as necessary.

H-3997 FILED APRIL 24, 1987 BY BRAMMER of Linn

*Place in the file of 1987*

SENATE FILE 484

H-3998

1 Amend Senate File 484 as amended, passed, and  
2 reprinted by the Senate, as follows:

3 1. Page 3, by inserting after line 10 the  
4 following:

5 "5. Each health care provider seeking to qualify  
6 under this chapter shall disclose to the administrator  
7 information concerning all policies held at any time  
8 by the health care provider which are occurrence form  
9 medical liability insurance policies. The information  
10 shall include the name of the insurance carrier, the  
11 policy number, the policy period, and the policy  
12 limits."

13 2. Renumber as necessary.

H-3998 FILED APRIL 24, 1987 BY BRAMMER of Linn

*Place in the file of 1987*

SENATE FILE 484

H-3999

1 Amend the amendment, H-3905, to Senate File 484 as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 4, by inserting after line 33 the  
5 following:

6 "7. Each health care provider seeking to qualify  
7 under this chapter shall disclose to the administrator  
8 information concerning all policies held at any time  
9 by the health care provider which are occurrence form  
10 medical liability insurance policies. The information  
11 shall include the name of the insurance carrier, the  
12 policy number, the policy period, and the policy  
13 limits."

14 2. Renumber as necessary.

H-3999 FILED APRIL 24, 1987 BY ROSENBERG of Story

*Place in the file of 1987*

## SENATE FILE 484

4009

Amend the amendment, H-3905, to Senate File 484 as amended, passed, and reprinted by the Senate, as follows:

1. Page 1, line 4, by inserting after the word "FINDINGS." the following: "The general assembly finds and declares that it is in the public interest that the availability of competent health care services be assured and that a mechanism exists for providing total compensation of persons injured as a result of medical malpractice."

2. Page 1, line 4, by inserting after the word "assembly" the following: "further".

3. Page 6, by inserting after line 38 the following:

"4. If a judgment has been entered for an injured person, as defined in section 147B.10, which exceeds the amount recoverable as determined under this section, the injured person may file a claim pursuant to chapter 25 for the amount in excess of the amount recoverable."

4. Page 12, by inserting after line 22 the following:

"Sec.           . NEW SECTION. 147B.17A REPORT TO HEALTH DATA COMMISSION.

1. A health care provider, when giving notice to the commissioner of the provider's intention to apply for coverage under the fund, shall provide to the health data commission and the commissioner, before coverage under the fund is effective, information concerning both of the following:

a. Proof and amount of medical liability insurance premiums paid by the health care provider for the three years prior to the year for which application for coverage has been made, and the coverage provided

b. A schedule of fees charged by the health care provider for the three years prior to the year for which application for coverage has been made.

2. A qualified health care provider shall provide to the health data commission and the commissioner after January 1 but before March 1 of each year information required to be reported in subsection 1. The information in this report shall be for the preceding calendar year.

3. The commissioner shall certify to the administrator the names of those health care providers complying with subsections 1 and 2.

4. Health care providers shall reduce fees charged to patients by an amount equal to the reduced cost of medical liability insurance, including any surcharge or special surcharge, as evidenced by the reports

1 filed pursuant to subsections 1 and 2."

2 5. Page 12, by inserting after line 28 the  
3 following:

4 "Sec. \_\_\_\_ . Section 25.1, Code 1987, is amended to  
5 read as follows:

6 25.1 RECEIPT, INVESTIGATION, AND REPORT.

7 When a claim is filed or made against the state, on  
8 which in the judgment of the director of management  
9 the state would be liable except for the fact of its  
10 sovereignty or which has no appropriation available  
11 for its payment, the director of management shall  
12 deliver said claim to the state appeal board. The  
13 state appeal board shall make a record of the receipt  
14 of said claim and forthwith deliver same to the  
15 special assistant attorney general for claims who  
16 shall, with a view to determining the merits and  
17 legality thereof, fully investigate said claim,  
18 including the facts upon which it is based and report  
19 in duplicate findings and conclusions of law to the  
20 state appeal board. Notwithstanding this section, any  
21 claim made for an amount recoverable pursuant to  
22 section 147B.7, subsection 4, shall be delivered  
23 directly to the state appeal board.

24 Sec. \_\_\_\_ . Section 25.2, Code 1987, is amended to  
25 read as follows:

26 25.2 EXAMINATION OF REPORT -- APPROVAL OR  
27 REJECTION -- PAYMENT.

28 The state appeal board with the recommendation of  
29 the special assistant attorney general for claims may  
30 approve or reject claims against the state of less  
31 than ten years covering the following: Outdated  
32 warrants; outdated sales and use tax refunds; license  
33 refunds; additional agricultural land tax credits;  
34 outdated invoices; fuel and gas tax refunds; outdated  
35 homestead and veterans' exemptions; outdated funeral  
36 service claims; tractor fees; registration permits;  
37 outdated bills for merchandise; services furnished to  
38 the state; claims by any county or county official  
39 relating to the personal property tax credit; and  
40 refunds of fees collected by the state; and amounts  
41 recoverable pursuant to section 147B.7, subsection 4.  
42 Payments authorized by the state appeal board shall be  
43 paid from the appropriation or fund of original  
44 certification of the claim, except, that if such  
45 appropriation or fund has since reverted under section  
46 8.33 or the claim is made for an amount recoverable  
47 pursuant to section 147B.7, subsection 4, then such  
48 payment authorized by the state appeal board shall be  
49 out of any money in the state treasury not otherwise  
50 appropriated. Notwithstanding the provisions of this

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1 section, the state comptroller may reissue outdated  
2 warrants."

3 6. By renumbering, relettering, or redesignating  
4 and correcting internal references as necessary.

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1 the proceedings before the panel are not matters of  
2 public record.

3 2. Medical review panels shall be concerned only  
4 with the determination of the questions set forth in  
5 section 147B.22. The panels shall not consider or  
6 report on disputed questions of law."

7 2. Renumber as necessary.

H-4015 FILED APRIL 27, 1987 BY HANSEN of Woodbury

*Planned to 4/28/87 (7:15:00)*

SENATE FILE 484

H-4013

1 Amend amendment, H-3905, to Senate File 484 as  
2 amended, passed and reprinted by the Senate as  
3 follows:

4 1. Page 8, by inserting after line 14 the  
5 following:

6 "Sec. \_\_\_\_ . NEW SECTION. 147B.9A EVIDENCE OF  
7 PREVIOUS PAYMENT OR FUTURE RIGHT OF PAYMENT.

8 1. In an action brought pursuant to this chapter  
9 seeking damages for personal injury, the court shall  
10 permit evidence and argument as to the previous  
11 payment or future right of payment of actual economic  
12 losses incurred or to be incurred as a result of the  
13 personal injury for necessary medical care,  
14 rehabilitation services, and custodial care except to  
15 the extent that the previous payment or future right  
16 of payment is pursuant to a state or federal program  
17 or from assets of the claimant or the members of the  
18 claimant's immediate family.

19 2. Evidence of the existence of insurance  
20 applicable to the damages sought and the amount of  
21 coverage available shall be permitted by the court.

22 3. If evidence and argument regarding previous  
23 payments or future rights of payment is permitted  
24 pursuant to subsection 1, the court shall also permit  
25 evidence and argument as to the costs to the claimant  
26 of procuring the previous payments or future rights of  
27 payment and as to any existing rights of in-  
28 demnification or subrogation relating to the previous  
29 payments or future rights of payment.

30 4. If evidence or argument is permitted pursuant  
31 to subsection 1, 2, or 3, the court shall, unless  
32 otherwise agreed to by all parties, instruct the jury  
33 to answer special interrogatories or, if there is no  
34 jury, shall make findings indicating the effect of  
35 such evidence or argument on the verdict."

36 2. By renumbering as necessary.

H-4013 FILED APRIL 27, 1987 BY HANSEN of Woodbury

*Planned to 4/28/87*

1 Amend Senate File 484 as amended, passed, and  
2 reprinted by the Senate, as follows:

3 1. Page 6, by inserting after line 10 the  
4 following:

5 "Sec. \_\_\_\_ . NEW SECTION. 147B.17A DISCLOSURE OF  
6 CLAIMS.

7 1. All medical liability claims settled or  
8 adjudicated to final judgment against a health care  
9 provider and any liability claim closed without  
10 payment during the calendar year shall be reported to  
11 the commissioner by the health care provider or the  
12 provider's medical liability insurer. The report  
13 shall be submitted to the commissioner on or before  
14 the first day of February for claims for the previous  
15 calendar year.

16 2. The reports shall contain all of the following  
17 information:

- 18 a. Nature of each claim and damages asserted.
- 19 b. Amount of settlement or judgment, if any.
- 20 c. Professional and legal issues asserted with  
21 regard to each claim.
- 22 d. Specialty of each health care provider against  
23 whom each claim is filed and closed.

24 3. The reports shall be transmitted to the board  
25 of medical examiners. A report containing all the  
26 information included in the individual reports shall  
27 be made available to the public by the board for each  
28 calendar year."

29 2. Page 8, by inserting after line 1 the  
30 following:

31 "Sec. \_\_\_\_ . The commissioner shall collect  
32 information concerning all claims initiated and  
33 settled or adjudicated to final judgment or closed  
34 without payment against any health care provider  
35 currently licensed to practice in this state for the  
36 ten-year period preceding the effective date of this  
37 Act. This report shall be made available to the  
38 public no later than January 1, 1989."

39 3. Renumber as necessary.

H-4012 FILED APRIL 27, 1987 BY HANSEN of Woodbury

SENATE FILE 484

H-4014

1 Amend Senate File 484, as amended, passed, and  
2 reprinted by the Senate, as follows:

3 1. Page 8, by inserting after line 1 the  
4 following:

5 "Sec. \_\_\_\_ . The commissioner shall make a  
6 determination after January 1, 1989 but no later than  
7 July 1, 1989 as to whether the enactment of this Act  
8 impacts factors which affect the cost of medical  
9 liability insurance such that a mandatory rollback of  
10 premium rates is warranted.

11 The commissioner shall also require an immediate  
12 fifteen percent rollback of workers' compensation  
13 premium rates pursuant to the commissioner's denial of  
14 a rate increase request, issued April 16, 1987."

15 2. Renumber as necessary.

H-4014 FILED APRIL 27, 1987 BY HANSEN of Woodbury

SENATE FILE 484

H-4015

1 Amend the amendment, H-3905, to Senate File 484 as  
2 amended, passed and reprinted by the Senate as  
3 follows:

4 1. Page 12, by inserting after line 28 the  
5 following:

6 "Sec. \_\_\_\_ . NEW SECTION. 147B.19 MEDICAL REVIEW  
7 PANEL ESTABLISHED.

8 A medical review board is established to review all  
9 malpractice claims against qualified health care  
10 providers.

11 Sec. \_\_\_\_ . NEW SECTION. 147B.20 PANEL MEMBERS --  
12 SELECTION.

13 1. The medical review panel consists of one  
14 attorney admitted to practice law in this state and  
15 three physicians who hold unlimited licenses under the  
16 laws of this state to practice medicine. The attorney  
17 shall act in an advisory capacity and as chairperson  
18 of the panel, but shall have no vote.

19 2. The medical review panel shall be selected in  
20 the following manner:

21 a. All physicians engaged in the active practice  
22 of medicine in this state, whether in the teaching  
23 profession or otherwise, who hold a license to  
24 practice medicine, shall be available for selection.

25 b. Each party to the action has the right to  
26 select one physician and, upon selection, the  
27 physician is required to serve. The two physicians  
28 selected shall select the third physician panelist.  
29 If one of the health care providers involved is a  
30 hospital, a fourth panelist shall be selected who is a  
31 hospital administrator selected by the hospital.

32 c. If more than one plaintiff or defendant is  
33 involved, only one physician or hospital administrator  
34 shall be selected per side. The plaintiff has the  
35 right to select one physician and the defendant has  
36 the right to select one physician.

37 d. A panelist selected shall serve except that,  
38 for good cause shown, the panelist may be excused. To  
39 show good cause for relief from serving, the panelist  
40 is required to serve an affidavit upon a judge of a  
41 court having jurisdiction over the claim when filed.  
42 The affidavit shall set out the facts showing that  
43 service would constitute an unreasonable burden or  
44 undue hardship. The court may excuse the proposed  
45 panelist from serving.

46 e. Within twenty days after receipt of  
47 notification of a proposed panelist by the plaintiff,  
48 the defendant shall select a proposed panelist and  
49 advise the plaintiff or the plaintiff's attorney.

50 f. Within twenty days of receipt of notice of any

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1 selection, written challenge, without cause, may be  
2 made to the panel member. Upon challenge, a party  
3 shall select another panelist. If multiple plaintiffs  
4 or defendants are unable to agree on a physician  
5 panelist or if two challenges are made and submitted,  
6 the judge shall submit a list consisting of three  
7 qualified panelists and each side shall strike one and  
8 the remaining member shall serve in place of the  
9 challenged panelist designated by the party.

10 g. The parties may agree on the attorney member of  
11 the panel or, if no agreement can be reached, five  
12 proposed attorney members shall be designated by the  
13 judge having jurisdiction of the cause. The parties  
14 shall each strike two persons alternately with the  
15 claimant striking first until both sides have stricken  
16 two persons and the remaining person shall be the  
17 attorney member of the panel.

18 3. If the members of the medical review panel have  
19 not been selected within one hundred twenty days  
20 following filing of the petition or complaint, the  
21 court may select members of the panel and set a  
22 specific date for the hearing.

23 Sec. \_\_\_\_ . NEW SECTION. 147B.21 EVIDENCE  
24 CONSIDERED -- DEPOSITIONS.

25 1. The evidence considered by the medical review  
26 panel shall be promptly submitted by the parties in  
27 written form only. If any party to the proceedings  
28 fails to submit evidence within a reasonable time  
29 after notice from the panel requesting the evidence,  
30 the panel may proceed to decide the matter on the  
31 evidence previously submitted. The determination of  
32 reasonable time shall be made by the panel. The  
33 evidence submitted may consist of medical charts, X  
34 rays, laboratory test results, excerpts of treatises,  
35 depositions of witnesses, including the parties, and  
36 any other form of evidence allowable by the medical  
37 review panel.

38 2. Depositions of parties and witnesses may be  
39 taken prior to the convening of the panel and prior to  
40 the commencement of the action but the attorney for  
41 the medical care provider shall be furnished with a  
42 copy of the petition the claimant proposes to file at  
43 least ten days before any deposition is taken. The  
44 patient has the right to request and receive all  
45 medical and hospital records relating to the case  
46 which would be admissible in evidence in a court of  
47 law. The chairperson of the panel shall advise the  
48 panel relative to any legal question involved in the  
49 review proceeding and shall prepare the opinion of the  
50 panel. A copy of the evidence shall be sent to each

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1 member of the panel.

2 3. Either party, after submission of all evidence  
3 and upon ten days' notice to the other side, may  
4 convene the panel at a time and place agreeable to the  
5 members of the panel. Either party may present  
6 argument concerning any matters relevant to issues to  
7 be decided by the panel before the issuance of its  
8 report. The chairperson of the panel shall preside at  
9 all meetings.

10 4. If the members of the medical review panel have  
11 not convened within six months of the initiation of  
12 the proceeding, the judge may order the panel to  
13 convene.

14 Sec. \_\_\_\_ . NEW SECTION. 147B.22 ACCESS TO  
15 INFORMATION -- WRITTEN OPINION.

16 1. The panel has the right and duty to request all  
17 necessary information. The panel may consult with  
18 medical authorities and may examine reports of the  
19 health care providers as may be necessary to fully  
20 inform itself regarding the issue to be decided. Both  
21 parties have full access to any material submitted to  
22 the panel.

23 2. The panel has the sole duty to express its  
24 expert opinion in writing to each of the parties as to  
25 whether or not the evidence supports the conclusion  
26 that the defendant or defendants acted or failed to  
27 act within the appropriate standards of care as  
28 charged in the complaint and as to the issue of  
29 damages proximately caused by failure to act in  
30 accordance with such standards. Any issue relating to  
31 informed consent shall be considered as a charge of  
32 failure to act within the appropriate standard of  
33 care.

34 3. After reviewing all evidence and, unless  
35 waived, after argument by counsel representing either  
36 party, the panel shall, within thirty days, render one  
37 or more of the following expert opinions which shall  
38 be in writing and mailed to each of the parties:

39 a. The evidence supports the conclusion that the  
40 defendant failed to comply with the appropriate  
41 standard of care as charged in the complaint in  
42 specified particulars.

43 b. The evidence supports the conclusion that the  
44 defendant involved met the applicable standard of care  
45 required under the circumstances.

46 c. A material issue of fact exists, not requiring  
47 expert opinion, bearing on liability for consideration  
48 by the court or jury in specified particulars.

49 4. Dollar amounts or percentages of disability  
50 shall not be provided by the panel. A majority vote

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1 of the voting members controls action by the panel.  
2 The report of the panel shall be signed only by the  
3 chairperson who shall certify that the report reflects  
4 the opinion of a majority of the voting members. If  
5 requested, a minority report shall be provided to any  
6 party.

7 Sec. \_\_\_\_ . NEW SECTION. 147B.23 REQUEST FOR  
8 REVIEW OF A CLAIM -- EFFECT.

9 1. The filing of the request for review of a claim  
10 tolls the applicable statute of limitations for a  
11 period of ninety days following the issuance of the  
12 opinion by the medical review panel. The request for  
13 review of a claim is deemed filed when a copy of the  
14 request together with a copy of the proposed complaint  
15 is delivered or mailed by certified mail or restricted  
16 certified mail to the director, who shall immediately  
17 forward a copy to each health care provider named as a  
18 defendant at the health care provider's last place of  
19 residence or office.

20 2. The report and any minority report of the  
21 medical review panel are admissible as evidence in any  
22 action subsequently brought by the claimant in a court  
23 of law, but the report is not conclusive and either  
24 party may call any member of the medical review panel  
25 as a witness. If called, the witness shall be  
26 required to appear and testify.

27 3. A panelist has absolute immunity from civil  
28 liability for all communications, findings, opinions,  
29 and conclusions made in the course and scope of duties  
30 of the panel.

31 Sec. \_\_\_\_ . NEW SECTION. 147B.24 COMPENSATION OF  
32 MEMBERS.

33 Each member of the medical review panel shall be  
34 paid at the rate of thirty dollars per day for all  
35 work performed as a member of the panel, exclusive of  
36 time and services involved if called as a witness to  
37 testify in court and reasonable expenses incurred.  
38 Fees of the panel, including expenses, shall be paid  
39 equally by each side. If a panel member is called as  
40 an expert witness at the trial the panelist shall be  
41 paid the customary expert witness fee.

42 Sec. \_\_\_\_ . NEW SECTION. 147B.25 PROCEEDINGS  
43 BEFORE PANEL.

44 1. Except for the introduction into evidence of  
45 the report of the panel, all proceedings before the  
46 medical review panel, all actions taken by any party  
47 or party's counsel in preparation for the proceedings,  
48 and the submission of any matter to the medical review  
49 panel shall be handled on a confidential basis. The  
50 hearing shall not be conducted as a public hearing and

## SENATE FILE 484

H-4016

1 Amend Senate File 484 as amended, passed and  
2 reprinted by the Senate as follows:

3 1. Page 6, by inserting after line 30 the  
4 following:

5 "Sec. \_\_\_\_ . NEW SECTION. 147B.11 MEDICAL REVIEW  
6 PANEL ESTABLISHED.

7 A medical review board is established to review all  
8 malpractice claims against qualified health care  
9 providers.

10 Sec. \_\_\_\_ . NEW SECTION. 147B.12 PANEL MEMBERS --  
11 SELECTION.

12 1. The medical review panel consists of one  
13 attorney admitted to practice law in this state and  
14 three physicians who hold unlimited licenses under the  
15 laws of this state to practice medicine. The attorney  
16 shall act in an advisory capacity and as chairperson  
17 of the panel, but shall have no vote.

18 2. The medical review panel shall be selected in  
19 the following manner:

20 a. All physicians engaged in the active practice  
21 of medicine in this state, whether in the teaching  
22 profession or otherwise, who hold a license to  
23 practice medicine, shall be available for selection.

24 b. Each party to the action has the right to  
25 select one physician and, upon selection, the  
26 physician is required to serve. The two physicians  
27 selected shall select the third physician panelist.  
28 If one of the health care providers involved is a  
29 hospital, a fourth panelist shall be selected who is a  
30 hospital administrator selected by the hospital.

31 c. If more than one plaintiff or defendant is  
32 involved, only one physician or hospital administrator  
33 shall be selected per side. The plaintiff has the  
34 right to select one physician and the defendant has  
35 the right to select one physician.

36 d. A panelist selected shall serve except that,  
37 for good cause shown, the panelist may be excused. To  
38 show good cause for relief from serving, the panelist  
39 is required to serve an affidavit upon a judge of a  
40 court having jurisdiction over the claim when filed.  
41 The affidavit shall set out the facts showing that  
42 service would constitute an unreasonable burden or  
43 undue hardship. The court may excuse the proposed  
44 panelist from serving.

45 e. Within twenty days after receipt of  
46 notification of a proposed panelist by the plaintiff,  
47 the defendant shall select a proposed panelist and  
48 advise the plaintiff or the plaintiff's attorney.

49 f. Within twenty days of receipt of notice of any  
50 selection, written challenge, without cause, may be

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1 made to the panel member. Upon challenge, a party  
2 shall select another panelist. If multiple plaintiffs  
3 or defendants are unable to agree on a physician  
4 panelist or if two challenges are made and submitted,  
5 the judge shall submit a list consisting of three  
6 qualified panelists and each side shall strike one and  
7 the remaining member shall serve in place of the  
8 challenged panelist designated by the party.

9 g. The parties may agree on the attorney member of  
10 the panel or, if no agreement can be reached, five  
11 proposed attorney members shall be designated by the  
12 judge having jurisdiction of the cause. The parties  
13 shall each strike two persons alternately with the  
14 claimant striking first until both sides have stricken  
15 two persons and the remaining person shall be the  
16 attorney member of the panel.

17 3. If the members of the medical review panel have  
18 not been selected within one hundred twenty days  
19 following filing of the petition or complaint, the  
20 court may select members of the panel and set a  
21 specific date for the hearing.

22 Sec.     . NEW SECTION. 147B.13 EVIDENCE  
23 CONSIDERED -- DEPOSITIONS.

24 1. The evidence considered by the medical review  
25 panel shall be promptly submitted by the parties in  
26 written form only. If any party to the proceedings  
27 fails to submit evidence within a reasonable time  
28 after notice from the panel requesting the evidence,  
29 the panel may proceed to decide the matter on the  
30 evidence previously submitted. The determination of  
31 reasonable time shall be made by the panel. The  
32 evidence submitted may consist of medical charts, X  
33 rays, laboratory test results, excerpts of treatises,  
34 depositions of witnesses, including the parties, and  
35 any other form of evidence allowable by the medical  
36 review panel.

37 2. Depositions of parties and witnesses may be  
38 taken prior to the convening of the panel and prior to  
39 the commencement of the action but the attorney for  
40 the medical care provider shall be furnished with a  
41 copy of the petition the claimant proposes to file at  
42 least ten days before any deposition is taken. The  
43 patient has the right to request and receive all  
44 medical and hospital records relating to the case  
45 which would be admissible in evidence in a court of  
46 law. The chairperson of the panel shall advise the  
47 panel relative to any legal question involved in the  
48 review proceeding and shall prepare the opinion of the  
49 panel. A copy of the evidence shall be sent to each  
50 member of the panel.

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1 3. Either party, after submission of all evidence  
2 and upon ten days' notice to the other side, may  
3 convene the panel at a time and place agreeable to the  
4 members of the panel. Either party may present  
5 argument concerning any matters relevant to issues to  
6 be decided by the panel before the issuance of its  
7 report. The chairperson of the panel shall preside at  
8 all meetings.

9 4. If the members of the medical review panel have  
10 not convened within six months of the initiation of  
11 the proceeding, the judge may order the panel to  
12 convene.

13 Sec. \_\_\_\_ . NEW SECTION. 147B.14 ACCESS TO  
14 INFORMATION -- WRITTEN OPINION.

15 1. The panel has the right and duty to request all  
16 necessary information. The panel may consult with  
17 medical authorities and may examine reports of the  
18 health care providers as may be necessary to fully  
19 inform itself regarding the issue to be decided. Both  
20 parties have full access to any material submitted to  
21 the panel.

22 2. The panel has the sole duty to express its  
23 expert opinion in writing to each of the parties as to  
24 whether or not the evidence supports the conclusion  
25 that the defendant or defendants acted or failed to  
26 act within the appropriate standards of care as  
27 charged in the complaint and as to the issue of  
28 damages proximately caused by failure to act in  
29 accordance with such standards. Any issue relating to  
30 informed consent shall be considered as a charge of  
31 failure to act within the appropriate standard of  
32 care.

33 3. After reviewing all evidence and, unless  
34 waived, after argument by counsel representing either  
35 party, the panel shall, within thirty days, render one  
36 or more of the following expert opinions which shall  
37 be in writing and mailed to each of the parties:

38 a. The evidence supports the conclusion that the  
39 defendant failed to comply with the appropriate  
40 standard of care as charged in the complaint in  
41 specified particulars.

42 b. The evidence supports the conclusion that the  
43 defendant involved met the applicable standard of care  
44 required under the circumstances.

45 c. A material issue of fact exists, not requiring  
46 expert opinion, bearing on liability for consideration  
47 by the court or jury in specified particulars.

48 4. Dollar amounts or percentages of disability  
shall not be provided by the panel. A majority vote  
of the voting members controls action by the panel.

1 The report of the panel shall be signed only by the  
2 chairperson who shall certify that the report reflects  
3 the opinion of a majority of the voting members. If  
4 requested, a minority report shall be provided to any  
5 party.

6 Sec. \_\_\_\_ . NEW SECTION. 147B.15 REQUEST FOR  
7 REVIEW OF A CLAIM -- EFFECT.

8 1. The filing of the request for review of a claim  
9 tolls the applicable statute of limitations for a  
10 period of ninety days following the issuance of the  
11 opinion by the medical review panel. The request for  
12 review of a claim is deemed filed when a copy of the  
13 request together with a copy of the proposed complaint  
14 is delivered or mailed by certified mail or restricted  
15 certified mail to the director, who shall immediately  
16 forward a copy to each health care provider named as a  
17 defendant at the health care provider's last place of  
18 residence or office.

19 2. The report and any minority report of the  
20 medical review panel are admissible as evidence in any  
21 action subsequently brought by the claimant in a court  
22 of law, but the report is not conclusive and either  
23 party may call any member of the medical review panel  
24 as a witness. If called, the witness shall be  
25 required to appear and testify.

26 3. A panelist has absolute immunity from civil  
27 liability for all communications, findings, opinions,  
28 and conclusions made in the course and scope of duties  
29 of the panel.

30 Sec. \_\_\_\_ . NEW SECTION. 147B.16 COMPENSATION OF  
31 MEMBERS.

32 Each member of the medical review panel shall be  
33 paid at the rate of thirty dollars per day for all  
34 work performed as a member of the panel, exclusive of  
35 time and services involved if called as a witness to  
36 testify in court and reasonable expenses incurred.  
37 Fees of the panel, including expenses, shall be paid  
38 equally by each side. If a panel member is called as  
39 an expert witness at the trial the panelist shall be  
40 paid the customary expert witness fee.

41 Sec. \_\_\_\_ . NEW SECTION. 147B.17 PROCEEDINGS  
42 BEFORE PANEL.

43 1. Except for the introduction into evidence of  
44 the report of the panel, all proceedings before the  
45 medical review panel, all actions taken by any party  
46 or party's counsel in preparation for the proceedings,  
47 and the submission of any matter to the medical review  
48 panel shall be handled on a confidential basis. The  
49 hearing shall not be conducted as a public hearing and  
50 the proceedings before the panel are not matters of

1 public record.

2 2. Medical review panels shall be concerned only  
3 with the determination of the questions set forth in  
4 section 147B.14. The panels shall not consider or  
5 report on disputed questions of law."

6 2. Renumber as necessary.

## SENATE FILE 484

1084

Amend amendment, H-3905, to Senate File 484 as amended, passed and reprinted by the Senate, as follows:

1. By striking page 1, line 1 through page 12, line 36, and inserting the following:

"Amend Senate File 484 as amended, passed and reprinted by the Senate as follows:

By striking everything after the enacting clause and inserting the following:

"Section 1. NEW SECTION. 147B.1 SHORT TITLE.

This Act shall be known as the "Iowa Patient Compensation Fund Act".

Sec. 2. NEW SECTION. 147B.2 PUBLIC POLICY.

It is the policy of this state to assure the availability of quality medical and hospital services to the citizens of Iowa, and to effectuate that policy it is essential to assure the availability of medical liability insurance so that competent physicians will enter into and remain in the practice of medicine in this state. This chapter shall be construed to carry out this policy.

Sec. 3. NEW SECTION. 147B.3 DEFINITIONS.

As used in this chapter, unless the context requires otherwise:

1. "Administrator" means the patient compensation fund administrator.

2. "Commissioner" means the commissioner of insurance.

3. "Fund" means the patient compensation fund.

4. "Health care practitioner" means a health care provider other than a hospital.

5. "Health care provider" means a physician and surgeon licensed pursuant to chapter 148; an osteopath licensed pursuant to chapter 150; an osteopathic physician and surgeon licensed pursuant to chapter 150A; a dentist licensed pursuant to chapter 153; an association, partnership, or professional corporation composed of or owned by such persons; a hospital and an employee of such person, association, partnership, professional corporation, or hospital.

6. "Hospital" means a hospital licensed pursuant to chapter 135B.

7. "Medical malpractice" means acts or omissions of a health care practitioner in the practice of the practitioner's profession or occupation or acts or omissions of a hospital in patient treatment or care, including but not limited to negligence, failure to provide care, breach of contract relating to providing care, or claim based upon failure to obtain informed consent for an operation or treatment.

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1     Sec. 4. NEW SECTION. 147B.4 QUALIFIED PROVIDER.

2     1. A health care practitioner is qualified to  
3 participate under this chapter if the health care  
4 practitioner does all of the following:

5     a. Files with the commissioner proof that the  
6 health care practitioner is insured with an insurance  
7 company admitted to this state under a policy of  
8 medical liability insurance providing the following  
9 coverage for medical malpractice:

10     (1) Coverage pursuant to subparagraph part (a) or  
11 (b) per occurrence in an amount of one hundred percent  
12 for all sums required to be paid up to and including  
13 one hundred thousand dollars and ten percent of all  
14 sums required to be paid in excess of one hundred  
15 thousand dollars but not exceeding one million  
16 dollars:

17     (a) Under a claims-made form of medical  
18 malpractice insurance for each claim made during the  
19 term of the policy.

20     (b) Under an occurrence form of medical  
21 malpractice insurance for each claim arising out of an  
22 occurrence during the policy period.

23     (2) Coverage pursuant to subparagraph part (a) or  
24 (b) in the aggregate of five hundred seventy thousand  
25 dollars for all occurrences:

26     (a) Under a claims-made form of medical  
27 malpractice liability insurance for all claims made  
28 during the term of the policy.

29     (b) Under an occurrence form of medical  
30 malpractice insurance for all claims arising out of  
31 all occurrences during the policy period.

32     b. Pays a surcharge or special surcharge levied on  
33 health care practitioners pursuant to section 147B.6,  
34 subsection 2, or section 147B.9.

35     c. Agrees to treat victims of medical negligence  
36 for injuries resulting from such negligent acts at the  
37 current rate paid in this state pursuant to Title XIX  
38 of the federal Social Security Act.

39     2. A hospital is qualified to participate under  
40 this chapter if the hospital does both of the  
41 following:

42     a. Files with the commissioner proof that the  
43 hospital is insured with an insurance company admitted  
44 to this state under a policy of medical liability  
45 insurance providing the following coverage for medical  
46 malpractice:

47     (1) Coverage pursuant to subparagraph part (a) or  
48 (b) per occurrence in an amount of one hundred percent  
49 for all sums required to be paid up to and including  
50 one hundred thousand dollars and ten percent of all

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sums required to be paid in excess of one hundred thousand dollars but not exceeding one million dollars;

(a) Under a claims-made form of medical malpractice insurance for each claim made during the term of the policy.

(b) Under an occurrence form of medical malpractice insurance for each claim arising out of an occurrence during the policy period.

(2) Coverage pursuant to subparagraph part (a) or (b) in the aggregate of one million dollars for all occurrences:

(a) Under a claims-made form of medical malpractice liability insurance for all claims made during the term of the policy.

(b) Under an occurrence form of medical malpractice insurance for all claims arising out of all occurrences during the policy period.

b. Pays a surcharge or special surcharge levied on hospitals pursuant to section 147B.6, subsection 2, or section 147B.9.

3. Coverage required under subsections 1 and 2 shall be adjusted in the same manner as provided in section 147B.8, subsection 3.

4. The commissioner may permit qualification of a health care practitioner who has retired or ceased practicing in this state, if the health care

practitioner files proof of insurance and pays any surcharge or special surcharge levied as required in subsection 1.

5. A health care provider may qualify to participate under this chapter with respect to all medical malpractice claims made subsequent to the

health care provider's qualification. A health care provider is not eligible to qualify under this chapter with respect to a medical malpractice claim made prior

to the time of the health care provider's qualification.

6. If at any time prior to the health care provider's qualification under this section the health care provider was insured under an occurrence form of

policy of medical liability insurance for all occurrences during the term of that policy, for an occurrence of alleged medical malpractice occurring

during the time that policy was in effect, this chapter applies only to claims for alleged medical malpractice covered under the occurrence policy to the extent the judgment or settlement exceeds the limits of that policy.

Sec. 5. NEW SECTION. 147B.5 PATIENT ELECTION TO

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1 BE BOUND.

2 1. This chapter applies to all occurrences of  
3 alleged medical malpractice occurring prior to the  
4 effective date of this Act for which a medical  
5 malpractice claim has not been made unless the patient  
6 elects not to be bound under this chapter for the  
7 prior occurrence. A patient may elect not to be bound  
8 under this chapter with respect to an occurrence of  
9 alleged medical malpractice occurring prior to the  
10 effective date of this Act by filing an election with  
11 the commissioner and providing notice to any health  
12 care provider alleged to be liable for the occurrence  
13 within one hundred eighty days of the effective date  
14 of this Act according to rules adopted by the  
15 commissioner. Failure to provide the required notice  
16 is deemed to be evidence of the patient's election to  
17 be bound by this chapter for a prior occurrence.

18 2. A patient's exclusive remedy against a health  
19 care provider qualifying under section 147B.4 for  
20 medical malpractice occurring after the effective date  
21 of this Act is the remedy provided for under this  
22 chapter unless the patient has elected not to be bound  
23 by the remedies provided for in this chapter. A  
24 patient may elect not to be bound under this chapter  
25 by filing an election with the commissioner, pursuant  
26 to rules adopted by the commissioner, in advance of  
27 the treatment, act, or omission upon which a claim may  
28 be based, and notifying the health care provider of  
29 the election within a reasonable time before any  
30 treatment begins. Failure to provide the required  
31 notice is deemed to be evidence of the patient's  
32 election to be bound by this chapter. An election by  
33 a patient not to be bound by this chapter is effective  
34 for a period of two years after filing unless the  
35 election is withdrawn. The patient may withdraw the  
36 election in writing at any time by filing the  
37 withdrawal with the commissioner.

38 3. A qualified health care provider must provide a  
39 patient with notice that the health care provider is  
40 qualified under this chapter prior to any treatment,  
41 and must inform the patient of the patient's right to  
42 elect not to be bound by this chapter.

43 Sec. 6. NEW SECTION. 147B.6 PATIENT COMPENSATION  
44 FUND.

45 1. A patient compensation fund is created for the  
46 purposes stated in this chapter. The fund and income  
47 from the fund shall be deposited with the treasurer of  
48 state to be used for the payment of qualifying claims  
49 under this chapter, and the fund is appropriated for  
50 that purpose. The fund shall not be used for purposes

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other than those of this chapter. Appropriations from the fund are not subject to reversion under section 8.33.

2. An annual surcharge shall be levied on all qualified health care providers. The surcharge for a health care provider is determined by the commissioner subject to the following limitations:

a. The annual surcharge shall not exceed fifty percent of the annual premium paid by the health care provider for maintenance of current medical liability insurance as provided in section 147B.4, including the cost of reinsurance under section 147B.12.

b. The charge shall not exceed the amount necessary to maintain the fund in an amount determined by the commissioner to be actuarially adequate.

3. The surcharge due under this section is due and payable within thirty days after the surcharge has been levied on the qualified health care provider.

4. If the annual surcharge under this section is not paid within the time specified in subsection 3, the qualification of the health care provider shall be suspended until the annual surcharge is paid. The suspension is not effective as to patients claiming against the health care provider unless, at least thirty days before the effective date of the suspension, a written notice giving the date upon which the suspension becomes effective has been provided by the commissioner to the health care provider and notice of the suspension has been given to a patient prior to any treatment.

5. All actual expenses of collecting, protecting, and administering the fund shall be paid from the fund, including necessary costs of outside legal counsel. The attorney general is not responsible for legal defense of the fund.

Sec. 7. NEW SECTION. 147B.7 LIABILITY OF FUND.

Subject to section 147B.4, subsection 6, the fund is liable on a following form basis for all sums required to be paid in excess of the coverage provided by the health care provider's medical liability insurance specified in section 147B.4, subsection 1 or 2, in a medical malpractice action against a health care provider qualified to participate under this chapter by a patient who has elected to be bound under this chapter with respect to an occurrence within the state of Iowa to which this chapter applies, except as provided in section 147B.8. In no event shall the fund be liable with respect to an occurrence to which this chapter applies for more than ninety percent of nine hundred thousand dollars of all sums required to

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1 be paid in excess of one hundred thousand dollars.

2 Sec. 8. NEW SECTION. 147B.8 LIMITATION ON  
3 RECOVERY.

4 1. Except as provided in subsection 3, the total  
5 amount recoverable from all liable health care  
6 providers and the fund for an occurrence to which this  
7 chapter applies resulting in an injury or death of a  
8 patient arising out of medical malpractice shall not  
9 exceed one million dollars.

10 2. Except as provided in subsection 3, a health  
11 care provider qualified under this chapter is not  
12 liable to a patient who has elected to be covered by  
13 this chapter for an amount in excess of one hundred  
14 thousand dollars plus ten percent of all sums required  
15 to be paid in excess of one hundred thousand dollars  
16 but not exceeding one million dollars for all claims  
17 or causes of action for medical malpractice arising  
18 from an occurrence to which this chapter applies.  
19 Subject to limits in this section, an amount due from  
20 a judgment or settlement which is in excess of the  
21 liability of all liable health care providers shall be  
22 paid from the fund pursuant to section 147B.6.

23 3. a. The commissioner shall determine on or  
24 after July 1 but on or before December 31 of each year  
25 an amount by which the total amount recoverable under  
26 subsection 1 and an amount by which the maximum  
27 liability of a health care provider under subsection 2  
28 are adjusted for the calendar year beginning eighteen  
29 months after the July 1 date on which the adjusted  
30 amounts can first be determined. The amount of the  
31 adjustment is equal to the product of the amount  
32 determined for the previous calendar year and the  
33 percentage rate of change in the consumer price index  
34 for goods and services published by the United States  
35 department of labor for the fiscal year ending on June  
36 30 immediately preceding the July 1 date on which the  
37 adjusted amounts can first be determined. However, if  
38 the percentage rate of change in the consumer price  
39 index is less than five percent, adjustments shall not  
40 be made under this paragraph.

41 b. If adjustments are not made under paragraph "a"  
42 for one or more years, the commissioner shall  
43 determine a cumulative percentage rate of change and  
44 when that cumulative percentage rate of change is five  
45 percent or greater the commissioner shall determine  
46 the adjusted amounts for the next rate adjustment  
47 year.

48 c. The commissioner shall publish on or before  
49 December 31 preceding the next rate adjustment year  
50 any adjusted amounts which will apply to the next rate

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adjustment year.

4. If a judgment has been entered for an injured person, as defined in section 147B.10, which exceeds the amount recoverable as determined under this section, the injured person may file a claim pursuant to chapter 25 for the amount in excess of the amount recoverable.

Sec. 9. NEW SECTION. 147B.9 SPECIAL SURCHARGE.

The commissioner may, at any time, analyze the fund to determine if the amount in the fund is inadequate to pay in full all claims allowed or to be allowed during the calendar year. If the fund is determined to be inadequate, the commissioner may levy a special surcharge on all health care providers who have qualified under this chapter on the date of the special surcharge or at any time during the preceding twelve months and the special surcharge shall be in an amount proportionate to the surcharge each health care provider has paid to the fund. The special surcharge shall be an amount sufficient to permit full payment of all claims allowed against the fund during a calendar year, but shall not exceed fifty percent of the annual premium paid by the health care provider for maintenance of current medical liability insurance as provided in section 147B.4. The special surcharge shall be levied against all health care providers who have qualified under this chapter. The special surcharge is due and payable within thirty days after the special surcharge is levied.

If the special surcharge under this section is not paid within the time specified, the qualification of the health care provider shall be suspended until the special surcharge is paid. The suspension is not effective as to patients claiming against the health care provider unless, at least thirty days before the effective date of the suspension, a written notice giving the date upon which the suspension becomes effective has been provided by the commissioner to the health care provider and notice of the suspension has been given to a patient prior to any treatment.

Sec. 10. NEW SECTION. 147B.9A EVIDENCE OF ADVANCE PAYMENT NOT CONSTRUED AS ADMISSION TO LIABILITY.

A payment made by a health care provider or the health care provider's insurer to or for the patient or any other person on the patient's behalf in advance of a final determination of liability shall not be construed as an admission of liability for injuries or damages suffered in an action brought pursuant to this chapter. In the event of any advance payment, the

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1 court shall reduce the judgment to the plaintiff by an  
2 amount of the advance payment. If the advance payment  
3 exceeds the liability of the defendant, the court  
4 shall order any adjustment necessary to equalize the  
5 amount under which each defendant is obligated to pay  
6 but in no case shall an advance in excess of the  
7 amount found to be due be repayable to the health care  
8 provider making the advance.

9 Sec. 11. NEW SECTION. 147B.10 STRUCTURED  
10 JUDGMENTS.

11 1. As used in this section, unless the context  
12 requires otherwise:

13 a. "Future injuries" means all legal harm relating  
14 to an injury which the trier of fact determines will  
15 be incurred by the injured party subsequent to the  
16 entry of judgment.

17 b. "Injured person" means the person during whose  
18 medical treatment or care the acts or omissions of  
19 medical malpractice are determined to have occurred.

20 c. "Injured party" means a party plaintiff to a  
21 medical malpractice action, and includes the injured  
22 person if that person is a party to the action.

23 d. "Injury" means a legal harm for which damages  
24 are recoverable in an action arising under this  
25 chapter.

26 2. In a medical malpractice action against a  
27 health care provider arising under this chapter, the  
28 verdict shall be itemized to distribute the monetary  
29 damages, if any, between past loss and future loss.  
30 In a trial to the court, the court shall itemize its  
31 findings in accordance with this section.

32 3. The court, in a medical malpractice action  
33 arising under this chapter in which a damage award for  
34 future injuries to a party exceeds one hundred  
35 thousand dollars, shall enter a judgment ordering the  
36 award to the party to be paid in periodic payments,  
37 subject to the limitations contained in this section.  
38 The court shall make a specified finding as to the  
39 dollar amount of regular payments which will be  
40 required to compensate the party periodically for loss  
41 of future income and future noneconomic harm, based  
42 upon the life expectancy of the party and the damages  
43 awarded. The periodic payments shall reflect interest  
44 in accordance with annuity principles. The judgment  
45 shall specify the recipient of the periodic payments,  
46 the dollar amount of each payment, the interval  
47 between payments, and the number of payments required  
48 to be made. The judgment shall specify the amount of  
49 and the purposes for which the balance of the judgment  
50 awarded for the future care and treatment of the party

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may be used.

2 4. Attorney fees of the party receiving an award,  
3 if payable out of the judgment, shall be assessed by  
4 the court and applied pro rata against amounts awarded  
5 for past injuries and for future injuries. The amount  
6 determined by the court to be payable out of damages  
7 for future injuries shall be deducted by the court  
8 from the amount to be ordered paid as provided in this  
9 subsection, and shall be deducted pro rata from those  
10 amounts awarded, if any, for loss of future income,  
11 future expenses for care and treatment, and future  
12 noneconomic harm. The amount of attorney fees  
13 attributable to the award for future injuries shall be  
14 payable upon entry of judgment.

15 5. If a judgment has been entered ordering  
16 periodic payments pursuant to this section, the health  
17 care provider's insurer shall pay to the fund the  
18 amount for which the insurer is liable under this  
19 chapter, after apportionment of costs of defense, for  
20 distribution by the fund to the party receiving the  
21 award.

22 6. If a judgment has been entered ordering  
23 periodic payments pursuant to this section, the fund  
24 shall make the payments as ordered or, alternatively,  
25 the fund may purchase an annuity from an insurance  
26 company admitted to Iowa sufficient to make the  
27 periodic payments.

28 7. If the party receiving the award dies, amounts  
29 to be paid for loss of future income are payable to  
30 those persons to whom the party receiving the award  
31 owed a duty of support. If the party receiving the  
32 award dies prior to payment of the amounts for other  
33 than loss of future income, the judgment is satisfied  
34 upon the payment of all obligations incurred up to the  
35 time of death and of the expenses of final illness and  
36 reasonable burial expenses.

37 8. Except with respect to amounts representing  
38 loss of future income, a judgment for future injuries  
39 is a contingent award, and the right to payment vests  
40 only at such times and in such amounts as accrue  
41 pursuant to the order specifying the amount of  
42 periodic payments and the interval of those payments.

43 9. The district court shall retain jurisdiction of  
44 a medical malpractice action in which the judgment in  
45 the action orders periodic payments, and upon the  
46 death of the party receiving the award in the case of  
47 an award for loss of future income, the dependents of  
48 the decedent or any other interested party to the  
49 action or a representative of an interested party, may  
petition the court for a modification of the judgment

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1 for a redesignation of the recipient of the payments,  
2 in accordance with the rights of persons established  
3 by this section. Unless otherwise ordered, the  
4 redesignated recipients of payments for loss of future  
5 income shall be paid in those amounts and at those  
6 intervals specified in the original judgment.  
7 Payments shall continue until the remaining amounts  
8 designated for that purpose have been paid, or until  
9 the death of those dependents, whichever occurs first.  
10 If the last surviving dependent dies prior to  
11 depletion of the amount specified for loss of future  
12 income, the judgment is deemed satisfied upon payment  
13 of amounts accrued up to the time of death.

14 Sec. 12. NEW SECTION. 147B.11 COSTS OF DEFENSE.

15 1. The fund may employ the services of outside  
16 legal counsel to defend the fund against claims and to  
17 assist the health care provider's insurer in defending  
18 the claim.

19 2. The fund may by agreement with the health care  
20 provider's insurer, allow the health care provider's  
21 insurer to provide a defense for a claim against the  
22 health care provider and the fund. The fund and the  
23 health care provider's insurer may agree to any  
24 apportionment of the costs of defense.

25 Sec. 13. NEW SECTION. 147B.12 REINSURANCE.

26 The commissioner may cause all or any part of the  
27 potential liability of the fund to be reinsured, if  
28 reinsurance is available on a fair and reasonable  
29 basis. The cost of the reinsurance shall be paid by  
30 the fund and the fact of the reinsurance shall be  
31 taken into account in determining the surcharge under  
32 section 147B.6, subsection 2, or the special surcharge  
33 under section 147B.9.

34 Sec. 14. NEW SECTION. 147B.13 NOTICE --

35 APPLICATION FEE.

36 1. Prior to consideration for coverage pursuant to  
37 this chapter, a health care provider shall first give  
38 notice to the commissioner of the provider's intention  
39 to apply for coverage. The notice of intention shall  
40 be accompanied by a one-time application fee of fifty  
41 dollars for health care providers and five hundred  
42 dollars for hospitals.

43 2. Funds received by the commissioner pursuant to  
44 subsection 1 shall only be expended for purposes of  
45 payment of the reasonable expenses incurred or to be  
46 incurred in the implementation of this chapter.

47 3. To the extent that funds received pursuant to  
48 subsection 1 are in excess of the expenses of  
49 implementation of this chapter, the commissioner shall  
50 transfer such excess funds to the fund.

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4. Notice and application fees received subsequent to the implementation of this chapter shall be placed in the fund upon receipt.

4 Sec. 15. NEW SECTION. 147B.14 PATIENT  
5 COMPENSATION FUND ADMINISTRATOR.

5 The commissioner may appoint an administrator to  
7 perform all duties and responsibilities pursuant to  
8 this chapter. The administrator shall serve as  
9 administrator at the pleasure of the commissioner.  
10 The salary and expenses of the administrator shall be  
11 paid from the fund.

12 Sec. 16. NEW SECTION. 147B.15 ADMINISTRATION.

13 The commissioner shall either provide staff  
14 services necessary for the operation of this chapter  
15 or may contract with an insurance company licensed to  
16 do business in this state, or both, to perform any  
17 administrative duties and responsibilities of the  
18 commissioner pursuant to this chapter. The  
19 commissioner shall retain supervisory control over all  
20 matters for which a contract is entered into. All  
21 reasonable costs and charges incurred in the  
22 administration of this chapter shall be paid from the  
23 fund.

24 The administrator and all persons employed or  
contracted with to provide staff services necessary  
for the operation of this chapter shall not be  
27 considered employees of the state except for purposes  
28 of chapter 25A.

29 Sec. 17. NEW SECTION. 147B.16 RECIPROCITY.

30 The commissioner may enter into reciprocity  
31 agreements with the authorized representatives of any  
32 jurisdiction to allow health care providers from that  
33 jurisdiction to become qualified health care providers  
34 for purposes of the fund and to the extent that a  
35 claim against the health care provider arises in this  
36 state.

37 An agreement shall only be entered into with a  
38 jurisdiction to the same extent as the other  
39 jurisdiction allows Iowa health care providers to  
40 participate in a similar program in the other  
41 jurisdiction. The agreement shall include any  
42 conditions, restrictions, and privileges the  
43 commissioner deems necessary.

44 Sec. 18. NEW SECTION. 147B.17 ANNUAL REPORT.

45 The commissioner shall, pursuant to rules issued by  
46 the commissioner, on or before the first day of  
47 February of each year, provide to the chairs, vice  
48 chairs, and ranking members of the senate standing  
committees on judiciary and commerce, and the house of  
representatives standing committees on judiciary and

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1 law enforcement, and small business and commerce, a  
2 report regarding claims filed against the fund and  
3 claims closed involving the fund for the previous  
4 calendar year. The report shall contain to the extent  
5 the information is available the following  
6 information:

- 7 1. Parties to the claims.
- 8 2. Cause or causes of action.
- 9 3. Amounts reserved or paid per claim, including  
10 the present value for structured settlements or  
11 awards.
- 12 4. Legal fees, expert witness fees, court costs,  
13 or other associated costs of judgments or decrees per  
14 claim.
- 15 5. Other claims information as deemed necessary by  
16 the commissioner.

17 6. The report shall be a public record.

18 Sec. 19. NEW SECTION. 147B.17A REPORT TO HEALTH  
19 DATA COMMISSION.

20 It is the intent and expectation of the general  
21 assembly that health care providers will pass on to  
22 patients, third-party payors, and self-insurers,  
23 savings realized by the health care providers  
24 resulting from this Act. The health data commission  
25 shall analyze the physician billing information  
26 collected pursuant to section 145.3, subsection 3,  
27 paragraph "h", to determine whether the savings  
28 resulting from this Act are being passed on. The  
29 health data commission shall report its findings to  
30 the general assembly by July 1, 1989.

31 Sec. 20. NEW SECTION. 147B.18 RULES.

32 The commissioner shall establish rules relating to  
33 the administration of this chapter as deemed necessary  
34 by the commissioner to promote the efficient operation  
35 of this chapter in accordance with its terms and  
36 intent.

37 Sec. 21. Section 25.1, Code 1987, is amended to  
38 read as follows:

39 25.1 RECEIPT, INVESTIGATION, AND REPORT.

40 When a claim is filed or made against the state, on  
41 which in the judgment of the director of management  
42 the state would be liable except for the fact of its  
43 sovereignty or which has no appropriation available  
44 for its payment, the director of management shall  
45 deliver said claim to the state appeal board. The  
46 state appeal board shall make a record of the receipt  
47 of said claim and forthwith deliver same to the  
48 special assistant attorney general for claims who  
49 shall, with a view to determining the merits and  
50 legality thereof, fully investigate said claim,

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including the facts upon which it is based and report  
in duplicate findings and conclusions of law to the  
state appeal board. Notwithstanding this section, any  
claim made for an amount recoverable pursuant to  
section 147B.8, subsection 4, shall be delivered  
directly to the state appeal board.

Sec. 22. Section 25.2, Code 1987, is amended to  
read as follows:

25.2 EXAMINATION OF REPORT -- APPROVAL OR  
REJECTION -- PAYMENT.

The state appeal board with the recommendation of  
the special assistant attorney general for claims may  
approve or reject claims against the state of less  
than ten years covering the following: Outdated  
warrants; outdated sales and use tax refunds; license  
refunds; additional agricultural land tax credits;  
outdated invoices; fuel and gas tax refunds; outdated  
homestead and veterans' exemptions; outdated funeral  
service claims; tractor fees; registration permits;  
outdated bills for merchandise; services furnished to  
the state; claims by any county or county official  
relating to the personal property tax credit; and  
refunds of fees collected by the state; and amounts  
recoverable pursuant to section 147B.8, subsection 4.  
Payments authorized by the state appeal board shall be  
paid from the appropriation or fund of original  
certification of the claim, except, that if such  
appropriation or fund has since reverted under section  
8.33 or the claim is made for an amount recoverable  
pursuant to section 147B.8, subsection 4, then such  
payment authorized by the state appeal board shall be  
out of any money in the state treasury not otherwise  
appropriated. Notwithstanding the provisions of this  
section, the state comptroller may reissue outdated  
warrants.

Sec. 23. FINDINGS. The general assembly finds and  
declares that it is in the public interest that the  
availability of competent health care services be  
assured and that a mechanism exists for providing  
total compensation of persons injured as a result of  
medical malpractice. The general assembly further  
finds and declares that it is in the public interest  
that high quality medical and hospital services be  
available to the citizens of Iowa at reasonable costs.  
It is essential to the public interest to assure  
continuing availability of medical care to encourage  
competent physicians to enter into and remain in the  
practice of medicine in this state. It is in the  
public interest to assure that funds are available to  
compensate an injured party while providing for the

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1 availability of medical liability insurance.  
 2 The general assembly further finds and declares  
 3 that a critical situation exists impacting on the  
 4 accessibility and affordability of quality health care  
 5 for Iowa citizens because of the high cost and  
 6 impending unavailability of medical malpractice  
 7 insurance. Physicians in certain speciality and high-  
 8 risk areas are increasingly choosing no longer to  
 9 provide these services as a result of the potential  
 10 liability and the high cost and uncertain availability  
 11 of medical liability insurance. The general assembly  
 12 further finds that it is in the public interest that  
 13 statistical data be obtained so that an analysis of  
 14 the cause of unavailability and unaffordability of  
 15 liability insurance be undertaken in an attempt to  
 16 determine the cause of such problems so that a long-  
 17 term solution can be found.

18 The general assembly further finds that to assure  
 19 the uninterrupted delivery of affordable health care  
 20 services to the citizens of Iowa it is necessary to  
 21 carefully balance the interest of persons who are  
 22 damaged by medical accidents and the interest of all  
 23 persons, who may be in need of future medical care, in  
 24 keeping medical liability insurance affordable and  
 25 available in this state. The general assembly further  
 26 finds that without medical liability insurance,  
 27 physicians, other health care providers, and hospitals  
 28 cannot provide health care services to the public.

29 The general assembly further finds that the present  
 30 critical situation has resulted in a decrease in the  
 31 availability of certain health care services and that  
 32 this problem of availability will become more severe  
 33 unless addressed. Physicians are discontinuing their  
 34 practices and leaving Iowa.

35 The general assembly further finds and declares it  
 36 is necessary and essential that the provisions of this  
 37 Act be enacted in order to provide for the health and  
 38 welfare of the people of Iowa. It is the intent of  
 39 this Act to protect the health and welfare of the  
 40 people of this state by assuring the availability of  
 41 health care services.

42 Sec. 24. Notwithstanding section 4.12, if any pro-  
 43 vision of this Act is held invalid, the whole Act is  
 44 invalid, and to this end the provisions of the Act are  
 45 not severable.

46 Sec. 25. This Act takes effect upon enactment, and  
 47 the commissioner shall take all actions necessary to  
 48 implement the provisions of this Act on or before  
 49 January 1, 1988."

BY SWARTZ of Marshall  
 HARBOR of Mills  
 RUNNING of Linn  
 SCHNEKLOTH of Scott

SHOULTZ of Black Hawk  
 ROYER of Page  
 SKOW of Guthrie  
 CHAPMAN of Linn

H-4084 FILED APRIL 29, 1987

*Placed o/s 4/6/88 (p. 1500)*

## SENATE FILE 484

4018

Amend the amendment, H-3905, to Senate File 484 as amended, passed, and reprinted by the Senate, as follows:

1. By striking page 1, line 49 through page 2, line 1.

2. By striking page 2, line 11 through page 12, line 36 and inserting the following:

"Sec. \_\_\_\_ . NEW SECTION. 147B.3 MALPRACTICE INSURANCE FUND.

The state shall establish a medical malpractice insurance fund which shall be administered by the division of insurance of the department of commerce. The fund shall be established by January 1, 1988 and shall operate under the following conditions:

1. Every hospital licensed pursuant to 135B, every physician and surgeon licensed pursuant to chapter 148, every osteopath licensed pursuant to chapter 150, and every osteopathic physician and surgeon licensed pursuant to chapter 150A shall participate.

2. The insurance division shall underwrite the coverage provided by the fund by an initial surcharge of each hospital and health care provider required to participate pursuant to subsection 1. The surcharge is to be allocated on a scale determined equitably by the division based upon the premiums paid by each provider.

3. The continuing rates charged health care providers and hospitals shall be determined by generally accepted actuarial methods using Iowa loss experience only.

4. The division shall classify health care providers into four classifications based upon the amount of surgery performed and the risk of diagnostic and therapeutic services provided or procedures performed.

Sec. \_\_\_\_ . NEW SECTION. 147B.4 COVERAGE OPTION.

A hospital may elect not to participate under this chapter if the hospital can prove that it has adequate coverage either through self-insurance or other insurance as determined and approved by the division. A hospital may indemnify a health care provider listed in section 147B.3, subsection 1, and thereby allow that health care provider to elect not to participate under this chapter. The indemnification agreement shall be in conformance with section 147B.5.

Sec. \_\_\_\_ . NEW SECTION. 147B.5 INDEMNIFICATION AGREEMENT.

1. An agreement between a hospital and a health care provider may be entered into providing that the hospital shall indemnify the health care provider for

1 any liability of the health care provider arising  
 2 while the health care provider is providing services  
 3 only at the hospital with which the agreement is made.  
 4 The agreement may provide that the hospital shall  
 5 indemnify the health care provider for liability  
 6 arising from services provided outside of the  
 7 hospital.

8 2. Before entering into an agreement pursuant to  
 9 this section, a hospital may require the health care  
 10 provider to provide information regarding all claims  
 11 filed against the health care provider and losses  
 12 resulting from the claims."

13 3. By renumbering as necessary.

H-4018 FILED APRIL 27, 1987 BY JAY of Appanoose

*Handwritten note:* Amend H-3905

SENATE FILE 484

H-4017

1 Amend the amendment, H-3905, to Senate File 484 as  
 2 amended, passed, and reprinted by the Senate, as  
 3 follows:

4 1. Page 11, by inserting after line 49 the  
 5 following:

6 "Sec. \_\_\_\_ . NEW SECTION. 147B.16A DISCLOSURE OF  
 7 CLAIMS.

8 1. All medical liability claims settled or  
 9 adjudicated to final judgment against a health care  
 10 provider and any liability claim closed without  
 11 payment during the calendar year shall be reported to  
 12 the commissioner by the health care provider or the  
 13 provider's medical liability insurer. The report  
 14 shall be submitted to the commissioner on or before  
 15 the first day of February for claims for the previous  
 16 calendar year.

17 2. The reports shall contain all of the following  
 18 information:

19 a. Nature of each claim and damages asserted.

20 b. Amount of settlement or judgment, if any.

21 c. Professional and legal issues asserted with  
 22 regard to each claim.

23 d. Specialty of each health care provider against  
 24 whom each claim is filed and closed.

25 3. The reports shall be transmitted to the board  
 26 of medical examiners. A report containing all the  
 27 information included in the individual reports shall  
 28 be made available to the public by the board for each  
 29 calendar year."

30 2. Page 12, by inserting after line 28 the  
 31 following:

32 "Sec. \_\_\_\_ . The commissioner shall collect  
 33 information concerning all claims initiated and  
 34 settled or adjudicated to final judgment or closed  
 35 without payment against any health care provider  
 36 currently licensed to practice in this state for the  
 37 ten-year period preceding the effective date of this  
 38 Act. This report shall be made available to the  
 39 public no later than January 1, 1989."

40 3. Renumber as necessary.

H-4017 FILED APRIL 27, 1987

BY HANSEN of Woodbury

## SENATE FILE 484

H-4256

1 Amend the amendment, H-3700, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 1, by inserting after line 2 the fol-  
5 lowing:

6 "\_\_\_\_\_. By striking everything after the enacting  
7 clause and inserting the following:

8 "Section 1. FINDINGS. The general assembly finds  
9 and declares that it is in the public interest that  
10 high quality medical and hospital services be  
11 available to the citizens of Iowa at reasonable costs.  
12 It is essential to the public interest to assure  
13 continuing availability of medical care to encourage  
14 competent physicians to enter into and remain in the  
15 practice of medicine in this state. It is in the  
16 public interest to assure that funds are available to  
17 compensate an injured party while providing for the  
18 availability of medical liability insurance.

19 The general assembly further finds and declares  
20 that a critical situation exists impacting on the  
21 accessibility and affordability of quality health care  
22 for Iowa citizens because of the high cost and  
23 impending unavailability of medical malpractice  
24 insurance. Physicians in certain speciality and high-  
25 risk areas are increasingly choosing no longer to  
26 provide these services as a result of the potential  
27 liability and the high cost and uncertain availability  
28 of medical liability insurance.

29 The general assembly further finds that to assure  
30 the uninterrupted delivery of affordable health care  
31 services to the citizens of Iowa it is necessary to  
32 carefully balance the interest of persons who are  
33 damaged by medical accidents and the interest of all  
34 persons, who may be in need of future medical care, in  
35 keeping medical liability insurance affordable and  
36 available in this state. The general assembly further  
37 finds that without medical liability insurance,  
38 physicians, other health care providers, and hospitals  
39 cannot provide health care services to the public.

40 The general assembly further finds that the present  
41 critical situation has resulted in a decrease in the  
42 availability of certain health care services and that  
43 this problem of availability will become more severe  
44 unless addressed. Physicians are discontinuing their  
45 practices and leaving Iowa.

46 The general assembly further finds and declares it  
47 is necessary and essential that the provisions of this  
48 Act be enacted in order to provide for the health and  
49 welfare of the people of Iowa. It is the intent of  
50 this Act to protect the health and welfare of the

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1 people of this state by assuring the availability of  
2 health care services.

3 Sec. 2. NEW SECTION. 147B.1 SHORT TITLE.

4 This Act shall be known as the "Iowa Patient  
5 Compensation Fund Act".

6 Sec. 3. NEW SECTION. 147B.2 PUBLIC POLICY.

7 It is the policy of this state to assure the avail-  
8 ability of quality medical and hospital services to  
9 the citizens of Iowa, and to effectuate that policy it  
10 is essential to assure the availability of medical  
11 liability insurance so that competent physicians will  
12 enter into and remain in the practice of medicine in  
13 this state. This chapter shall be construed to carry  
14 out this policy.

15 Sec. 4. NEW SECTION. 147B.3 DEFINITIONS.

16 As used in this chapter, unless the context  
17 requires otherwise:

18 1. "Administrator" means the patient compensation  
19 fund administrator.

20 2. "Commissioner" means the commissioner of  
21 insurance.

22 3. "Fund" means the patient compensation fund.

23 4. "Health care practitioner" means a health care  
24 provider other than a hospital.

25 5. "Health care provider" means a physician and  
26 surgeon licensed pursuant to chapter 148; an osteopath  
27 licensed pursuant to chapter 150; an osteopathic  
28 physician and surgeon licensed pursuant to chapter  
29 150A; an association, partnership, or professional  
30 corporation composed of or owned by such persons; a  
31 hospital and an employee of such person, association,  
32 partnership, professional corporation, or hospital.

33 6. "Hospital" means a hospital licensed pursuant  
34 to chapter 135B.

35 7. "Medical malpractice" means acts or omissions  
36 of a health care practitioner in the practice of the  
37 practitioner's profession or occupation or acts or  
38 omissions of a hospital in patient treatment or care,  
39 including but not limited to negligence, failure to  
40 provide care, breach of contract relating to providing  
41 care, or claim based upon failure to obtain informed  
42 consent for an operation or treatment.

43 Sec. 5. NEW SECTION. 147B.4 QUALIFIED PROVIDER.

44 1. A health care practitioner is qualified to  
45 participate under this chapter if the health care  
46 practitioner does both of the following:

47 a. Files with the commissioner proof that the  
48 health care practitioner is insured with an insurance  
49 company admitted to this state under a policy of  
50 medical liability insurance providing the following

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coverage for medical malpractice:

2 (1) Coverage pursuant to subparagraph part (a) or  
3 (b) per occurrence in an amount of one hundred percent  
4 for all sums required to be paid up to and including  
5 one hundred thousand dollars and ten percent of all  
6 sums required to be paid in excess of one hundred  
7 thousand dollars but not exceeding one million  
8 dollars:

9 (a) Under a claims-made form of medical  
10 malpractice insurance for each claim made during the  
11 term of the policy.

12 (b) Under an occurrence form of medical  
13 malpractice insurance for each claim arising out of an  
14 occurrence during the policy period.

15 (2) Coverage pursuant to subparagraph part (a) or  
16 (b) in the aggregate of three hundred thousand dollars  
17 for all occurrences:

18 (a) Under a claims-made form of medical  
19 malpractice liability insurance for all claims made  
20 during the term of the policy.

21 (b) Under an occurrence form of medical  
22 malpractice insurance for all claims arising out of  
23 all occurrences during the policy period.

24 b. Pays a surcharge or special surcharge levied on  
25 health care practitioners pursuant to section 147B.8,  
26 subsection 2, or section 147B.9.

27 2. A hospital is qualified to participate under  
28 this chapter if the hospital does both of the  
29 following:

30 a. Files with the commissioner proof that the  
31 hospital is insured with an insurance company admitted  
32 to this state under a policy of medical liability  
33 insurance providing the following coverage for medical  
34 malpractice:

35 (1) Coverage pursuant to subparagraph part (a) or  
36 (b) per occurrence in an amount of one hundred percent  
37 for all sums required to be paid up to and including  
38 one hundred thousand dollars and ten percent of all  
39 sums required to be paid in excess of one hundred  
40 thousand dollars but not exceeding one million  
41 dollars:

42 (a) Under a claims-made form of medical  
43 malpractice insurance for each claim made during the  
44 term of the policy.

45 (b) Under an occurrence form of medical  
46 malpractice insurance for each claim arising out of an  
47 occurrence during the policy period.

48 (2) Coverage pursuant to subparagraph part (a) or  
49 (b) in the aggregate of one million dollars for all  
50 occurrences:

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1 (a) Under a claims-made form of medical  
2 malpractice liability insurance for all claims made  
3 during the term of the policy.

4 (b) Under an occurrence form of medical  
5 malpractice insurance for all claims arising out of  
6 all occurrences during the policy period.

7 b. Pays a surcharge or special surcharge levied on  
8 hospitals pursuant to section 147B.8, subsection 2, or  
9 section 147B.9.

10 3. Coverage required under subsections 1 and 2  
11 shall be adjusted in the same manner as provided in  
12 section 147B.7, subsection 3.

13 4. The commissioner may permit qualification of a  
14 health care practitioner who has retired or ceased  
15 practicing in this state, if the health care  
16 practitioner files proof of insurance and pays any  
17 surcharge or special surcharge levied as required in  
18 subsection 1.

19 5. A health care provider may qualify to  
20 participate under this chapter with respect to all  
21 medical malpractice claims made subsequent to the  
22 health care provider's qualification. A health care  
23 provider is not eligible to qualify under this chapter  
24 with respect to a medical malpractice claim made prior  
25 to the time of the health care provider's  
26 qualification.

27 6. If at any time prior to the health care  
28 provider's qualification under this section the health  
29 care provider was insured under an occurrence form of  
30 policy of medical liability insurance for all  
31 occurrences during the term of that policy, for an  
32 occurrence of alleged medical malpractice occurring  
33 during the time that policy was in effect, this  
34 chapter applies only to claims for alleged medical  
35 malpractice covered under the occurrence policy to the  
36 extent the judgment or settlement exceeds the limits  
37 of that policy.

38 Sec. 6. NEW SECTION. 147B.5 PATIENT ELECTION TO  
39 BE BOUND.

40 1. This chapter applies to all occurrences of  
41 alleged medical malpractice occurring prior to the  
42 effective date of this Act for which a medical  
43 malpractice claim has not been made unless the patient  
44 elects not to be bound under this chapter for the  
45 prior occurrence. A patient may elect not to be bound  
46 under this chapter with respect to an occurrence of  
47 alleged medical malpractice occurring prior to the  
48 effective date of this Act by filing an election with  
49 the commissioner and providing notice to any health  
50 care provider alleged to be liable for the occurrence

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1 within one hundred eighty days of the effective date  
2 of this Act according to rules adopted by the  
3 commissioner. Failure to provide the required notice  
4 is deemed to be evidence of the patient's election to  
5 be bound by this chapter for a prior occurrence.

6 2. A patient's exclusive remedy against a health  
7 care provider qualifying under section 147B.4 for  
8 medical malpractice occurring after the effective date  
9 of this Act is the remedy provided for under this  
10 chapter unless the patient has elected not to be bound  
11 by the remedies provided for in this chapter. A  
12 patient may elect not to be bound under this chapter  
13 by filing an election with the commissioner, pursuant  
14 to rules adopted by the commissioner, in advance of  
15 the treatment, act, or omission upon which a claim may  
16 be based, and notifying the health care provider of  
17 the election within a reasonable time before any  
18 treatment begins. Failure to provide the required  
19 notice is deemed to be evidence of the patient's  
20 election to be bound by this chapter. An election by  
21 a patient not to be bound by this chapter is effective  
22 for a period of two years after filing unless the  
23 election is withdrawn. The patient may withdraw the  
24 election in writing at any time by filing the  
25 withdrawal with the commissioner.

26 3. A qualified health care provider must provide a  
27 patient with notice that the health care provider is  
28 qualified under this chapter prior to any treatment,  
29 and must inform the patient of the patient's right to  
30 elect not to be bound by this chapter.

31 Sec. 7. NEW SECTION. 147B.6 LIABILITY OF FUND.  
32 Subject to section 147B.4, subsection 6, the fund  
33 is liable on a following form basis for all sums  
34 required to be paid in excess of the coverage provided  
35 by the health care provider's medical liability  
36 insurance specified in section 147B.4, subsection 1 or  
37 2, in a medical malpractice action against a health  
38 care provider qualified to participate under this  
39 chapter by a patient who has elected to be bound under  
40 this chapter with respect to an occurrence within the  
41 state of Iowa to which this chapter applies, except as  
42 provided in section 147B.7.

43 Sec. 8. NEW SECTION. 147B.7 LIMITATION ON  
44 RECOVERY.

45 1. Except as provided in subsection 3, the total  
46 amount recoverable from all liable health care  
47 providers and the fund for an occurrence to which this  
48 chapter applies resulting in an injury or death of a  
49 patient arising out of medical malpractice shall not  
50 exceed one million dollars.

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1 2. Except as provided in subsection 3, a health  
2 care provider qualified under this chapter is not  
3 liable to a patient who has elected to be covered by  
4 this chapter for an amount in excess of one hundred  
5 thousand dollars plus ten percent of all sums required  
6 to be paid in excess of one hundred thousand dollars  
7 but not exceeding one million dollars for all claims  
8 or causes of action for medical malpractice arising  
9 from an occurrence to which this chapter applies.

10 Subject to limits in this section, an amount due from  
11 a judgment or settlement which is in excess of the  
12 liability of all liable health care providers shall be  
13 paid from the fund pursuant to section 147B.8.

14 3. a. The commissioner shall determine on or  
15 after July 1 but on or before December 31 of each year  
16 an amount by which the total amount recoverable under  
17 subsection 1 and an amount by which the maximum  
18 liability of a health care provider under subsection 2  
19 are adjusted for the calendar year beginning eighteen  
20 months after the July 1 date on which the adjusted  
21 amounts can first be determined. The amount of the  
22 adjustment is equal to the product of the amount  
23 determined for the previous calendar year and the  
24 percentage rate of change in the consumer price index  
25 for goods and services published by the United States  
26 department of labor for the fiscal year ending on June  
27 30 immediately preceding the July 1 date on which the  
28 adjusted amounts can first be determined. However, if  
29 the percentage rate of change in the consumer price  
30 index is less than five percent, adjustments shall not  
31 be made under this paragraph.

32 b. If adjustments are not made under paragraph "a"  
33 for one or more years, the commissioner shall  
34 determine a cumulative percentage rate of change and  
35 when that cumulative percentage rate of change is five  
36 percent or greater the commissioner shall determine  
37 the adjusted amounts for the next rate adjustment  
38 year.

39 c. The commissioner shall publish on or before  
40 December 31 preceding the next rate adjustment year  
41 any adjusted amounts which will apply to the next rate  
42 adjustment year.

43 Sec. 9. NEW SECTION. 147B.8 PATIENT COMPENSATION  
44 FUND.

45 1. A patient compensation fund is created for the  
46 purposes stated in this chapter. The fund and income  
47 from the fund shall be deposited with the treasurer of  
48 state to be used for the payment of qualifying claims  
49 under this chapter, and the fund is appropriated for  
50 that purpose. The fund shall not be used for purposes

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1 other than those of this chapter. Appropriations from  
2 the fund are not subject to reversion under section  
3 8.33.

4 2. An annual surcharge shall be levied on all  
5 qualified health care providers. The surcharge for a  
6 health care provider is determined by the commissioner  
7 subject to the following limitations:

8 a. The annual surcharge shall not exceed fifty  
9 percent of the annual premium paid by the health care  
10 provider for maintenance of current medical liability  
11 insurance as provided in section 147B.4, including the  
12 cost of reinsurance under section 147B.12.

13 b. The charge shall not exceed the amount  
14 necessary to maintain the fund in an amount determined  
15 by the commissioner to be actuarially adequate.

16 3. The surcharge due under this section is due and  
17 payable within thirty days after the surcharge has  
18 been levied on the qualified health care provider.

19 4. If the annual surcharge under this section is  
20 not paid within the time specified in subsection 3,  
21 the qualification of the health care provider shall be  
22 suspended until the annual surcharge is paid. The  
23 suspension is not effective as to patients claiming  
24 against the health care provider unless, at least  
25 thirty days before the effective date of the  
26 suspension, a written notice giving the date upon  
27 which the suspension becomes effective has been  
28 provided by the commissioner to the health care  
29 provider and notice of the suspension has been given  
30 to a patient prior to any treatment.

31 5. All actual expenses of collecting, protecting,  
32 and administering the fund shall be paid from the  
33 fund, including necessary costs of outside legal  
34 counsel. The attorney general is not responsible for  
35 legal defense of the fund.

36 Sec. 10. NEW SECTION. 147B.9 SPECIAL SURCHARGE.  
37 The commissioner may, at any time, analyze the fund  
38 to determine if the amount in the fund is inadequate  
39 to pay in full all claims allowed or to be allowed  
40 during the calendar year. If the fund is determined  
41 to be inadequate, the commissioner may levy a special  
42 surcharge on all health care providers who have  
43 qualified under this chapter on the date of the  
44 special surcharge or at any time during the preceding  
45 twelve months and the special surcharge shall be in an  
46 amount proportionate to the surcharge each health care  
47 provider has paid to the fund. The special surcharge  
48 shall be an amount sufficient to permit full payment  
49 of all claims allowed against the fund during a  
50 calendar year, but shall not exceed fifty percent of

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1 the annual premium paid by the health care provider  
2 for maintenance of current medical liability insurance  
3 as provided in section 147B.4. The special surcharge  
4 shall be levied against all health care providers who  
5 have qualified under this chapter. The special sur-  
6 charge is due and payable within thirty days after the  
7 special surcharge is levied.

8 If the special surcharge under this section is not  
9 paid within the time specified, the qualification of  
10 the health care provider shall be suspended until the  
11 special surcharge is paid. The suspension is not  
12 effective as to patients claiming against the health  
13 care provider unless, at least thirty days before the  
14 effective date of the suspension, a written notice  
15 giving the date upon which the suspension becomes  
16 effective has been provided by the commissioner to the  
17 health care provider and notice of the suspension has  
18 been given to a patient prior to any treatment.

19 Sec. 11. NEW SECTION. 147B.10 STRUCTURED  
20 JUDGMENTS.

21 1. As used in this section, unless the context  
22 requires otherwise:

23 a. "Future injuries" means all legal harm relating  
24 to an injury which the trier of fact determines will  
25 be incurred by the injured party subsequent to the  
26 entry of judgment.

27 b. "Injured person" means the person during whose  
28 medical treatment or care the acts or omissions of  
29 medical malpractice are determined to have occurred.

30 c. "Injured party" means a party plaintiff to a  
31 medical malpractice action, and includes the injured  
32 person if that person is a party to the action.

33 d. "Injury" means a legal harm for which damages  
34 are recoverable in an action arising under this  
35 chapter.

36 2. In a medical malpractice action against a  
37 health care provider arising under this chapter, the  
38 verdict shall be itemized to distribute the monetary  
39 damages, if any, between past loss and future loss.  
40 In a trial to the court, the court shall itemize its  
41 findings in accordance with this section.

42 3. The court, in a medical malpractice action  
43 arising under this chapter in which a damage award for  
44 future injuries to a party exceeds one hundred  
45 thousand dollars, shall enter a judgment ordering the  
46 award to the party to be paid in periodic payments,  
47 subject to the limitations contained in this section.  
48 The court shall make a specified finding as to the  
49 dollar amount of regular payments which will be  
50 required to compensate the party periodically for loss

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of future income and future noneconomic harm, based upon the life expectancy of the party and the damages awarded. The periodic payments shall reflect interest in accordance with annuity principles. The judgment shall specify the recipient of the periodic payments, the dollar amount of each payment, the interval between payments, and the number of payments required to be made. The judgment shall specify the amount of and the purposes for which the balance of the judgment awarded for the future care and treatment of the party may be used.

4. Attorney fees of the party receiving an award, if payable out of the judgment, shall be assessed by the court and applied pro rata against amounts awarded for past injuries and for future injuries. The amount determined by the court to be payable out of damages for future injuries shall be deducted by the court from the amount to be ordered paid as provided in this subsection, and shall be deducted pro rata from those amounts awarded, if any, for loss of future income, future expenses for care and treatment, and future noneconomic harm. The amount of attorney fees attributable to the award for future injuries shall be payable upon entry of judgment.

5. If a judgment has been entered ordering periodic payments pursuant to this section, the health care provider's insurer shall pay to the fund the amount for which the insurer is liable under this chapter, after apportionment of costs of defense, for distribution by the fund to the party receiving the award.

6. If a judgment has been entered ordering periodic payments pursuant to this section, the fund shall make the payments as ordered or, alternatively, the fund may purchase an annuity from an insurance company admitted to Iowa sufficient to make the periodic payments.

7. If the party receiving the award dies, amounts to be paid for loss of future income are payable to those persons to whom the party receiving the award owed a duty of support. If the party receiving the award dies prior to payment of the amounts for other than loss of future income, the judgment is satisfied upon the payment of all obligations incurred up to the time of death and of the expenses of final illness and reasonable burial expenses.

8. Except with respect to amounts representing loss of future income, a judgment for future injuries is a contingent award, and the right to payment vests only at such times and in such amounts as accrue

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1 pursuant to the order specifying the amount of  
2 periodic payments and the interval of those payments.  
3 9. The district court shall retain jurisdiction of  
4 a medical malpractice action in which the judgment in  
5 the action orders periodic payments, and upon the  
6 death of the party receiving the award in the case of  
7 an award for loss of future income, the dependents of  
8 the decedent or any other interested party to the  
9 action or a representative of an interested party, may  
10 petition the court for a modification of the judgment  
11 for a redesignation of the recipient of the payments,  
12 in accordance with the rights of persons established  
13 by this section. Unless otherwise ordered, the  
14 redesignated recipients of payments for loss of future  
15 income shall be paid in those amounts and at those  
16 intervals specified in the original judgment.  
17 Payments shall continue until the remaining amounts  
18 designated for that purpose have been paid, or until  
19 the death of those dependents, whichever occurs first.  
20 If the last surviving dependent dies prior to  
21 depletion of the amount specified for loss of future  
22 income, the judgment is deemed satisfied upon payment  
23 of amounts accrued up to the time of death.

24 Sec. 12. NEW SECTION. 147B.11 COSTS OF DEFENSE.

25 1. The fund may employ the services of outside  
26 legal counsel to defend the fund against claims and to  
27 assist the health care provider's insurer in defending  
28 the claim.

29 2. The fund may by agreement with the health care  
30 provider's insurer, allow the health care provider's  
31 insurer to provide a defense for a claim against the  
32 health care provider and the fund. The fund and the  
33 health care provider's insurer may agree to any  
34 apportionment of the costs of defense.

35 Sec. 13. NEW SECTION. 147B.12 REINSURANCE.

36 The commissioner may cause all or any part of the  
37 potential liability of the fund to be reinsured, if  
38 reinsurance is available on a fair and reasonable  
39 basis. The cost of the reinsurance shall be paid by  
40 the fund and the fact of the reinsurance shall be  
41 taken into account in determining the surcharge under  
42 section 147B.8, subsection 2, or the special surcharge  
43 under section 147B.9.

44 Sec. 14. NEW SECTION. 147B.13 NOTICE --  
45 APPLICATION FEE.

46 1. Prior to consideration for coverage pursuant to  
47 this chapter, a health care provider shall first give  
48 notice to the commissioner of the provider's intention  
49 to apply for coverage. The notice of intention shall  
50 be accompanied by a one-time application fee of sixty

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1 dollars for health care providers and five hundred  
2 dollars for hospitals.

3 2. Funds received by the commissioner pursuant to  
4 subsection 1 shall only be expended for purposes of  
5 payment of the reasonable expenses incurred or to be  
6 incurred in the implementation of this chapter.

7 3. To the extent that funds received pursuant to  
8 subsection 1 are in excess of the expenses of  
9 implementation of this chapter, the commissioner shall  
10 transfer such excess funds to the fund.

11 4. Notice and application fees received subsequent  
12 to the implementation of this chapter shall be placed  
13 in the fund upon receipt.

14 Sec. 15. NEW SECTION. 147B.14 PATIENT  
15 COMPENSATION FUND ADMINISTRATOR.

16 The commissioner may appoint an administrator to  
17 perform all duties and responsibilities pursuant to  
18 this chapter. The administrator shall serve as  
19 administrator at the pleasure of the commissioner.  
20 The salary and expenses of the administrator shall be  
21 paid from the fund.

22 Sec. 16. NEW SECTION. 147B.15 ADMINISTRATION.

23 The commissioner shall either provide staff  
24 services necessary for the operation of this chapter  
25 or may contract with an insurance company licensed to  
26 do business in this state, or both, to perform any  
27 administrative duties and responsibilities of the  
28 commissioner pursuant to this chapter. The  
29 commissioner shall retain supervisory control over all  
30 matters for which a contract is entered into. All  
31 reasonable costs and charges incurred in the  
32 administration of this chapter shall be paid from the  
33 fund.

34 The administrator and all persons employed or  
35 contracted with to provide staff services necessary  
36 for the operation of this chapter shall not be  
37 considered employees of the state except for purposes  
38 of chapter 25A.

39 Sec. 17. NEW SECTION. 147B.16 RECIPROCITY.

40 The commissioner may enter into reciprocity  
41 agreements with the authorized representatives of any  
42 jurisdiction to allow health care providers from that  
43 jurisdiction to become qualified health care providers  
44 for purposes of the fund and to the extent that a  
45 claim against the health care provider arises in this  
46 state.

47 An agreement shall only be entered into with a  
48 jurisdiction to the same extent as the other  
49 jurisdiction allows Iowa health care providers to  
50 participate in a similar program in the other

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1 jurisdiction. The agreement shall include any  
2 conditions, restrictions, and privileges the  
3 commissioner deems necessary.

4 Sec. 18. NEW SECTION. 147B.17 ANNUAL REPORT.

5 The commissioner shall, pursuant to rules issued by  
6 the commissioner, on or before the first day of  
7 February of each year, provide to the chairs, vice  
8 chairs, and ranking members of the senate standing  
9 committees on judiciary and commerce, and the house of  
10 representatives standing committees on judiciary and  
11 law enforcement, and small business and commerce, a  
12 report regarding claims filed against the fund and  
13 claims closed involving the fund for the previous  
14 calendar year. The report shall contain to the extent  
15 the information is available the following  
16 information:

17 1. Parties to the claims.

18 2. Cause or causes of action.

19 3. Amounts reserved or paid per claim, including  
20 the present value for structured settlements or  
21 awards.

22 4. Legal fees, expert witness fees, court costs,  
23 or other associated costs of judgments or decrees per  
24 claim.

25 5. Other claims information as deemed necessary by  
26 the commissioner.

27 Sec. 19. NEW SECTION. 147B.18 RULES.

28 The commissioner shall establish rules relating to  
29 the administration of this chapter as deemed necessary  
30 by the commissioner to promote the efficient operation  
31 of this chapter in accordance with its terms and  
32 intent.

33 Sec. 20. Notwithstanding section 4.12, if any pro-  
34 vision of this Act is held invalid, the whole Act is  
35 invalid, and to this end the provisions of the Act are  
36 not severable.

37 Sec. 21. This Act takes effect upon enactment, and  
38 the commissioner shall take all actions necessary to  
39 implement the provisions of this Act on or before  
40 January 1, 1988."

H-4256 FILED MAY 6, 1987

BY STROMER of Hancock

*Filed in the House of Representatives*

SENATE FILE 484

H-5985

1 Amend Senate File 484 as amended, passed, and  
2 reprinted by the Senate as follows:

3 1. By striking everything after the enacting  
4 clause and inserting the following:

5 "Section 1. FINDINGS. The general assembly finds  
6 that a situation exists in Iowa's health care provider  
7 industry impacting high quality health care.  
8 Physicians in certain specialty and high-risk areas  
9 are paying high costs for liability insurance.

10 The general assembly further finds that it is in  
11 the public interest that statistical data be obtained  
12 so that an analysis of the cause of unavailability and  
13 unaffordability of liability insurance be undertaken  
14 so that an attempt to determine the cause of the  
15 problems can be made and a long-term solution can be  
16 provided.

17 The general assembly further finds that it is in  
18 the public interest that high quality medical and  
19 hospital services be available to the citizens of Iowa  
20 at reasonable costs. It is in the public interest to  
21 encourage competent physicians to enter into and  
22 remain in the practice of medicine in this state. It  
23 is in the public interest to assure that funds are  
24 available to compensate an injured party while  
25 protecting health care providers from catastrophic  
26 injury liability.

27 Sec. 2. NEW SECTION. 147B.1 SHORT TITLE.

28 This chapter shall be known as the "Health Care  
29 Provider and Patient Assistance Act."

30 Sec. 3. NEW SECTION. 147B.2 DEFINITIONS.

31 As used in this chapter, unless the context  
32 requires otherwise:

33 1. "Administrator" means the compensation fund  
34 administrator appointed pursuant to section 147B.12,  
35 or the administrator's designee.

36 2. "Commissioner" means the commissioner of  
37 insurance.

38 3. "Fund" means the patient catastrophic injury  
39 fund established in section 147B.6.

40 4. "Health care provider" means a person licensed  
41 or certified in this state under chapter 148, 150A,  
42 152, or 153 to provide professional health care  
43 services to an individual during that individual's  
44 medical care, treatment, or confinement.

45 5. "Health services" means clinically related  
46 diagnostic, curative, or rehabilitative services, and  
47 includes alcoholism, drug abuse, and mental health  
48 services.

49 6. "Hospital" means a hospital licensed pursuant  
50 to chapter 135B.

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1 7. "Injured person" means the person during whose  
2 medical treatment or care the acts or omissions of  
3 medical malpractice are determined to have occurred.

4 8. "Injured party" means a party plaintiff to a  
5 medical malpractice action or other person not a party  
6 to the action but who may have a cause of action  
7 against a health care provider or hospital as a result  
8 of an injury alleged to have occurred as a result of  
9 medical malpractice, and includes the injured person.

10 9. "Injury" means a legal harm for which damages  
11 are recoverable in an action arising under this  
12 chapter.

13 10. "Medical malpractice" means acts or omissions  
14 of a health care practitioner in the practice of the  
15 practitioner's profession or occupation, or acts or  
16 omissions of a hospital in patient treatment or care,  
17 including but not limited to negligence, failure to  
18 provide care, breach of contract relating to providing  
19 care, or claim based upon failure to obtain informed  
20 consent for an operation or treatment.

21 Sec. 4. NEW SECTION. 147B.3 QUALIFIED PROVIDER -  
22 - PATIENT.

23 1. A health care provider is qualified to  
24 participate under this chapter if the health care  
25 provider does the following:

26 a. Files with the commissioner proof that the  
27 health care provider is insured with an insurance  
28 company admitted to do business in this state under a  
29 policy of medical liability insurance providing a  
30 minimum of five hundred thousand dollars in coverage.

31 b. Pays a surcharge or special surcharge levied on  
32 the health care provider pursuant to section 147B.6 or  
33 147B.8.

34 2. A hospital is qualified to participate under  
35 this chapter if the hospital does the following:

36 a. Files with the commissioner proof of financial  
37 responsibility in an amount of five hundred thousand  
38 dollars per occurrence. The hospital is qualified as  
39 long as the required proof of financial responsibility  
40 remains effective. Financial responsibility is proven  
41 by providing a certified copy of a professional  
42 liability insurance policy currently in force, with  
43 annual proof of policy renewal required; a notarized  
44 letter from the professional liability insurance  
45 carrier stating that the hospital is covered by a  
46 policy of professional liability insurance, with  
47 annual proof of policy renewal required; the posting  
48 of a bond; or the payment of cash to the commissioner.  
49 If proof of financial responsibility is by  
50 professional liability insurance the hospital shall

1 provide information evidencing the policy period,  
2 amount of coverage, premium paid, claim form of  
3 policy, and any reservation of rights by the carrier.

4 b. Pays a surcharge or special surcharge levied on  
5 the hospital pursuant to section 147B.6 or 147B.8.

6 3. The commissioner or the commissioner's designee  
7 may permit qualification of a health care provider who  
8 has retired or ceased doing business if the health  
9 care provider files proof of financial responsibility  
10 as required in subsection 1.

11 4. A claim or cause of action against a health  
12 care provider or hospital shall not be denied as a  
13 result of the health care provider or hospital not  
14 being qualified at the time the action is instituted  
15 if the health care provider or hospital was qualified  
16 at the time of the alleged occurrence. A health care  
17 provider or hospital not qualified at the time of the  
18 alleged occurrence is not qualified under this chapter  
19 by filing proof of financial responsibility and making  
20 payment of the required surcharge subsequent to the  
21 occurrence giving rise to the claim.

22 Sec. 5. NEW SECTION. 147B.4 EXPRESS CONTRACT  
23 ASSURING RESULTS.

24 Liability shall not be imposed upon a health care  
25 provider or hospital as a result of an alleged breach  
26 of an express or implied contract assuring results to  
27 be obtained by any procedure undertaken in the course  
28 of health care unless the contract is expressly set  
29 forth in writing and is signed by the health care  
30 provider or hospital or by an authorized agent of the  
31 health care provider or hospital. The only exception  
32 to the written requirement shall be when the health  
33 care provider or hospital expressly represents to the  
34 patient in the presence of an employee of the health  
35 care provider or hospital the results to be obtained  
36 from a procedure undertaken. This section does not  
37 exempt a health care provider or hospital from the  
38 standard of due care in administering any procedure  
39 undertaken.

40 Sec. 6. NEW SECTION. 147B.5 PATIENT ELECTION NOT  
41 TO BE BOUND.

42 1. A patient's exclusive remedy against a health  
43 care provider or hospital qualifying under section  
44 147B.3 for medical malpractice is the remedy provided  
45 for under this chapter unless the patient has elected  
46 not to be bound by this chapter. A patient may elect  
47 not to be bound by this chapter by filing the election  
48 with the commissioner, pursuant to rules adopted by  
49 the commissioner, in advance of any treatment, act, or  
50 omission upon which a claim may be based, and

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1 notifying the health care provider or hospital of the  
2 election within a reasonable time before any treatment  
3 begins. Failure to provide the required notice is  
4 conclusive evidence of the patient's election to be  
5 bound by this chapter.

6 2. The election to be bound under this section  
7 shall not affect in any way an action against a health  
8 care provider or hospital which is based upon the  
9 common law doctrine of res ipsa loquitor.

10 3. An election by a patient not to be bound by  
11 this chapter is effective for a period of two years  
12 after filing unless the election is withdrawn. The  
13 patient may withdraw the election in writing at any  
14 time by filing the withdrawal with the commissioner.

15 4. A qualified health care provider or hospital  
16 shall provide a patient with notice that the health  
17 care provider or hospital is qualified under this  
18 chapter prior to any treatment, and shall inform the  
19 patient of the patient's right to elect not to be  
20 bound by this chapter. A copy of any notice provided  
21 for under this section must be provided to the patient  
22 or the patient's guardian, signed by the patient or  
23 the patient's guardian, and witnessed by an employee  
24 of the health care provider or hospital after the  
25 notice is explained to the patient or the patient's  
26 guardian by the employee. If the patient is not  
27 provided a copy of the form, the election is invalid.

28 5. An election under this chapter does not apply  
29 to an action brought by a patient based upon an  
30 express or implied contract assuring results.

31 6. Notwithstanding subsections 1 through 5 of this  
32 section, in the case of a medical emergency, when  
33 immediate care and treatment are required and a  
34 patient, or someone authorized to act on the patient's  
35 behalf, is not able or is otherwise not available to  
36 receive notice, a provider shall not be required to  
37 give notice as set forth in this section and for  
38 purposes of the immediate care and treatment received,  
39 the patient shall be deemed to have elected to be  
40 bound by this chapter.

41 Sec. 7. NEW SECTION. 147B.6 PATIENT CATASTROPHIC  
42 INJURY FUND.

43 1. A patient catastrophic injury fund is created  
44 for the purposes stated in this chapter. The fund and  
45 income from the fund shall be deposited with the  
46 treasurer of state to be used for the payment of  
47 qualifying claims under this chapter, and the fund is  
48 appropriated for that purpose. Appropriations to the  
49 fund are not subject to reversion under section 8.33.

50 The fund shall be wholly responsible for paying

1 settlements or judgments in excess of the amount of  
2 the combined financial responsibility required under  
3 section 147B.3. If more than one health care provider  
4 or hospital, or both, are liable on a claim, the  
5 combined financial responsibility amounts shall be  
6 primary coverage, and the fund shall constitute  
7 secondary coverage.

8 2. An annual surcharge shall be levied on all  
9 health care providers and hospitals qualifying under  
10 section 147B.3. The surcharge for a health care  
11 provider or hospital is determined by the commissioner  
12 subject to the following limitations:

13 a. The annual surcharge shall not exceed fifty  
14 percent of the annual premium paid by the health care  
15 provider or hospital for maintenance of current  
16 financial responsibility as provided in section  
17 147B.3, or as provided by the commissioner if the  
18 health care provider or hospital proves financial  
19 responsibility by the posting of a bond or the payment  
20 of cash to the commissioner pursuant to section  
21 147B.3.

22 b. The amount of the surcharge shall not exceed  
23 the amount necessary to maintain the fund.

24 3. The surcharge required for qualification under  
25 section 147B.3 is due and payable within thirty days  
26 after the health care provider or hospital has  
27 qualified pursuant to section 147B.3, and is payable  
28 annually thereafter in amounts as determined by the  
29 commissioner.

30 4. If the annual premium surcharge required for  
31 qualification under section 147B.3 is not paid within  
32 the time specified in subsection 3, the qualification  
33 of the health care provider or hospital shall be  
34 suspended until the annual premium surcharge is paid.  
35 The suspension shall not be effective as to patients  
36 claiming against the health care provider or hospital  
37 unless, at least thirty days before the effective date  
38 of the suspension, a written notice giving the date  
39 upon which the suspension becomes effective has been  
40 provided by the commissioner to the health care  
41 provider or hospital.

42 5. All expenses of collecting, protecting, and  
43 administering the funds shall be paid from the fund,  
44 including necessary costs of outside legal counsel.  
45 The attorney general is not responsible for  
46 representation or legal defense of the fund.

47 Sec. 8. NEW SECTION. 147B.7 COVERAGE BY FUND.  
48 The fund shall provide coverage to the health care  
49 provider or hospital on the same basis as the  
50 underlying professional liability insurance or other

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1 proof of financial responsibility maintained by the  
2 health care provider or hospital.

3 Sec. 9. NEW SECTION. 147B.8 SPECIAL SURCHARGE --  
4 REINSURANCE.

5 The commissioner may, at any time, analyze the fund  
6 to determine if the amount in the fund is adequate to  
7 pay in full all claims allowed or to be allowed during  
8 the calendar year. If the fund is determined to be  
9 inadequate, the commissioner may levy a special  
10 surcharge on all health care providers and hospitals  
11 who have qualified under this chapter on the date of  
12 the special surcharge or at any time during the  
13 preceding twelve months. The special surcharge shall  
14 be in an amount proportionate to the surcharge each  
15 health care provider or hospital has paid to the fund.  
16 The special surcharge shall be an amount sufficient to  
17 permit full payment of all claims allowed against the  
18 fund during a calendar year. The special surcharge  
19 shall be levied against all health care providers and  
20 hospitals who have qualified under this chapter. The  
21 special surcharge is due and payable within thirty  
22 days after it is levied.

23 The commissioner may cause all or any part of the  
24 potential liability of the fund to be reinsured, if  
25 reinsurance is available on a fair and reasonable  
26 basis. The cost of the reinsurance shall be paid by  
27 the fund and the fact of the reinsurance shall be  
28 taken into account in determining the surcharge or  
29 special surcharge.

30 Sec. 10. NEW SECTION. 147B.9 SOURCE OF FUNDING  
31 FOR PATIENT CATASTROPHIC INJURY FUND.

32 1. An assessment of one percent is imposed upon  
33 the gross billings for all charges, other than those  
34 involving Medicaid and Medicare, by hospitals  
35 beginning January 1, 1989. The receipts of this  
36 assessment shall be collected by the hospitals and  
37 transferred to the patient catastrophic injury fund  
38 monthly. The assessment created by this section shall  
39 be considered a usual, customary, and reasonable  
40 charge for purposes of third-party reimbursement, and  
41 shall be paid to the charging hospital. The  
42 assessment shall be paid to the fund on a quarterly  
43 basis. The assessment created by this section shall  
44 be charged to and paid in full by the primary payor  
45 directly to the charging hospital. An assessment  
46 shall not be made or collected where no charge is made  
47 by the hospital.

48 2. The assessment on uncollectible billings shall,  
49 upon application by the hospital on a form determined  
50 by the treasurer, be refunded to the paying hospital

1 out of the fund on a quarterly basis for the quarter  
2 ending six months prior to the start of the quarter in  
3 which the application is made for refund.

4 3. The assessment pursuant to subsection 1 shall  
5 be implemented on January 1, 1989, and shall only  
6 continue in force and effect until the patient  
7 catastrophic injury fund is found to be actuarially  
8 sound. The determination that the fund is actuarially  
9 sound shall be made by the commissioner. The  
10 assessment shall only be reinstated upon order of  
11 the commissioner based upon evidence that the fund is  
12 no longer actuarially sound. The order shall only be  
13 made following notice and hearing to interested  
14 parties.

15 Sec. 11. NEW SECTION. 147B.10 LIABILITY OF  
16 PATIENT CATASTROPHIC INJURY FUND -- STANDING  
17 APPROPRIATION.

18 The patient catastrophic injury fund is liable for  
19 all sums to be paid exceeding five hundred thousand  
20 dollars under a judgment, verdict, award, or  
21 settlement approved by the court with respect to an  
22 occurrence of medical malpractice in this state.

23 There is appropriated from the general fund of the  
24 state to the patient catastrophic injury fund each  
25 fiscal year an amount sufficient to pay any amounts  
26 outstanding for which the fund is liable when all  
27 moneys deposited in the fund for that year have been  
28 expended.

29 Sec. 12. NEW SECTION. 147B.11 ANNUAL REPORT.

30 The commissioner shall, pursuant to rules issued by  
31 the commissioner, on or before the first day of  
32 February of each year, provide to the chairpersons,  
33 vice chairpersons, and ranking members of the senate  
34 standing committees on judiciary and commerce, and the  
35 house of representatives standing committees on  
36 judiciary and law enforcement, and small business and  
37 commerce, a report regarding claims filed against the  
38 fund and claims closed involving the fund for the  
39 previous calendar year. However, the report shall not  
40 include any confidential information regarding a claim  
41 currently being litigated or which will be litigated,  
42 or a claim where the parties have entered into or will  
43 enter into discussions intended to result in a  
44 settlement of the claim, if the release of the  
45 information may impede settlement negotiations or  
46 adversely affect either party to the negotiations or  
47 litigation. The report shall contain to the extent  
48 the information is available the following  
49 information:

50 1. Parties to the claims.

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- 1 2. Causes of action.
- 2 3. Amounts reserved or paid per claim, including
- 3 the present value for structured settlements or
- 4 awards.
- 5 4. Legal fees, expert witness fees, court costs,
- 6 or other associated costs of judgments or decrees per
- 7 claim.
- 8 5. Allocated loss adjustment expense.
- 9 6. Administrative costs.
- 10 7. Other claims information as deemed necessary by
- 11 the commissioner.

12 The report is a public record.

13 Sec. 13. NEW SECTION. 147B.12 CLAIM REPORT.

14 1. Each malpractice claim settled or adjudicated

15 to final judgment against a health care provider or

16 hospital under this chapter shall be reported to the

17 commissioner by the plaintiff's attorney and by the

18 health care provider or hospital or the provider's or

19 hospital's insurer within sixty days following final

20 disposition of the claim. The report to the

21 commissioner shall state the following:

- 22 a. The nature of the claim and date of occurrence.
- 23 b. The alleged injury and the damages asserted.
- 24 c. Attorney's fees and expenses incurred in
- 25 connection with the claim or defense.
- 26 d. The amount of any settlement or judgment.
- 27 e. The name and address of each health care
- 28 provider or hospital assessed any fault or found to be
- 29 liable under chapter 668.

30 2. The commissioner shall forward the name of

31 every health care provider, except a hospital, against

32 whom a settlement has been made or judgment has been

33 rendered to the appropriate licensing board of the

34 health care provider for any action it deems to be

35 appropriate under the circumstances.

36 3. The commissioner shall forward the identity of

37 every hospital against which a settlement has been

38 made or judgment has been rendered to the department

39 of inspections and appeals for any action it deems to

40 be appropriate under the circumstances.

41 Sec. 14. NEW SECTION. 147B.13 CATASTROPHIC

42 INJURY FUND ADMINISTRATOR.

43 The commissioner may appoint an administrator to

44 perform all duties and responsibilities pursuant to

45 this chapter. The administrator shall serve at the

46 pleasure of the commissioner. The salary and expenses

47 of the administrator shall be paid from the fund.

48 Sec. 15. NEW SECTION. 147B.14 ADMINISTRATION.

49 The commissioner shall provide staff services

50 necessary for the implementation of this chapter, or

1 may contract with an insurance company licensed to do  
2 business in this state, or both, to perform any  
3 administrative duties of the commissioner pursuant to  
4 this chapter. The commissioner shall retain  
5 supervisory control over all services for which a  
6 contract is entered into. All reasonable costs and  
7 charges incurred in the administration of this chapter  
8 shall be paid from the fund.

9 Sec. 16. NEW SECTION. 147B.15 RULES.

10 The commissioner shall adopt rules pursuant to  
11 chapter 17A for the efficient administration of this  
12 chapter in accordance with its terms and intent.

13 Sec. 17. NEW SECTION. 147B.16 INDEMNIFICATION  
14 AGREEMENT.

15 1. A hospital and a health care provider may agree  
16 that the hospital shall indemnify the health care  
17 provider for any liability of the health care provider  
18 arising while the health care provider is providing  
19 services at the hospital. The agreement may also  
20 provide that the hospital shall indemnify the health  
21 care provider for liability arising from services  
22 provided outside of the hospital. The agreement shall  
23 not provide for indemnification of liability arising  
24 from services provided by the health care provider in  
25 another hospital.

26 2. A hospital may, before entering into an  
27 agreement pursuant to this section, require the health  
28 care provider to provide information regarding all  
29 claims filed against the health care provider and  
30 losses resulting from the claims.

31 Sec. 18. NEW SECTION. 147B.17 ADVANCE PAYMENT  
32 NOT ADMISSION.

33 A payment made by a health care provider or  
34 hospital or the health care provider's or hospital's  
35 insurer or surety to or for the patient or any other  
36 person on the patient's behalf in advance of a final  
37 determination of liability shall not be construed as  
38 an admission of liability for injuries or damages  
39 suffered in a medical malpractice action. In the  
40 event of an advance payment, the court shall reduce  
41 the judgment to the plaintiff by the amount of the  
42 advance payment. If the advance payment exceeds the  
43 liability of the defendant, the court shall order any  
44 adjustment necessary to equalize the amount under  
45 which each defendant is obligated to pay and in no  
46 case shall an advance in excess of the amount found to  
47 be due be repayable to the health care provider or  
48 hospital or the issuer or surety making the payment.

49 Sec. 19. NEW SECTION. 147B.18 SETTLEMENT NOT  
50 ADMISSION.

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1 If at any time the health care provider, hospital,  
2 an insurance carrier, a surety, or the fund tenders  
3 payment to the patient or a person acting on the  
4 patient's behalf of any sum for the purpose of  
5 settlement and not as an advance, the tender shall not  
6 be considered an admission of liability by the health  
7 care provider or hospital. Liability or fault is not  
8 deemed admitted as a matter of law.

9 Sec. 20. NEW SECTION. 147B.19 PRIVOLOUS ACTIONS.

10 In all cases against a health care provider or  
11 hospital under this chapter, the court may, in its  
12 discretion, upon application by the prevailing party  
13 and in an amount determined by the court, charge  
14 reasonable attorney fees as costs payable to the  
15 prevailing party, if the court finds that the losing  
16 party did not have a reasonable likelihood of recovery  
17 or a reasonable likelihood of a successful defense.  
18 The charging of costs under this section is the sole  
19 responsibility of the named parties and shall not in  
20 any way be considered a cost of defense or reduce in  
21 any manner insurance coverage provided to either party  
22 thereby reducing the amount of coverage available for  
23 the payment of any judgment rendered against that  
24 party.

25 Sec. 21. NEW SECTION. 147B.20 DEFENSE COSTS.

26 Coverage for medical malpractice under the fund and  
27 under professional liability policies or other items  
28 posted for proof of financial responsibility to comply  
29 with the requirements of this chapter shall include  
30 defense costs and allocation for loss adjustment  
31 expense. Such benefits or coverage shall not in any  
32 way reduce the coverage available to provide for  
33 payment of judgments by a health care provider or  
34 hospital to an injured party.

35 Sec. 22. NEW SECTION. 147B.21 FAILURE TO  
36 QUALIFY.

37 1. A health care provider or hospital who fails to  
38 qualify under this chapter is not covered by this  
39 chapter and is subject to liability under any  
40 applicable doctrine of common law. A patient's  
41 remedies against a nonqualified health care provider  
42 or hospital shall not be affected by this chapter.

43 2. A health care provider need not be a resident  
44 of this state to be eligible for coverage under this  
45 chapter. A nonresident may submit an application to  
46 the commissioner or the commissioner's designee to  
47 qualify for coverage under the terms and conditions  
48 provided by rule.

49 Sec. 23. NEW SECTION. 147B.22 ACTION -- AMOUNT  
50 RECOVERABLE -- SETTLEMENT.

1 1. Parties commencing an action governed by the  
2 provisions of this chapter have all rights afforded to  
3 them under common law unless provided otherwise, and  
4 actions shall be commenced and governed as provided  
5 for under the rules of civil procedure.

6 2. The fund shall not be a named party to any  
7 suit. However, notice of suit shall be served upon  
8 the commissioner.

9 3. Payment of policy limits by the health care  
10 provider's or hospital's professional liability  
11 carrier or surety absolves the health care provider or  
12 hospital from any additional individual liability.  
13 The payment of policy or bond limits or any portion  
14 thereof must be coordinated with the fund and shall  
15 not absolve the carrier from participation in the  
16 defense of the fund on behalf of the health care  
17 provider or hospital. The payment of policy or bond  
18 limits or any portion thereof shall not affect the  
19 injured parties' right to a jury trial.

20 4. The fund may participate in the settlement of  
21 claims prior to a health care provider's or hospital's  
22 liability carrier or surety tendering policy limits.

23 5. If multiple health care providers or hospitals  
24 are named as individual defendants, this chapter  
25 applies only to those providers or hospitals who are  
26 qualified under this chapter.

27 Sec. 24. NEW SECTION. 147B.23 STRUCTURED  
28 JUDGMENTS.

29 1. In a medical malpractice action against a  
30 health care provider subject to this chapter, the  
31 verdict shall be itemized to distribute the monetary  
32 damages, if any, between past loss and future loss.  
33 In a trial to the court, the court shall itemize its  
34 findings in accordance with this section.

35 2. The court, in a medical malpractice action  
36 subject to this chapter in which a damage award for  
37 future injuries to a party exceeds one hundred  
38 thousand dollars and upon application of one of the  
39 parties, shall enter a judgment ordering the portion  
40 of the award to the party in excess of one hundred  
41 thousand dollars to be paid in periodic payments,  
42 subject to the limitations contained in this section.  
43 The court shall make a specific finding as to the  
44 dollar amount of regular payments which will be  
45 required to compensate the party periodically for loss  
46 of future income and future noneconomic harm, based  
47 upon the life expectancy of the party and the damages  
48 awarded. The periodic payments shall reflect interest  
49 in accordance with annuity principles. The judgment  
50 shall specify the recipient of the periodic payments,

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1 the dollar amount of each payment, the interval  
2 between payments, and the number of payments required  
3 to be made. The judgment shall specify the amount of  
4 and the purposes for which the balance of the judgment  
5 awarded for the future care and treatment of the party  
6 may be used.

7 3. Attorney fees of the party receiving an award,  
8 if payable out of the judgment, shall be assessed by  
9 the court and applied pro rata against amounts awarded  
10 for past injuries and for future injuries. The amount  
11 determined by the court to be payable out of damages  
12 for future injuries shall be deducted by the court  
13 from the amount to be ordered paid as provided in this  
14 subsection, and shall be deducted pro rata from those  
15 amounts awarded, if any, for loss of future income,  
16 future expenses for care and treatment, and future  
17 noneconomic harm. The amount of attorney fees  
18 attributable to the award for future injuries shall be  
19 payable upon entry of judgment.

20 4. If a judgment has been entered ordering  
21 periodic payments pursuant to this section, the health  
22 care provider's insurer shall pay to the fund the  
23 amount for which the insurer is liable under this  
24 chapter, after apportionment of costs of defense, for  
25 distribution by the fund to the party receiving the  
26 award.

27 5. If a judgment has been entered ordering  
28 periodic payments pursuant to this section, the fund  
29 shall make the payments as ordered or, alternatively,  
30 the fund may purchase an annuity from an insurance  
31 company admitted to do business in this state  
32 sufficient to make the periodic payments.

33 6. If the party receiving the award dies, amounts  
34 to be paid for loss of future income are payable to  
35 those persons to whom the party receiving the award  
36 owes a duty of support. If the party receiving the  
37 award dies prior to payment of the amounts for other  
38 than loss of future income, the judgment is satisfied  
39 upon the payment of all obligations incurred up to the  
40 time of death and of the expenses of final illness and  
41 reasonable burial expenses. Amounts remaining for  
42 other than loss of future income upon satisfaction of  
43 the judgment shall remain in the fund.

44 7. Except with respect to amounts representing  
45 loss of future income, a judgment for future injuries  
46 is a contingent award, and the right to payment vests  
47 only at such times and in such amounts as accrue  
48 pursuant to the order specifying the amount of  
49 periodic payments and the interval of those payments.

50 8. The district court shall retain jurisdiction of

1 a medical malpractice action in which the judgment in  
2 the action orders periodic payments, and upon the  
3 death of the party receiving the award in the case of  
4 an award for loss of future income, the dependents of  
5 the decedent or any other interested party to the  
6 action or a representative of an interested party, may  
7 petition the court for a modification of the judgment  
8 and for a redesignation of the recipient of the  
9 payments, in accordance with the rights of persons  
10 established by this section. Unless otherwise  
11 ordered, the redesignated recipients of payments for  
12 loss of future income shall be paid in those amounts  
13 and at those intervals specified in the original  
14 judgment. Payments shall continue until the remaining  
15 amounts designated for that purpose have been paid, or  
16 until the death of those dependents, whichever occurs  
17 first. If the last surviving dependent dies prior to  
18 depletion of the amount specified for loss of future  
19 income, the judgment is deemed satisfied upon payment  
20 of amounts accrued up to the time of that death.

21 Amounts remaining for loss of future income upon  
22 satisfaction of the judgment shall remain in the fund.

23 Sec. 25. NEW SECTION. 147B.24 MEDIATION SYSTEM.

24 The commissioner shall establish a mediation system  
25 which consists of mediation panels to assist in the  
26 resolution of disputes, regarding medical malpractice  
27 between an injured party and a health care provider.

28 Sec. 26. NEW SECTION. 147B.25 REQUEST FOR  
29 MEDIATION.

30 1. An injured party who may have a cause of action  
31 against a health care provider or hospital as a result  
32 of an injury alleged to have occurred as a result of  
33 medical malpractice may file a request for mediation.  
34 However, if the injured party has filed a court action  
35 claiming a cause of action against a health care  
36 provider or hospital as a result of an injury alleged  
37 to have occurred as a result of medical malpractice,  
38 the injured party shall file a request for mediation  
39 within fifteen days after the date of filing.

40 2. A request for mediation must be in writing and  
41 must include all of the following:

42 a. The name and address of all injured parties.

43 b. The name and address of the injured patient, if  
44 not included in paragraph "a".

45 c. The name and address of all health care  
46 providers and hospitals alleged to have committed  
47 medical malpractice resulting in the injury.

48 d. The condition or disease for which the health  
49 care provider or hospital was treating the injured  
50 party when the alleged medical malpractice occurred.

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1 e. A brief description of the injury alleged to  
2 have been caused by the health care provider or  
3 hospital.

4 3. a. A request for mediation shall be delivered  
5 to the commissioner in person or by certified mail.  
6 The injured party requesting mediation and all health  
7 care providers named in the request for mediation  
8 shall participate in the mediation.

9 b. An injured party shall pay a filing fee of  
10 eleven dollars at the time the request is filed with  
11 the commissioner.

12 4. If a court action has not been commenced at the  
13 time the request for mediation is filed with the  
14 commissioner, any applicable statute of limitations is  
15 tolled on the date the commissioner receives the  
16 request for mediation if delivered in person or on the  
17 date of mailing if sent by certified mail and remains  
18 tolled until thirty days after the last day of the  
19 mediation period. A court action shall not be  
20 commenced unless a request for mediation has been  
21 filed and the mediation period has expired. An  
22 injured party who has filed a request for mediation  
23 and commences a court action after the expiration of  
24 the mediation period shall notify the commissioner  
25 that a court action has been filed.

26 5. If a court action has been commenced prior to  
27 the time the request for mediation is filed with the  
28 commissioner, any applicable statute of limitations is  
29 tolled during the mediation period.

30 Sec. 27. NEW SECTION. 147B.26 NOTICE TO HEALTH  
31 CARE PROVIDERS AND HOSPITALS.

32 The commissioner shall serve notice upon all health  
33 care providers and hospitals named in the request for  
34 mediation by certified mail within seven days after  
35 the commissioner receives the request if delivered in  
36 person or within ten days after the date of mailing of  
37 the request to the commissioner if sent by certified  
38 mail.

39 Sec. 28. NEW SECTION. 147B.27 MEDIATION PANELS.

40 1. The commissioner shall appoint the members of a  
41 mediation panel and send notice to the claimant and  
42 all respondents by certified mail. The notice shall  
43 inform the claimant and all respondents of the names  
44 of the members appointed to the mediation panel and  
45 the date, time, and place of the first mediation  
46 session. The commissioner may change the date, time,  
47 or place of the mediation session as necessary to  
48 accommodate the parties, but the session shall be held  
49 before the expiration of the mediation period.

50 2. A mediation panel shall consist of the

1 following members appointed by the commissioner:

2 a. One public member who is neither an attorney  
3 nor a health care provider and who is selected from a  
4 list of ten public member mediators appointed by the  
5 commissioner every two years. A member on the list  
6 may be reappointed to the list.

7 b. One attorney who is licensed to practice law in  
8 this state.

9 c. One health care provider as follows:

10 (1) Except as provided in subparagraphs (4) and  
11 (5), if all respondents named in the request for  
12 mediation are health care providers, a health care  
13 provider who is licensed to practice in this state and  
14 who is selected from a list prepared by the Iowa  
15 medical society.

16 (2) Except as provided in subparagraphs (4) and  
17 (5), if none of the respondents named in the request  
18 for mediation is a health care provider, a health care  
19 provider who is licensed to practice in this state in  
20 the same health care field as the respondent and who  
21 is selected from a list prepared by the examining  
22 board that regulates health care providers in that  
23 health care field.

24 (3) Except as provided in subparagraphs (4) and  
25 (5), if more than one respondent is named in the  
26 request for mediation at least one of whom is a health  
27 care provider and one of whom is a hospital, a health  
28 care provider who is licensed to practice in this  
29 state and who is selected from a list under  
30 subparagraph (1) or (2), as determined by the  
31 commissioner.

32 (4) If the commissioner determines that a list  
33 under subparagraph (1) or (2) is inadequate to permit  
34 the selection of an appropriate health care provider,  
35 a health care provider who is licensed to practice in  
36 this state and who is selected from an additional list  
37 prepared by the commissioner.

38 (5) If the commissioner determines that the lists  
39 under subparagraph (1) or (2) and subparagraph (4) are  
40 inadequate to permit the selection of an appropriate  
41 health care provider for a particular dispute, a  
42 health care provider who is licensed to practice in  
43 this state and is selected by the commissioner.

44 3. If a person appointed to a panel resigns from  
45 or is unable to serve on the mediation panel, the  
46 commissioner shall appoint a replacement selected  
47 pursuant to subsection 2.

48 4. A person shall not serve on a mediation panel  
49 if the person has a professional or personal interest  
50 in the dispute.

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1 5. Each member of the mediation panel is entitled  
2 to one hundred fifty dollars per diem plus actual and  
3 necessary expenses for each day of mediation  
4 conducted. The amounts provided for under this  
5 subsection shall be paid from the mediation fund  
6 established under section 147B.30.

7 6. A person serving as a mediator is immune from  
8 civil liability for any good faith act or omission  
9 within the scope of the mediator's powers and duties  
10 under this chapter.

11 Sec. 29. NEW SECTION. 147B.28 MEDIATION PERIOD.

12 The period for mediation shall expire ninety days  
13 after the commissioner receives a request for  
14 mediation if delivered in person or within ninety-  
15 three days after the date of mailing the request to  
16 the commissioner by certified mail, or within a longer  
17 period agreed to by the claimant and all respondents  
18 and specified by them in writing.

19 Sec. 30. NEW SECTION. 147B.29 PROCEDURE.

20 The mediation shall be conducted without record or  
21 transcript. Physical examinations or production of  
22 records are not allowed, and no witnesses may be  
23 subpoenaed and no oaths may be administered during the  
24 mediation period. However, the mediation panel or any  
25 member of the panel may consult with any expert, and  
26 upon authorization of the commissioner, the expert may  
27 be compensated out of the mediation fund established  
28 under section 147B.30.

29 All patient health care records in the possession  
30 of a mediation panel shall be kept confidential by all  
31 members of the mediation panel and all other persons  
32 participating in the mediation. Any finding,  
33 statement, or opinion made in the course of mediation  
34 is not admissible in any court action.

35 Any person participating in mediation may be  
36 represented by counsel authorized to act for the  
37 person.

38 Sec. 31. NEW SECTION. 147B.30 MEDIATION FUND.

39 A mediation fund is created in the state treasury  
40 to pay the administrative expenses of the mediation  
41 system established in this chapter. Management of the  
42 fund is vested in the commissioner.

43 The mediation fund shall be financed from fees  
44 charged to health care providers and other fees  
45 designated to be deposited in this fund. The  
46 commissioner shall determine by February 1, annually,  
47 the amount needed for the operation of the mediation  
48 system during the succeeding fiscal year. The  
49 commissioner shall assess each health care provider  
50 and hospital an annual fee sufficient to finance the

1 mediation system. The commissioner shall adopt rules  
2 pursuant to chapter 17A for the collection of the  
3 fees.

4 The commissioner shall submit a report on the  
5 operation of the mediation system and on the status of  
6 the mediation fund on or before March 1 of each year  
7 to the majority leader and minority leader of the  
8 senate, and the speaker, majority leader, and minority  
9 leader of the house of representatives.

10 Sec. 32. NEW SECTION. 519B.1 DEFINITIONS.

11 As used in this chapter, unless the context  
12 requires otherwise:

13 1. "Commissioner" means the commissioner of  
14 insurance.

15 2. "Fund" means the Iowa medical care availability  
16 assistance trust fund.

17 3. "Hospital" means a hospital licensed pursuant  
18 to chapter 135B.

19 4. "Medical malpractice" means acts or omissions  
20 of a health care provider in the practice of the  
21 provider's profession or occupation, or acts or  
22 omissions of a hospital in patient treatment or care,  
23 including but not limited to negligence, failure to  
24 provide care, breach of contract relating to providing  
25 care, or claim based upon failure to obtain informed  
26 consent for an operation or treatment.

27 5. "Physician" means a physician and surgeon  
28 licensed pursuant to chapter 148; an osteopath  
29 licensed pursuant to chapter 150; an osteopathic  
30 physician and surgeon licensed pursuant to chapter  
31 150A; or a dentist licensed pursuant to chapter 153.

32 Sec. 33. NEW SECTION. 519B.2 TRUST FUND -- DIS-  
33 TRIBUTIONS.

34 1. The Iowa medical care availability assistance  
35 trust fund is established to be administered by the  
36 commissioner for the purposes set forth in this  
37 chapter. Distributions from the fund shall be made on

38 an annual basis commencing July 1, 1989, as follows:

39 a. The commissioner shall, on July 1 of each year,  
40 distribute from the fund to each eligible physician an  
41 amount equal to the amount by which the physician's  
42 premium payments for medical liability insurance for  
43 the preceding calendar year exceeded fifteen percent  
44 of the physician's annual gross income derived from  
45 the physician's delivery of medical services for the  
46 preceding calendar year. The physician shall have the  
47 burden of establishing to the commissioner's  
48 satisfaction the gross income derived from the  
49 delivery of medical services in the preceding calendar  
50 year, the amount of premiums paid for medical

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1 liability insurance in the preceding calendar year,  
2 the medical specialty practiced by the physician  
3 during the previous calendar year, and the physician's  
4 eligibility to participate in the premium assistance  
5 plan.

6 b. If the amount in the fund is inadequate to pay  
7 in full all claims to qualified physicians, the amount  
8 paid to each eligible physician shall be prorated.

9 2. The amount of premium payments considered under  
10 this section shall not be less than or exceed the  
11 premium amount necessary for the physician to obtain  
12 medical liability insurance coverage in an amount of  
13 one million dollars per occurrence and three million  
14 dollars annual aggregate. If a physician applying for  
15 assistance is currently paying premiums for coverage  
16 in excess of one million dollars per occurrence and  
17 three million dollars annual aggregate, the department  
18 shall determine the premium amount which would be paid  
19 if coverage were limited to one million dollars per  
20 occurrence and three million dollars annual aggregate.  
21 If more than one policy is in effect during a calendar  
22 year for which application for assistance is made, the  
23 premium paid under each policy shall be prorated by  
24 the number of months the policy is in effect during  
25 that calendar year, and the amounts determined for  
26 each policy for that year shall constitute in total  
27 the premium paid for the calendar year.

28 If a single policy provides coverage for more than  
29 one physician, the commissioner shall determine the  
30 amount of premium to be attributed to the coverage for  
31 the applying physician.

32 3. An eligible physician entitled to a  
33 distribution under this section must file an  
34 application with the commissioner on or before May 1  
35 of the year following the year for which assistance is  
36 sought. Failure to file an application by May 1 of  
37 any year constitutes a waiver of any distribution to  
38 which the physician might have been entitled for the  
39 preceding year. The commissioner shall provide the  
40 application form.

41 4. Prior to making a distribution to an eligible  
42 physician, the commissioner shall obtain an assignment  
43 of any right the physician may have to a dividend,  
44 refund, or reimbursement of premium under the terms of  
45 the physician's medical liability insurance contract  
46 or agreement. Amounts received by the commissioner as  
47 a result of the assignment shall be deposited in the  
48 fund. The commissioner's rights under an assignment  
49 shall not exceed the amount distributed to the  
50 physician under this section.

1     Sec. 34.   NEW SECTION.   519B.3   PHYSICIAN  
2   ELIGIBILITY.

3     1.   A physician is eligible to receive a  
4   distribution if the physician files an application for  
5   a distribution as provided in section 519B.2, and  
6   meets the following requirements:

7     a.   The physician was engaged in the active  
8   practice of medicine in Iowa during the entire  
9   preceding calendar year.

10    b.   The physician was insured with an insurance  
11   company admitted to this state under a policy of  
12   medical liability insurance during the entire  
13   preceding calendar year providing coverage in an  
14   amount of at least one million dollars per occurrence.

15    c.   The physician had staff privileges during the  
16   entire preceding calendar year at a hospital in this  
17   state, which had an emergency room and which required  
18   physicians with staff privileges to provide, when  
19   needed, medical care to unassigned patients entering  
20   the hospital through the emergency room. The  
21   physician has the burden of establishing to the  
22   commissioner's satisfaction that the physician was  
23   available to provide medical care to unassigned  
24   patients and that, when needed, did provide medical  
25   care to unassigned patients entering the hospital  
26   through the emergency room.

27    d.   The physician has not incurred two or more  
28   claims for medical malpractice resulting in judgments,  
29   awards, or settlements exceeding one hundred twenty-  
30   five thousand dollars each in the preceding five  
31   years. Payment of a claim by an uninsured physician  
32   exceeding one hundred twenty-five thousand dollars  
33   shall be counted when determining the number of  
34   judgments, awards, or settlements under this  
35   paragraph.

36    e.   The physician does not have an unsatisfied  
37   medical malpractice judgment which was entered within  
38   the preceding five years, or if one exists, the  
39   physician can show that at least two hundred fifty  
40   thousand dollars of the judgment has been satisfied.

41    2.   The burden to establish eligibility under all  
42   criteria in this chapter by clear and convincing  
43   evidence is upon an applying physician.

44    Sec. 35.   STUDY OF MEDICAL SERVICES.   The division  
45   of insurance shall conduct a study to determine where  
46   the state is experiencing a shortage of needed medical  
47   services, which shall be based on the availability of  
48   physicians by geographic area and medical specialty.  
49   The division shall consider the following factors in  
50   conducting the study:

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1 1. The supply and demand for medical services and  
2 facilities.

3 2. The health of the population in a geographic  
4 area, including mortality, morbidity, and births.

5 3. Any other relevant demographic information  
6 which indicates the need for medical services and  
7 facilities.

8 The results of the study shall be reported on or  
9 before January 15, 1989, to the governor, majority and  
10 minority leaders of the senate, and the speaker and  
11 majority and minority leaders of the house of  
12 representatives.

13 Sec. 36. APPROPRIATION. There is appropriated  
14 from the general fund of the state to the division of  
15 insurance in the department of commerce for the fiscal  
16 year beginning July 1, 1988, and ending June 30, 1989,  
17 one hundred fifty thousand dollars, or as much thereof  
18 as is necessary, for services necessary for the  
19 implementation of sections 32 through 34 this Act. In  
20 addition, the commissioner shall provide an estimate  
21 of the cost of the program and shall provide that  
22 estimate to the governor, majority and minority  
23 leaders of the senate, and the speaker and majority  
24 and minority leaders of the house of representatives  
25 on or before January 15, 1989.

26 Sec. 37. Sections 1 through 31 of this Act apply  
27 only to occurrences after January 1, 1989.

28 Sec. 38. Sections 32 through 34 of this Act take  
29 effect on January 1, 1990, with the initial  
30 distribution to be made to eligible physicians  
31 commencing July 1, 1990, for the 1989 calendar year."

32 2. Title page, by striking lines 1 through 11 and  
33 inserting the following: "An Act relating to health  
34 care providers, hospitals, and patients by providing  
35 for the creation of a patient catastrophic injury fund  
36 for health care providers and hospitals, establishing  
37 a surcharge and a special surcharge to be deposited in  
38 the fund, providing for an assessment on hospital  
39 charges, establishing qualifications for a health care  
40 provider, hospital, or patient to be protected by the  
41 fund, establishing a limitation on the liability of  
42 the fund, and a health care provider or hospital,  
43 establishing a study and certain other powers and  
44 duties of the commissioner of insurance, providing for  
45 indemnification agreements between a hospital and a  
46 health care provider, providing that the Act does not  
47 apply to certain contracts guaranteeing results,  
48 establishing certain reporting requirements, providing  
49 for the appointment of a fund administrator and for  
50 administration of the fund, providing that an advance

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- 1 payment or a settlement is not an admission of
- 2 liability, providing for liability of defense costs in
- 3 certain actions, authorizing the fund to procure
- 4 reinsurance, providing for structured settlements,
- 5 establishing a mediation system ensuring the
- 6 availability of physicians to all citizens of this
- 7 state by establishing a medical care availability
- 8 assistance plan and trust fund, providing
- 9 appropriations, establishing an effective date, and
- 10 providing for applicability."

By COMMITTEE ON JUDICIARY AND  
LAW ENFORCEMENT

JAY of Appanoose, Chairperson

H-5985 FILED MARCH 28, 1988

*Amended on 3/28/88 (p. 1495)*  
*Amended on 3/28/88 (p. 1495)*  
*Amended on 3/28/88 by 6255, 6261, 6263,  
 6264, 6274, 6277, 6280 (p. 1500)*

SENATE FILE 484  
AS AMENDED BY H-5985  
FISCAL NOTE

In compliance with a written request received April 6, 1988, a fiscal note for SENATE FILE 484 AS AMENDED BY H5985 is hereby submitted pursuant to Joint Rule 17. Data used in developing this fiscal note are available from the Legislative Fiscal Bureau to members of the Legislature upon request.

Senate File 484 as amended by H 5985 creates an excess liability fund for health care providers, establishes a surcharge to be deposited into the fund, establishes a special surcharge, establishing qualifications for a health care provider or a patient to be protected by the fund, establishing a maximum limitation on the liability of the fund, creation of a compensation review board, authorization of the fund to procure reinsurance to protect the fund, authorization of the fund to provide primary insurance coverage to health care providers and providing for structured settlements.

#### Explanation

The patient compensation injury fund is expected to reduce insurance premiums by establishing a fund that would exempt health care providers from certain limits of liability. The fund would effectively reduce the amount of liability for which a health care provider could be liable. The fund would be financed by a 1% charge on hospital billings for inpatient acute care services and an annual surcharge based on premiums paid by health care providers for liability coverage. The fund will pay malpractice awards from \$500,000 to \$3 million, and a health care professional and hospitals shall provide coverage for awards under \$500,000 and over \$3 million.

A mediation service is established that would require an injured party to request mediation within fifteen days after filing a court action. Persons who have not filed a court action may also participate in mediation, however, it is mandatory. Mediation services will be funded by imposing an \$11.00 filing fee for mediation hearings.

The amendment establishes a Iowa Medical Care Availability Assistance Trust Fund for physicians who cannot afford their medical malpractice premiums. Physicians are eligible to receive compensation from the fund if their annual gross income derived from delivery of medical services.

#### Fiscal Effect

1. The Patient Compensation Fund is estimated to produce approximately \$6.5 million annually. It is unknown what amount would be paid out of the fund for claims within the established limits. However, the commissioner of Insurance shall determine when health care providers and hospitals would no longer have to pay into the fund, but would also require the general fund to be liable for any awards that could not be covered by the amount in the Patient Compensation Fund.
2. A mediation fund is established by charging a \$11.00 filing fee on the number of malpractice cases brought before the courts. It is unknown how much will be generated as a result of the filing fee, as it depends upon the number of malpractice cases filed.

Two, Fiscal Note, Senate File 484, as amended by H-5985

-2-

3. The Insurance Division shall distribute from funds appropriated from the general fund to physicians an amount equal to the amount by which the physicians premium payments for medical liability insurance exceed 15% of the physician's annual gross income. The bill appropriates \$150,000 to the Iowa Medical Care Availability Assistance Trust Fund.
4. Section 35 of the amendment requires the Insurance Division of the Department of Commerce to conduct a study to determine where the state has a shortage of needed medical services. No additional funds or staff are needed.

Source: The Insurance Division of the Department of Commerce (LSB 2860s, JEM)

APRIL 6, 1988

BY DENNIS PROUTY, FISCAL DIRECTOR

## SENATE FILE 484

H-6255

1 Amend the amendment, H-5985, to Senate File 484 as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 1, line 34, by striking the figure  
5 "147B.12" and inserting the following: "147B.13".

6 2. Page 1, by inserting after line 39 the  
7 following:

8 "\_\_\_\_\_. "Future injuries" means all legal harm  
9 relating to an injury which the trier of fact  
10 determines will be incurred by the injured party  
11 subsequent to the entry of judgment."

12 3. Page 2, line 31, by striking the words "or  
13 special surcharge".

14 4. Page 2, lines 32 and 33 by striking the word  
15 and figure "or 147B.8".

16 5. Page 3, line 4, by striking the words "or  
17 special surcharge".

18 6. Page 3, line 5, by striking the word and  
19 figure "or 147B.8".

20 7. Page 3, line 6, by striking the words "or the  
21 commissioner's designee".

22 8. Page 3, line 9, by striking the words  
23 "financial responsibility" and inserting the  
24 following: "insurance".

25 9. Page 3, by inserting after line 21 the  
26 following:

27 "Sec. \_\_\_\_\_. NEW SECTION. 147B.3A NOTICE -- AP-  
28 PLICATION FEE.

29 1. Prior to consideration for qualification  
30 pursuant to this chapter, a health care provider shall  
31 give notice to the commissioner of the provider's  
32 intention to qualify. The notice of intention shall  
33 be accompanied by a one-time application fee of fifty  
34 dollars for health care practitioners and five hundred  
35 dollars for hospitals.

36 2. Fees received by the commissioner pursuant to  
37 subsection 1 shall only be expended for purposes of  
38 payment of the reasonable expenses incurred or to be  
39 incurred in the implementation of this chapter.

40 3. To the extent that fees received pursuant to  
41 subsection 1 are in excess of the expenses of  
42 implementation of this chapter, the commissioner shall  
43 transfer the excess fees to the fund.

44 4. Notice and application fees received subsequent  
45 to the implementation of this chapter shall be placed  
46 in the fund upon receipt."

47 10. By striking page 3, line 40 through page 4,  
48 line 40.

49 11. Page 4, by striking lines 47 and 48 and  
50 inserting the following: "qualifying claims under

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1 this chapter and administrative expenses of the  
2 mediation system established pursuant to section  
3 147B.24, and the fund is appropriated for those  
4 purposes. Appropriations to the".

5 12. Page 5, by striking lines 13 through 21 and  
6 inserting the following:

7 "a. The annual surcharge shall not exceed the  
8 difference of the premium amount which the health care  
9 provider or hospital would pay annually to maintain a  
10 policy of medical liability insurance providing one  
11 million dollars of coverage less the premium amount  
12 which the health care provider or hospital pays or  
13 would pay to maintain a policy of medical liability  
14 insurance providing five hundred thousand dollars of  
15 coverage."

16 13. Page 5, by striking lines 25 through 27 and  
17 inserting the following: "section 147B.3 is due and  
18 payable at the time the health care provider or  
19 hospital qualifies pursuant to section 147B.3, and is  
20 payable".

21 14. Page 6, by striking lines 3 through 22 and  
22 inserting the following:

23 "Sec. 9. NEW SECTION. 147B.8 REINSURANCE."

24 15. Page 6, lines 28 and 29, by striking the  
25 words "or special surcharge".

26 16. By striking page 6, line 32 through page 7,  
27 line 3 and inserting the following:

28 "1. An assessment of one percent is imposed on  
29 patient billings for inpatient acute care services and  
30 routine and surgical outpatient services, other than  
31 those involving Medicaid or Medicare, by hospitals  
32 beginning January 1, 1989. This assessment shall be  
33 collected by the hospital and the assessments received  
34 shall be remitted by the hospital to the patient cata-  
35 strophic injury fund monthly. A hospital shall not be  
36 responsible for the collection or remittance of  
37 assessments on billings deemed uncollectible by the  
38 hospital.

39 2. The assessment created by this section shall be  
40 charged to and paid in full by the primary payor and  
41 shall be considered a covered benefit for purposes of  
42 third-party reimbursement. A primary payor's  
43 obligations under this section shall not be altered by  
44 contract or agreement."

45 17. Page 7, lines 11 and 12, by striking the  
46 words "fund is no longer actuarially sound" and  
47 inserting the following: "reinstatement of the  
48 assessment is necessary to maintain actuarial  
49 soundness of the fund".

50 18. Page 7, by inserting after line 28, the

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following:

2 "Sec. \_\_\_\_ . NEW SECTION. 147B.10A FUND NOT PART  
3 OF THE IOWA INSURANCE GUARANTY ASSOCIATION.

4 The fund is not an insurance company or insurer  
5 under the laws of this state and shall not be a member  
6 of, nor be entitled to file a claim against, the Iowa  
7 insurance guaranty association created under chapter  
8 515B."

9 19. Page 8, by striking lines 13 through 40 and  
10 inserting the following:

11 "Sec. \_\_\_\_ . NEW SECTION. 147B.12A PROFESSIONAL  
12 LIABILITY PREMIUM DISCOUNT.

13 Every insurer providing a policy of professional  
14 liability insurance to a health care provider in Iowa  
15 on or after January 1, 1989, shall review the health  
16 care provider's civil and criminal record for a period  
17 of not less than five years prior to the effective  
18 date of any new or renewed policy of insurance.

19 If the record establishes that the health care  
20 provider is claim-free for the period, the insurer  
21 shall do one of the following according to rules  
22 established by the commissioner:

23 1. Discount the provider's premium by an amount to  
24 be determined annually by the commissioner.

25 2. Issue the health care provider a policy based  
upon a preferred risk selection program, if the  
insurer has previously established such a program.

28 3. Specifically provide within the policy a review  
29 of the underwriting considerations accounting for the  
30 fact that the provider has had no claims within the  
31 last five years. However, the policy may be reviewed  
32 by the commissioner for reasonableness of underwriting  
33 considerations, and the commissioner may order that  
34 the underwriting considerations be replaced by a  
35 discount in the minimum amount provided in subsection  
36 1."

37 20. Page 9, by inserting after line 8, the  
38 following:

39 "The administrator and all persons employed or  
40 contracted with to provide staff services necessary  
41 for the operation of this chapter are employees of the  
42 state for purposes of chapter 25A, but for no other  
43 purposes."

44 21. Page 10, by striking lines 9 through 24.

45 22. Page 10, line 25, by striking the words  
46 "DEFENSE COSTS" and inserting the following: "COSTS  
47 OF DEFENSE".

48 23. Page 10, line 26, by striking the word  
49 "Coverage" and inserting the following: "1.  
50 Coverage".

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1 24. Page 10, by inserting after line 34, the  
2 following:

3 "2. The administrator may employ the services of  
4 outside legal counsel to defend the fund against  
5 claims and to assist a health care provider's insurer  
6 in defending a claim.

7 3. The administrator may, by agreement with the  
8 health care provider's insurer, allow the health care  
9 provider's insurer to provide a defense for a claim  
10 against the health care provider and the fund. The  
11 administrator and the health care provider's insurer  
12 may agree to any apportionment of the costs of  
13 defense.

14 4. All actual expenses of collecting, protecting,  
15 and administering the fund shall be paid from the  
16 fund, including necessary costs of outside legal  
17 counsel. The attorney general is not responsible for  
18 representation or legal defense of the fund."

19 25. Page 10, lines 39 and 40, by striking the  
20 words "under any applicable doctrine of" and inserting  
21 the following: "as provided elsewhere in statute or".

22 26. Page 10, line 48, by inserting after the word  
23 "rule." the following: "However, the fund shall not  
24 be liable for any occurrence occurring outside of this  
25 state involving a resident or nonresident health care  
26 provider, unless the commissioner has by rule reached  
27 an agreement of reciprocity with the other state."

28 27. Page 11, line 3, by inserting after the word  
29 "under" the following: "statute or".

30 28. Page 11, line 30, by inserting after the word  
31 "provider" the following: "or hospital".

32 29. Page 11, line 36, by inserting after the word  
33 "award" the following: "against all defendant health  
34 care providers and hospitals exceeds the financial  
35 responsibility of those health care providers and  
36 hospitals required under section 147B.3 and where the  
37 fund is responsible for paying damages".

38 30. Page 12, lines 8 and 9, by striking the words  
39 "assessed by the court and".

40 31. Page 12, line 22, by inserting after the word  
41 "provider's" the following: "or hospital's".

42 32. Page 13, line 27, by inserting after the word  
43 "provider" the following: "or hospital".

44 33. Page 14, line 7, by inserting after the word  
45 "providers" the following: "and hospitals".

46 34. Page 14, line 10, by striking the word  
47 "eleven" and inserting the following: "twenty".

48 35. Page 14, line 11, by inserting after the word  
49 "commissioner" the following: ", to be deposited in  
50 the patient catastrophic injury fund created pursuant

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to section 147B.6".

36. Page 15, line 12, by inserting after the word "providers" the following: "licensed under chapter 148 or 150A".

37. Page 15, lines 14 and 15, by striking the words "Iowa medical society" and inserting the following: "board of medical examiners".

38. Page 15, line 18, by inserting after the word "provider" the following: "licensed under chapter 148 or 150A".

39. Page 16, by striking lines 5 and 6 and inserting the following: "subsection shall be paid from the patient catastrophic injury fund created pursuant to section 147B.6."

40. Page 16, by striking lines 21 and 22 and inserting the following: "transcript and all parties shall be in attendance unless excused by the panel. Discovery is not allowed, and no witnesses may be".

41. Page 16, by striking lines 27 and 28 and inserting the following: "be compensated out of the patient catastrophic injury fund created pursuant to section 147B.6."

42. By striking page 16, line 38, through page 17, line 3, and inserting the following:

"Sec. \_\_\_\_ . NEW SECTION. 147B.30 MEDIATION SYSTEM EXPENSES AND REPORT.

The administrative expenses of the mediation system established in this chapter shall be paid out of the patient catastrophic injury fund created pursuant to section 147B.6."

43. Page 17, line 6, by striking the word "fund" and inserting the following: "system expenses".

44. Page 17, by inserting after line 9 the following:

"Sec. \_\_\_\_ . Section 258A.4, subsection 1, paragraph i, unnumbered paragraph 2, Code 1987, is amended to read as follows:

The commissioner of insurance shall by rule in consultation with the licensing boards enumerated in section 258A.1 and the department of public health, require insurance carriers which insure professional and occupational licensees or hospitals licensed pursuant to chapter 135B for acts or omissions which constitute negligence, careless acts or omissions in the practice of a profession or occupation or patient care to file reports with the commissioner of insurance within sixty days following final disposition of each malpractice claim settled or adjudicated. If the licensee or hospital is not insured by an insurance carrier admitted in this

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1 state, the licensee or hospital shall file the report.  
2 ~~The reports shall include information pertaining to~~  
3 ~~incidents by a licensee which may affect the licensee~~  
4 ~~as defined by rule, involving an insured of the~~  
5 ~~insurer the following:~~  
6 (1) The nature of the claim and date of  
7 occurrence.  
8 (2) The alleged injury and the damages asserted.  
9 (3) Attorney's fees and expenses incurred in  
10 connection with the claim or defense.  
11 (4) The amount of any settlement or judgment.  
12 (5) The name and address of the licensee or  
13 hospital. The commissioner of insurance shall forward  
14 reports pursuant to this section to the appropriate  
15 licensing board or to the department of public health.  
16 Reports of a settlement shall at the request of any  
17 party to the settlement be confidential and not a  
18 public record.

19 Sec. \_\_\_\_ . NEW SECTION. 258A.9A DUTIES OF CERTAIN  
20 MEDICAL LICENSEES.

21 1. As used in this section, unless the context  
22 otherwise requires, "licensee" means a person subject  
23 to the authority of a board specified in section  
24 258A.1, subsection 1, paragraph "j", "l", or "m", or  
25 subject to chapter 135B.

26 2. A licensee shall make a report within seven  
27 days to the appropriate licensing authority of any act  
28 which the licensee knows or should reasonably know  
29 constitutes malpractice, unauthorized practice, or  
30 professional misconduct. Where a hospital is a  
31 licensee, the hospital administrator shall make a  
32 report within ten days of any such acts by a person  
33 licensed under chapters 148, 150A, 152, or 153.  
34 Reports required under this section shall, where  
35 applicable, be coordinated with a report required  
36 under section 147.135, subsection 3. Failure to make  
37 the report is grounds for licensee discipline and a  
38 civil penalty of not less than five hundred dollars  
39 nor more than five thousand dollars. Fines collected  
40 pursuant to this section shall be transferred to the  
41 patient catastrophic injury fund created in section  
42 147B.6 for use as authorized in chapter 147B.

43 3. A report received pursuant to this section is  
44 confidential and shall not be released by the  
45 licensing board except where an action against the  
46 health care provider or hospital has been commenced  
47 and the release is pursuant to a court order. In no  
48 case shall the identity of the licensee making the  
49 report under subsection 2 be disclosed. Upon receipt  
50 of a report pursuant to this section, the licensing

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7

board shall investigate and take action as appropriate and within the authority provided in this chapter.

4. The duties in this section are in addition to any other duties of licensees and licensing boards contained elsewhere in this chapter.

Sec. . NEW SECTION. 515A.31 REGIONAL PRICING  
-- AUTHORIZATION TO COMMISSIONER -- PROCEDURE.

1. The commissioner of insurance shall conduct an examination of insurance rating practices relating to the use of nonstate specific experience in the setting of rates in this state, and shall take or recommend such action as necessary to maximize the impact which state experience has on the setting of rates in this state.

2. For purposes of such action, the commissioner may do all of the following:

a. Determine which lines of insurance necessary to the public welfare and safety are presently not price competitive.

b. Determine the lines of insurance which have sufficient state experience and permit the use of only state experience for ratemaking purposes.

c. Determine which lines of insurance presently lack sufficient state experience credibility and allow the use of regional experience to augment present state experience for ratemaking purposes.

d. Determine which lines of insurance presently lack sufficient state and regional credibility and allow the use of countrywide experience to augment present state and regional experience for ratemaking purposes.

e. Determine which states, jurisdictions, or rating areas are excessively dissimilar to this state, and suggesting the prohibition of their inclusion in any countrywide experience used for ratemaking purposes in this state. For purposes of this

paragraph, excessively dissimilar may be measured by evidence including, but not limited to, the following:

(1) The number of suits per one hundred thousand population in a covered line.

(2) The average size of judgments, awards, and settlements in a covered line.

(3) The significant differences in civil justice systems or procedures.

(4) The significant differences in insurance regulatory systems or procedures.

3. Prior to taking any action pursuant to this section, the commissioner shall publish notice of such action in the Iowa administrative bulletin not less than sixty days prior to the proposed action. Any

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1 affected insurer may request a hearing concerning the  
2 action prior to implementation."

3 45. Page 18, by striking lines 13 and 14, and  
4 inserting the following: "five hundred thousand  
5 dollars per occurrence. If a physician applying for".

6 46. Page 18, by striking lines 16 and 17, and  
7 inserting the following: "in excess of five hundred  
8 thousand dollars per occurrence, the department".

9 47. Page 18, by striking lines 19 and 20, and  
10 inserting the following: "if coverage were limited to  
11 five hundred thousand dollars per occurrence."

12 48. Page 19, line 14, by striking the words "one  
13 million" and inserting the following: "five hundred  
14 thousand".

15 49. Page 19, by inserting after line 43 the  
16 following:

17 "3. The commissioner may waive the requirements  
18 provided in subsection 1, paragraphs "a", "b", or "c",  
19 if the physician establishes that it was not possible  
20 for the physician to meet the requirement through no  
21 fault of the physician."

22 50. Page 19, line 45, by inserting after the word  
23 "insurance" the following: ", in conjunction with the  
24 department of public health,".

25 51. Page 20, line 37, by striking the words "and  
26 a special surcharge".

27 52. By renumbering, relettering, or redesignating  
28 and correcting internal references as necessary.

By JAY of Appanoose  
GRONINGA of Cerro Gordo  
HALVORSON of Clayton

H-6255 FILED APRIL 6, 1988

ADOPTED (p. 1484)

## SENATE FILE 484

H-6261

1 Amend amendment, H-5985, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 1, line 41, by inserting after the figure  
5 "148," the following: "150,".

6 2. Page 5, by striking line 23 and inserting the  
7 following: "the amount necessary to assure that the  
8 fund is actuarially sound."

9 3. Page 17, line 38, by striking the words  
10 "commencing July 1, 1989".

11 4. Page 20, line 25, by inserting after the  
12 figure "1989." the following: "Appropriations to the  
13 fund are not subject to reversion under section 8.33."

14 5. Page 20, line 31, by striking the words "July  
15 1" and inserting the following: "June 30".

By HALVORSON of Clayton  
JAY of Appanoose

H-6261 FILED APRIL 6, 1988

ADOPTED (p. 1484)

SENATE FILE 484

H-6264

1 Amend amendment, H-5985, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 5, by striking lines 42 through 46 and  
5 inserting the following:

6 "Sec. \_\_\_\_ . NEW SECTION. 147B.6A LIMITATION OF  
7 LIABILITY.

8 A health care provider or hospital qualified under  
9 this chapter determined to be liable for an  
10 occurrence, to which this chapter applies, resulting  
11 in an injury or death of a patient arising out of  
12 medical malpractice shall be liable for all amounts  
13 due under a judgment or settlement recoverable by an  
14 injured party in excess of any amount for which the  
15 fund is liable under section 147B.10."

16 2. Page 7, by striking lines 19 through 21 and  
17 inserting the following: "all sums to be paid under a  
18 judgment, verdict, award, or settlement approved by  
19 the court which exceeds five hundred thousand dollars,  
20 but does not exceed three million dollars, with  
21 respect to an".

22 3. Page 7, by inserting after line 28, the  
23 following:

24 "However, the fund is liable for the repayment to  
25 the general fund for any amounts expended for payment  
26 of any claims under this chapter. These amounts shall  
27 be repaid out of any amounts collected pursuant to  
28 this chapter in subsequent years which are in excess  
29 of the amount determined by the commissioner necessary  
30 to maintain the fund in an actuarially sound manner."

31 4. By renumbering as necessary.

By JAY of Appanoose

H-6264 FILED APRIL 6, 1988

ADOPTED (A 141)

## SENATE FILE 484

H-6263

1 Amend the amendment, H-5985, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 3, by striking line 10 and inserting the  
5 following: "as required in subsection 1 and pays a  
6 one-time surcharge as may be determined to be  
7 appropriate by the commissioner. The amount of the  
8 surcharge shall not exceed the cost of five hundred  
9 thousand dollars of medical liability coverage above  
10 the initial five hundred thousand dollars of medical  
11 liability coverage for the period subsequent to the  
12 health care provider's retirement or ceasing to do  
13 business. The commissioner shall adopt rules to  
14 implement this subsection."

15 2. Page 5, line 48, by striking the word "The"  
16 and inserting the following:

17 "1. The".

18 3. Page 6, by inserting after line 2 the  
19 following:

20 "2. If at any time prior to the health care  
21 provider's or hospital's qualification under this  
22 chapter, the health care provider or hospital had  
23 acquired coverage under an occurrence form policy of  
24 medical liability insurance for an occurrence of  
25 alleged medical malpractice occurring during the term  
26 that policy was in effect, the fund shall provide  
27 coverage only for claims for alleged medical  
28 malpractice covered under the policy to the extent  
29 that a judgment or settlement exceeds the limits of  
30 the policy.

31 3. The fund shall not provide coverage for a  
32 medical malpractice claim against a health care  
33 provider or hospital qualified under this chapter if  
34 the medical malpractice claim was made against that  
35 health care provider or hospital prior to the time of  
36 the health care provider's or hospital's qualification  
37 under this chapter.

38 4. The fund may provide coverage for an alleged  
39 occurrence of medical malpractice by a health care  
40 provider or hospital which occurred prior to the  
41 health care provider's or hospital's qualification  
42 under this chapter if the health care provider or  
43 hospital had not received notice and the health care  
44 provider or hospital had a claims made policy of  
45 medical liability insurance in effect immediately  
46 prior to the health care provider's or hospital's  
47 qualification under this chapter. A health care  
48 provider or hospital may be required to pay a  
49 surcharge for such coverage as determined by the  
50 commissioner to be appropriate if the prior claims

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1 made policy was not mature."

By GRONINGA of Cerro Gordo

H-6263 FILED APRIL 6, 1988

ADOPTED (p. 1785)

SENATE FILE 484

H-6269

1 Amend the amendment, H-5985, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

A 4 1. By striking page 1, line 5 through page 8,  
5 line 12.

6 2. Page 8, line 17, by striking the word  
7 "commissioner" and inserting the following: "health  
8 data commission".

9 3. Page 8, line 21, by striking the word  
10 "commissioner" and inserting the following: "health  
11 data commission".

B 12 4. Page 8, line 30, by striking the word  
13 "commissioner" and inserting the following: "health  
14 data commission".

15 5. Page 8, line 36, by striking the word  
16 "commissioner" and inserting the following: "health  
17 data commission".

18 6. By striking page 8, line 41 through page 13,  
19 line 22.

20 7. Page 19, by inserting after line 43 the  
21 following:

22 "Sec. \_\_\_\_ . Section 617.16, Code 1987, is amended  
23 by striking the section and inserting in lieu thereof  
24 the following:

25 617.16 FRIVOLOUS ACTIONS.

26 In all cases the court may, in its discretion, upon  
27 application by the prevailing party and in an amount  
28 determined by the court, charge reasonable attorney  
29 fees as costs payable to the prevailing party, if the  
30 court finds that the losing party did not have a  
31 reasonable likelihood of recovery or a reasonable  
32 likelihood of a successful defense. The charging of  
33 costs under this section is the sole responsibility of  
34 the named parties and shall not in any way be  
35 considered a cost of defense or reduce in any manner  
36 insurance coverage provided to either party thereby  
37 reducing the amount of coverage available for the  
38 payment of any judgment rendered against that party.

39 Sec. \_\_\_\_ . Section 668.3, subsection 7, Code  
40 Supplement 1987, is amended to read as follows:

41 7. ~~When a~~ A final judgment or award is entered,  
42 ~~any shall be itemized as to past and future losses.~~  
43 Any party may petition the court for a determination  
44 of the appropriate payment method of such judgment or  
45 award. If so petitioned the court may order that the  
46 payment method for all or part of the judgment or  
47 award be by structured, periodic, or other nonlump-sum  
48 payments. However, the court shall not order a  
49 structured, periodic, or other nonlump-sum payment  
50 method if it finds that any of the following are true:

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- 1 a. The payment method would be inequitable.
- 2 b. The payment method provides insufficient
- 3 guarantees of future collectibility of the judgment or
- 4 award.
- 5 c. Payments made under the payment method could be
- 6 subject to other claims, past or future, against the
- 7 defendant or the defendant's insurer.

8 The court shall enter a judgment ordering periodic  
 9 payments for future losses if the portion of the  
 10 judgment or award entered for future losses exceeds  
 11 one hundred thousand dollars.

12 Sec. . NEW SECTION. 668.15 MAXIMUM LIABILITY  
 13 FOR NONECONOMIC DAMAGES.

14 1. In a verdict issued pursuant to this chapter,  
 15 that portion of a verdict attributable to noneconomic  
 16 damages for pain and suffering, loss of consortium, or  
 17 loss of chance against any one defendant shall not  
 18 exceed two hundred fifty thousand dollars.

19 2. In an action pursuant to this chapter and tried  
 20 to a jury, and in which noneconomic damages for pain  
 21 and suffering, loss of consortium, or loss of chance  
 22 are sought or argued, the court shall, unless  
 23 otherwise agreed to by all parties, instruct the jury  
 24 that the portion of a verdict attributable to  
 25 noneconomic damages for pain and suffering, loss of  
 26 consortium, or loss of chance against any one  
 27 defendant shall not exceed two hundred fifty thousand  
 28 dollars.

29 3. In an action brought pursuant to this chapter  
 30 and tried to a jury, and in which noneconomic damages  
 31 for pain and suffering, loss of consortium, or loss of  
 32 chance are sought or argued, the court shall, unless  
 33 otherwise agreed to by all parties, require that the  
 34 jury return a verdict itemizing the injuries and  
 35 damages awarded pursuant to the verdict."

By HUMMEL of Benton

H-6269 FILED APRIL 6, 1988

DIVISION A - NOT GERMANE, DIVISION B - OUT OF ORDER

(p. 1422)

(p. 1444)

## SENATE FILE 484

H-6273

1 Amend the amendment, H-5985, to Senate File 484, as  
 2 amended, passed, and reprinted by the Senate, as  
 3 follows:

4 1. Page 7, by inserting after line 28 the fol-  
 5 lowing:

6 "Sec. \_\_\_\_ . NEW SECTION. 147B.10A MAXIMUM  
 7 LIABILITY FOR NONECONOMIC DAMAGES.

8 1. In a verdict issued pursuant to this chapter,  
 9 that portion of a verdict attributable to noneconomic  
 10 damages including, but not limited to, damages for  
 11 pain and suffering, loss of consortium, loss of  
 12 chance, or punitive or exemplary damages against any  
 13 one defendant shall not exceed two hundred fifty  
 14 thousand dollars.

15 2. In an action pursuant to this chapter and tried  
 16 to a jury, and in which noneconomic damages including,  
 17 but not limited to, damages for pain and suffering,  
 18 loss of consortium, loss of chance, or punitive or  
 19 exemplary damages are sought or argued, the court  
 20 shall, unless otherwise agreed to by all parties,  
 21 instruct the jury that the portion of a verdict  
 22 attributable to noneconomic damages including, but not  
 23 limited to, damages for pain and suffering, loss of  
 24 consortium, loss of chance, or punitive or exemplary  
 25 damages against any one defendant shall not exceed two  
 26 hundred fifty thousand dollars.

27 3. In an action brought pursuant to this chapter  
 28 and tried to a jury, and in which noneconomic damages  
 29 including, but not limited to, damages for pain and  
 30 suffering, loss of consortium, loss of chance, or  
 31 punitive or exemplary damages are sought or argued,  
 32 the court shall, unless otherwise agreed to by all  
 33 parties, require that the jury return a verdict  
 34 itemizing the injuries and damages awarded pursuant to  
 35 the verdict."

36 2. Renumber as necessary.

By STROMER of Hancock

H-6273 FILED APRIL 6, 1988

LOST (p. 1478)

## SENATE FILE 484

H-6274

1 Amend amendment, H-5985, to Senate File 484 as  
 2 amended, passed, and reprinted by the Senate, as  
 3 follows:

4 1. Page 2, line 30, by inserting after the word  
 5 "dollars" the following: "per occurrence".

By CHAPMAN of Linn

H-6274 FILED APRIL 6, 1988

ADOPTED (p. 1478)

## SENATE FILE 484

H-6270

1 Amend the amendment, H-5985, to Senate File 484 as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:  
4 1. Page 19, by inserting after line 43 the  
5 following:  
6 "Sec. \_\_\_\_ . Section 614.8, Code 1987, is amended to  
7 read as follows:  
8 614.8 MINORS AND MENTALLY ILL PERSONS.  
9 The Other than in actions by minors brought for  
10 medical malpractice, the times limited for actions  
11 herein, except those brought for penalties and  
12 forfeitures, shall-be are extended in favor of minors  
13 and mentally ill persons, so that they shall have one  
14 year from and after the termination of such the  
15 disability within which to commence said an action.  
16 The times limited for actions brought for medical  
17 malpractice are extended in favor of minors less than  
18 six years of age so that they have until their eighth  
19 birthday to commence an action."  
20 2. Renumber as necessary.

By HALVORSON of Clayton  
LAGESCHULTE of Bremer

H-6270 FILED APRIL 6, 1988

NOT GERMANE (1/14/88)

## SENATE FILE 484

H-6278

1 Amend amendment, H-5985, to Senate File 484 as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 13, by striking line 25 and inserting the  
5 following: "to assist the".

6 2. By striking page 14, line 39 through page 16,  
7 line 10 and inserting the following:

8 "Sec. \_\_\_\_ . NEW SECTION. 147B.27 MEDIATOR.

9 Upon receipt of a request for mediation by the  
10 injured party, the commissioner shall submit a written  
11 request to the American arbitration association for  
12 appointment of a mediator to resolve the dispute. If  
13 the parties fail to resolve the dispute the mediator  
14 shall file a report stating that the dispute has not  
15 been resolved with the commissioner upon expiration of  
16 the mediation period. The person serving as the  
17 mediator is immune from civil liability for any good  
18 faith act or omission within the scope of the  
19 mediator's powers and duties under this chapter. The  
20 mediator's fee and reasonable expenses shall be paid  
21 out of the patient catastrophic injury fund created  
22 pursuant to section 147B.6."

23 3. Page 16, lines 24 and 25, by striking the  
24 words "mediation panel or any member of the panel" and  
25 inserting the following: "mediator".

26 4. Page 16, by striking lines 30 and 31 and  
27 inserting the following: "of a mediator shall be kept  
28 confidential by the mediator and all other persons".

By CONNORS of Polk  
BISIGNANO of Polk

H-6278 FILED APRIL 6, 1988

LOST (y 1475)

## SENATE FILE 484

H-6279

1 Amend amendment, H-5985, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. By striking page 6, line 30 through page 7,  
5 line 14.

By BENNETT of Ida

H-6279 FILED APRIL 6, 1988

LOST (y 1491)

## SENATE FILE 484

H-6276

1 Amendment amendment, H-5985, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 5, by inserting after line 46 the  
5 following:

6 "Sec. \_\_\_\_ . NEW SECTION. 147B.6A LIMITATION OF  
7 RECOVERY.

8 1. The total amount recoverable by an injured  
9 party from all liable health care providers and  
10 hospitals and the fund for an occurrence to which this  
11 chapter applies resulting in an injury or death of a  
12 patient arising out of medical malpractice shall not  
13 exceed one million dollars.

14 2. A health care provider or hospital is not  
15 liable for an amount of any one judgment or settlement  
16 in excess of five hundred thousand dollars. Subject  
17 to the limits in this section, an amount due from a  
18 judgment or settlement which is in excess of the  
19 liability of all health care providers and hospitals  
20 shall be paid from the fund pursuant to this chapter."

21 2. Renumber as necessary.

By SCHNEKLOTH of Scott

H-6276 FILED APRIL 6, 1988

LOST (4/14/88)

## SENATE FILE 484

H-6277

1 Amend amendment, H-5985, to Senate File 484, as  
2 amended, passed, and reprinted by the Senate, as  
3 follows:

4 1. Page 9, by striking lines 13 through 30.

By GRONINGA of Cerro Gordo

H-6277 FILED APRIL 6, 1988

ADOPTED (4/14/88)

## SENATE FILE 484

H-6281

1 Amend the amendment, H-5985, to Senate File 484, as  
 2 amended, passed, and reprinted by the Senate, as  
 3 follows:

4 1. Page 11, by striking lines 35 through 38 and  
 5 inserting the following:

6 "2. The court, in a medical malpractice action  
 7 subject to this chapter in which the fund is liable  
 8 for a damage award for future injuries to a party in  
 9 excess of two hundred fifty thousand dollars and upon  
 10 application of one of the".

11 2. By striking page 12, line 33, through page 13,  
 12 line 22.

By HANSEN of Woodbury  
 BISIGNANO of Polk  
 JOCHUM of Dubuque

H-6281 FILED APRIL 6, 1988

LOST ( )

## SENATE FILE 484

H-6283

1 Amend amendment, H-5985, to Senate File 484, as  
 2 amended, passed, and reprinted by the Senate, as  
 3 follows:

4 1. Page 7, by inserting after line 28 the  
 5 following:

6 "Sec. \_\_\_\_ . NEW SECTION. 1478.10A MAXIMUM  
 7 LIABILITY FOR NONECONOMIC DAMAGES.

8 1. In a verdict issued pursuant to this chapter,  
 9 that portion of a verdict attributable to noneconomic  
 10 damages including, but not limited to, damages for  
 11 pain and suffering, loss of consortium, loss of  
 12 chance, or punitive or exemplary damages against any  
 13 one defendant shall not exceed five hundred thousand  
 14 dollars.

15 2. In an action pursuant to this chapter and tried  
 16 to a jury, and in which noneconomic damages including,  
 17 but not limited to, damages for pain and suffering,  
 18 loss of consortium, loss of chance, or punitive or  
 19 exemplary damages are sought or argued, the court  
 20 shall, unless otherwise agreed to by all parties,  
 21 instruct the jury that the portion of a verdict  
 22 attributable to noneconomic damages including, but not  
 23 limited to, damages for pain and suffering, loss of  
 24 consortium, loss of chance, or punitive or exemplary  
 25 damages against any one defendant shall not exceed  
 26 five hundred thousand dollars.

27 3. In an action brought pursuant to this chapter  
 28 and tried to a jury, and in which noneconomic damages  
 29 including, but not limited to, damages for pain and  
 30 suffering, loss of consortium, loss of chance, or  
 31 punitive or exemplary damages are sought or argued,  
 32 the court shall, unless otherwise agreed to by all  
 33 parties, require that the jury return a verdict  
 34 itemizing the injuries and damages awarded pursuant to  
 35 the verdict."

36 2. By renumbering as necessary.

By SKOW of Guthrie

H-6283 FILED APRIL 6, 1988

## SENATE FILE 484

H-6280

1 Amend the amendment, H-5985, to Senate File 484 as  
2 amended, passed, and reprinted by the Senate as  
3 follows:

4 1. Page 1, by striking lines 5 through 26, and  
5 inserting the following:

6 "Section 1. FINDINGS -- PURPOSE. The general  
7 assembly finds that access to high quality medical and  
8 hospital services at reasonable costs is in the public  
9 interest and is necessary to ensure the health,  
10 safety, and welfare of Iowa citizens.

11 The general assembly finds that the increasing  
12 costs and decreasing availability of adequate medical  
13 liability insurance for health care providers and  
14 hospitals threaten the public access to high quality  
15 medical and hospital services at reasonable costs.

16 The general assembly finds that it has become  
17 necessary to take legislative action to achieve the  
18 public interest and assure the health, safety, and  
19 welfare of Iowa citizens, such action to include the  
20 balancing of interests between an individual's right  
21 of recovery for injuries and society's need for  
22 necessary services.

23 It is the purpose of this Act to maintain and  
24 increase the public's access to high quality medical  
25 and hospital services at reasonable costs, thereby  
26 protecting the health, safety, and welfare of the  
27 citizens of this state. To effectuate this purpose,  
28 it is the intent of the general assembly that the  
29 provisions of this Act be construed liberally to  
30 achieve the following:

31 1. An increase in the availability and  
32 affordability of medical liability insurance for  
33 health care providers and hospitals.

34 2. To maximize an individual's right to redress  
35 for injuries within the confines of the broader  
36 purpose of protecting the health, safety, and welfare  
37 of all citizens.

38 3. To obtain such data as is necessary to develop  
39 long-term solutions to the problems related to these  
40 findings.

41 4. To decrease the incidence of medical  
42 malpractice.

43 5. To provide such incentives as are necessary to  
44 retain medical and hospital services in all parts of  
45 this state.

46 6. To increase the resolution of medical liability  
47 actions by more cost-efficient means than traditional  
48 litigation.

49 7. To insure that the costs of medical liability  
50 insurance accurately reflect the exposure to risk."

By JAY of Appanoose

GRONINGA of Cerro Gordo

HALVORSON of Clayton

H-6280 FILED APRIL 6, 1988

ADOPTED (p. 1436)

HOUSE AMENDMENT TO  
SENATE FILE 484

S-5840

1 Amend Senate File 484 as amended, passed, and  
2 reprinted by the Senate as follows:

3 1. By striking everything after the enacting  
4 clause and inserting the following:

5 "Section 1. FINDINGS -- PURPOSE. The general  
6 assembly finds that access to high quality medical and  
7 hospital services at reasonable costs is in the public  
8 interest and is necessary to ensure the health,  
9 safety, and welfare of Iowa citizens.

10 The general assembly finds that the increasing  
11 costs and decreasing availability of adequate medical  
12 liability insurance for health care providers and  
13 hospitals threaten the public access to high quality  
14 medical and hospital services at reasonable costs.

15 The general assembly finds that it has become  
16 necessary to take legislative action to achieve the  
17 public interest and assure the health, safety, and  
18 welfare of Iowa citizens, such action to include the  
19 balancing of interests between an individual's right  
20 of recovery for injuries and society's need for  
21 necessary services.

22 It is the purpose of this Act to maintain and  
23 increase the public's access to high quality medical  
24 and hospital services at reasonable costs, thereby  
25 protecting the health, safety, and welfare of the  
26 citizens of this state. To effectuate this purpose,  
27 it is the intent of the general assembly that the  
28 provisions of this Act be construed liberally to  
29 achieve the following:

30 1. An increase in the availability and  
31 affordability of medical liability insurance for  
32 health care providers and hospitals.

33 2. To maximize an individual's right to redress  
34 for injuries within the confines of the broader  
35 purpose of protecting the health, safety, and welfare  
36 of all citizens.

37 3. To obtain such data as is necessary to develop  
38 long-term solutions to the problems related to these  
39 findings.

40 4. To decrease the incidence of medical  
41 malpractice.

42 5. To provide such incentives as are necessary to  
43 retain medical and hospital services in all parts of  
44 this state.

45 6. To increase the resolution of medical liability  
46 actions by more cost-efficient means than traditional  
47 litigation.

48 7. To insure that the costs of medical liability  
49 insurance accurately reflect the exposure to risk.

50 Sec. 2. NEW SECTION. 147B.1 SHORT TITLE.

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1 This chapter shall be known as the "Health Care  
2 Provider and Patient Assistance Act."

3 Sec. 3. NEW SECTION. 147B.2 DEFINITIONS.

4 As used in this chapter, unless the context  
5 requires otherwise:

6 1. "Administrator" means the compensation fund  
7 administrator appointed pursuant to section 147B.13,  
8 or the administrator's designee.

9 2. "Commissioner" means the commissioner of  
10 insurance.

11 3. "Fund" means the patient catastrophic injury  
12 fund established in section 147B.6.

13 4. "Future injuries" means all legal harm relating  
14 to an injury which the trier of fact determines will  
15 be incurred by the injured party subsequent to the  
16 entry of judgment.

17 5. "Health care provider" means a person licensed  
18 or certified in this state under chapter 148, 150,  
19 150A, 152, or 153 to provide professional health care  
20 services to an individual during that individual's  
21 medical care, treatment, or confinement.

22 6. "Health services" means clinically related  
23 diagnostic, curative, or rehabilitative services, and  
24 includes alcoholism, drug abuse, and mental health  
25 services.

26 7. "Hospital" means a hospital licensed pursuant  
27 to chapter 135B.

28 8. "Injured person" means the person during whose  
29 medical treatment or care the acts or omissions of  
30 medical malpractice are determined to have occurred.

31 9. "Injured party" means a party plaintiff to a  
32 medical malpractice action or other person not a party  
33 to the action but who may have a cause of action  
34 against a health care provider or hospital as a result  
35 of an injury alleged to have occurred as a result of  
36 medical malpractice, and includes the injured person.

37 10. "Injury" means a legal harm for which damages  
38 are recoverable in an action arising under this  
39 chapter.

40 11. "Medical malpractice" means acts or omissions  
41 of a health care practitioner in the practice of the  
42 practitioner's profession or occupation, or acts or  
43 omissions of a hospital in patient treatment or care,  
44 including but not limited to negligence, failure to  
45 provide care, breach of contract relating to providing  
46 care, or claim based upon failure to obtain informed  
47 consent for an operation or treatment.

48 Sec. 4. NEW SECTION. 147B.3 QUALIFIED PROVIDER -  
49 - PATIENT.

50 1. A health care provider is qualified to

1 participate under this chapter if the health care  
2 provider does the following:

3 a. Files with the commissioner proof that the  
4 health care provider is insured with an insurance  
5 company admitted to do business in this state under a  
6 policy of medical liability insurance providing a  
7 minimum of five hundred thousand dollars per  
8 occurrence in coverage.

9 b. Pays a surcharge levied on the health care  
10 provider pursuant to section 147B.6.

11 2. A hospital is qualified to participate under  
12 this chapter if the hospital does the following:

13 a. Files with the commissioner proof of financial  
14 responsibility in an amount of five hundred thousand  
15 dollars per occurrence. The hospital is qualified as  
16 long as the required proof of financial responsibility  
17 remains effective. Financial responsibility is proven  
18 by providing a certified copy of a professional  
19 liability insurance policy currently in force, with  
20 annual proof of policy renewal required; a notarized  
21 letter from the professional liability insurance  
22 carrier stating that the hospital is covered by a  
23 policy of professional liability insurance, with  
24 annual proof of policy renewal required; the posting  
25 of a bond; or the payment of cash to the commissioner.  
26 If proof of financial responsibility is by  
27 professional liability insurance the hospital shall  
28 provide information evidencing the policy period,  
29 amount of coverage, premium paid, claim form of  
30 policy, and any reservation of rights by the carrier.

31 b. Pays a surcharge levied on the hospital  
32 pursuant to section 147B.6.

33 3. The commissioner may permit qualification of a  
34 health care provider who has retired or ceased doing  
35 business if the health care provider files proof of  
36 insurance as required in subsection 1 and pays a one-  
37 time surcharge as may be determined to be appropriate  
38 by the commissioner. The amount of the surcharge  
39 shall not exceed the cost of five hundred thousand  
40 dollars of medical liability coverage above the  
41 initial five hundred thousand dollars of medical  
42 liability coverage for the period subsequent to the  
43 health care provider's retirement or ceasing to do  
44 business. The commissioner shall adopt rules to  
45 implement this subsection.

46 4. A claim or cause of action against a health  
47 care provider or hospital shall not be denied as a  
48 result of the health care provider or hospital not  
49 being qualified at the time the action is instituted  
50 if the health care provider or hospital was qualified

1 at the time of the alleged occurrence. A health care  
2 provider or hospital not qualified at the time of the  
3 alleged occurrence is not qualified under this chapter  
4 by filing proof of financial responsibility and making  
5 payment of the required surcharge subsequent to the  
6 occurrence giving rise to the claim.

7 Sec. 5. NEW SECTION. 147B.3A NOTICE -- AP-  
8 PLICATION FEE.

9 1. Prior to consideration for qualification  
10 pursuant to this chapter, a health care provider shall  
11 give notice to the commissioner of the provider's  
12 intention to qualify. The notice of intention shall  
13 be accompanied by a one-time application fee of fifty  
14 dollars for health care practitioners and five hundred  
15 dollars for hospitals.

16 2. Fees received by the commissioner pursuant to  
17 subsection 1 shall only be expended for purposes of  
18 payment of the reasonable expenses incurred or to be  
19 incurred in the implementation of this chapter.

20 3. To the extent that fees received pursuant to  
21 subsection 1 are in excess of the expenses of  
22 implementation of this chapter, the commissioner shall  
23 transfer the excess fees to the fund.

24 4. Notice and application fees received subsequent  
25 to the implementation of this chapter shall be placed  
26 in the fund upon receipt.

27 Sec. 6. NEW SECTION. 147B.4 EXPRESS CONTRACT  
28 ASSURING RESULTS.

29 Liability shall not be imposed upon a health care  
30 provider or hospital as a result of an alleged breach  
31 of an express or implied contract assuring results to  
32 be obtained by any procedure undertaken in the course  
33 of health care unless the contract is expressly set  
34 forth in writing and is signed by the health care  
35 provider or hospital or by an authorized agent of the  
36 health care provider or hospital. The only exception  
37 to the written requirement shall be when the health  
38 care provider or hospital expressly represents to the  
39 patient in the presence of an employee of the health  
40 care provider or hospital the results to be obtained  
41 from a procedure undertaken. This section does not  
42 exempt a health care provider or hospital from the  
43 standard of due care in administering any procedure  
44 undertaken.

45 Sec. 7. NEW SECTION. 147B.6 PATIENT CATASTROPHIC  
46 INJURY FUND.

47 1. A patient catastrophic injury fund is created  
48 for the purposes stated in this chapter. The fund and  
49 income from the fund shall be deposited with the  
50 treasurer of state to be used for the payment of

1 qualifying claims under this chapter and  
2 administrative expenses of the mediation system  
3 established pursuant to section 147B.24, and the fund  
4 is appropriated for those purposes. Appropriations to  
5 the fund are not subject to reversion under section  
6 8.33.

7 The fund shall be wholly responsible for paying  
8 settlements or judgments in excess of the amount of  
9 the combined financial responsibility required under  
10 section 147B.3. If more than one health care provider  
11 or hospital, or both, are liable on a claim, the  
12 combined financial responsibility amounts shall be  
13 primary coverage, and the fund shall constitute  
14 secondary coverage.

15 2. An annual surcharge shall be levied on all  
16 health care providers and hospitals qualifying under  
17 section 147B.3. The surcharge for a health care  
18 provider or hospital is determined by the commissioner  
19 subject to the following limitations:

20 a. The annual surcharge shall not exceed the  
21 difference of the premium amount which the health care  
22 provider or hospital would pay annually to maintain a  
23 policy of medical liability insurance providing one  
24 million dollars of coverage less the premium amount  
25 which the health care provider or hospital pays or  
26 would pay to maintain a policy of medical liability  
27 insurance providing five hundred thousand dollars of  
28 coverage.

29 b. The amount of the surcharge shall not exceed  
30 the amount necessary to assure that the fund is  
31 actuarially sound.

32 3. The surcharge required for qualification under  
33 section 147B.3 is due and payable at the time the  
34 health care provider or hospital qualifies pursuant to  
35 section 147B.3, and is payable annually thereafter in  
36 amounts as determined by the commissioner.

37 4. If the annual premium surcharge required for  
38 qualification under section 147B.3 is not paid within  
39 the time specified in subsection 3, the qualification  
40 of the health care provider or hospital shall be  
41 suspended until the annual premium surcharge is paid.  
42 The suspension shall not be effective as to patients  
43 claiming against the health care provider or hospital  
44 unless, at least thirty days before the effective date  
45 of the suspension, a written notice giving the date  
46 upon which the suspension becomes effective has been  
47 provided by the commissioner to the health care  
48 provider or hospital.

49 Sec. 8. NEW SECTION. 147B.6A LIMITATION OF  
50 LIABILITY.

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1 A health care provider or hospital qualified under  
2 this chapter determined to be liable for an  
3 occurrence, to which this chapter applies, resulting  
4 in an injury or death of a patient arising out of  
5 medical malpractice shall be liable for all amounts  
6 due under a judgment or settlement recoverable by an  
7 injured party in excess of any amount for which the  
8 fund is liable under section 147B.10.

9 Sec. 9. NEW SECTION. 147B.7 COVERAGE BY FUND.

10 1. The fund shall provide coverage to the health  
11 care provider or hospital on the same basis as the  
12 underlying professional liability insurance or other  
13 proof of financial responsibility maintained by the  
14 health care provider or hospital.

15 2. If at any time prior to the health care  
16 provider's or hospital's qualification under this  
17 chapter, the health care provider or hospital had  
18 acquired coverage under an occurrence form policy of  
19 medical liability insurance for an occurrence of  
20 alleged medical malpractice occurring during the term  
21 that policy was in effect, the fund shall provide  
22 coverage only for claims for alleged medical  
23 malpractice covered under the policy to the extent  
24 that a judgment or settlement exceeds the limits of  
25 the policy.

26 3. The fund shall not provide coverage for a  
27 medical malpractice claim against a health care  
28 provider or hospital qualified under this chapter if  
29 the medical malpractice claim was made against that  
30 health care provider or hospital prior to the time of  
31 the health care provider's or hospital's qualification  
32 under this chapter.

33 4. The fund may provide coverage for an alleged  
34 occurrence of medical malpractice by a health care  
35 provider or hospital which occurred prior to the  
36 health care provider's or hospital's qualification  
37 under this chapter if the health care provider or  
38 hospital had not received notice and the health care  
39 provider or hospital had a claims made policy of  
40 medical liability insurance in effect immediately  
41 prior to the health care provider's or hospital's  
42 qualification under this chapter. A health care  
43 provider or hospital may be required to pay a  
44 surcharge for such coverage as determined by the  
45 commissioner to be appropriate if the prior claims  
46 made policy was not mature.

47 Sec. 10. NEW SECTION. 147B.8 REINSURANCE.

48 The commissioner may cause all or any part of the  
49 potential liability of the fund to be reinsured, if  
50 reinsurance is available on a fair and reasonable

1 basis. The cost of the reinsurance shall be paid by  
2 the fund and the fact of the reinsurance shall be  
3 taken into account in determining the surcharge.

4 Sec. 11. NEW SECTION. 147B.9 SOURCE OF FUNDING  
5 FOR PATIENT CATASTROPHIC INJURY FUND.

6 1. An assessment of one percent is imposed on  
7 patient billings for inpatient acute care services and  
8 routine and surgical outpatient services, other than  
9 those involving Medicaid or Medicare, by hospitals  
10 beginning January 1, 1989. This assessment shall be  
11 collected by the hospital and the assessments received  
12 shall be remitted by the hospital to the patient cata-  
13 strophic injury fund monthly. A hospital shall not be  
14 responsible for the collection or remittance of  
15 assessments on billings deemed uncollectible by the  
16 hospital.

17 2. The assessment created by this section shall be  
18 charged to and paid in full by the primary payor and  
19 shall be considered a covered benefit for purposes of  
20 third-party reimbursement. A primary payor's  
21 obligations under this section shall not be altered by  
22 contract or agreement.

23 3. The assessment pursuant to subsection 1 shall  
24 be implemented on January 1, 1989, and shall only  
25 continue in force and effect until the patient  
26 catastrophic injury fund is found to be actuarially  
27 sound. The determination that the fund is actuarially  
28 sound shall be made by the commissioner. The  
29 assessment shall only be reinstated upon order of  
30 the commissioner based upon evidence that the  
31 reinstatement of the assessment is necessary to  
32 maintain actuarial soundness of the fund. The order  
33 shall only be made following notice and hearing to  
34 interested parties.

35 Sec. 12. NEW SECTION. 147B.10 LIABILITY OF  
36 PATIENT CATASTROPHIC INJURY FUND -- STANDING  
37 APPROPRIATION.

38 The patient catastrophic injury fund is liable for  
39 all sums to be paid under a judgment, verdict, award,  
40 or settlement approved by the court which exceeds five  
41 hundred thousand dollars, but does not exceed three  
42 million dollars, with respect to an occurrence of  
43 medical malpractice in this state.

44 There is appropriated from the general fund of the  
45 state to the patient catastrophic injury fund each  
46 fiscal year an amount sufficient to pay any amounts  
47 outstanding for which the fund is liable when all  
48 moneys deposited in the fund for that year have been  
49 expended.

50 However, the fund is liable for the repayment to

1 the general fund for any amounts expended for payment  
2 of any claims under this chapter. These amounts shall  
3 be repaid out of any amounts collected pursuant to  
4 this chapter in subsequent years which are in excess  
5 of the amount determined by the commissioner necessary  
6 to maintain the fund in an actuarially sound manner.

7 Sec. 13. NEW SECTION. 147B.10A FUND NOT PART OF  
8 THE IOWA INSURANCE GUARANTY ASSOCIATION.

9 The fund is not an insurance company or insurer  
10 under the laws of this state and shall not be a member  
11 of, nor be entitled to file a claim against, the Iowa  
12 insurance guaranty association created under chapter  
13 515B.

14 Sec. 14. NEW SECTION. 147B.11 ANNUAL REPORT.

15 The commissioner shall, pursuant to rules issued by  
16 the commissioner, on or before the first day of  
17 February of each year, provide to the chairpersons,  
18 vice chairpersons, and ranking members of the senate  
19 standing committees on judiciary and commerce, and the  
20 house of representatives standing committees on  
21 judiciary and law enforcement, and small business and  
22 commerce, a report regarding claims filed against the  
23 fund and claims closed involving the fund for the  
24 previous calendar year. However, the report shall not  
25 include any confidential information regarding a claim  
26 currently being litigated or which will be litigated,  
27 or a claim where the parties have entered into or will  
28 enter into discussions intended to result in a  
29 settlement of the claim, if the release of the  
30 information may impede settlement negotiations or  
31 adversely affect either party to the negotiations or  
32 litigation. The report shall contain to the extent  
33 the information is available the following  
34 information:

- 35 1. Parties to the claims.
- 36 2. Causes of action.
- 37 3. Amounts reserved or paid per claim, including  
38 the present value for structured settlements or  
39 awards.
- 40 4. Legal fees, expert witness fees, court costs,  
41 or other associated costs of judgments or decrees per  
42 claim.
- 43 5. Allocated loss adjustment expense.
- 44 6. Administrative costs.
- 45 7. Other claims information as deemed necessary by  
46 the commissioner.

47 The report is a public record.

48 Sec. 15. NEW SECTION. 147B.12A PROFESSIONAL  
49 LIABILITY PREMIUM DISCOUNT.

50 Every insurer providing a policy of professional

1 liability insurance to a health care provider in Iowa  
2 on or after January 1, 1989, shall review the health  
3 care provider's civil and criminal record for a period  
4 of not less than five years prior to the effective  
5 date of any new or renewed policy of insurance.

6 If the record establishes that the health care  
7 provider is claim-free for the period, the insurer  
8 shall do one of the following according to rules  
9 established by the commissioner:

10 1. Discount the provider's premium by an amount to  
11 be determined annually by the commissioner.

12 2. Issue the health care provider a policy based  
13 upon a preferred risk selection program, if the  
14 insurer has previously established such a program.

15 3. Specifically provide within the policy a review  
16 of the underwriting considerations accounting for the  
17 fact that the provider has had no claims within the  
18 last five years. However, the policy may be reviewed  
19 by the commissioner for reasonableness of underwriting  
20 considerations, and the commissioner may order that  
21 the underwriting considerations be replaced by a  
22 discount in the minimum amount provided in subsection  
23 1.

24 Sec. 16. NEW SECTION. 147B.13 CATASTROPHIC  
25 INJURY FUND ADMINISTRATOR.

26 The commissioner may appoint an administrator to  
27 perform all duties and responsibilities pursuant to  
28 this chapter. The administrator shall serve at the  
29 pleasure of the commissioner. The salary and expenses  
30 of the administrator shall be paid from the fund.

31 Sec. 17. NEW SECTION. 147B.14 ADMINISTRATION.

32 The commissioner shall provide staff services  
33 necessary for the implementation of this chapter, or  
34 may contract with an insurance company licensed to do  
35 business in this state, or both, to perform any  
36 administrative duties of the commissioner pursuant to  
37 this chapter. The commissioner shall retain  
38 supervisory control over all services for which a  
39 contract is entered into. All reasonable costs and  
40 charges incurred in the administration of this chapter  
41 shall be paid from the fund.

42 The administrator and all persons employed or  
43 contracted with to provide staff services necessary  
44 for the operation of this chapter are employees of the  
45 state for purposes of chapter 25A, but for no other  
46 purposes.

47 Sec. 18. NEW SECTION. 147B.15 RULES.

48 The commissioner shall adopt rules pursuant to  
49 chapter 17A for the efficient administration of this  
50 chapter in accordance with its terms and intent.

1     Sec. 19. NEW SECTION. 147B.17 ADVANCE PAYMENT  
2 NOT ADMISSION.

3     A payment made by a health care provider or  
4 hospital or the health care provider's or hospital's  
5 insurer or surety to or for the patient or any other  
6 person on the patient's behalf in advance of a final  
7 determination of liability shall not be construed as  
8 an admission of liability for injuries or damages  
9 suffered in a medical malpractice action. In the  
10 event of an advance payment, the court shall reduce  
11 the judgment to the plaintiff by the amount of the  
12 advance payment. If the advance payment exceeds the  
13 liability of the defendant, the court shall order any  
14 adjustment necessary to equalize the amount under  
15 which each defendant is obligated to pay and in no  
16 case shall an advance in excess of the amount found to  
17 be due be repayable to the health care provider or  
18 hospital or the insurer or surety making the payment.

19     Sec. 20. NEW SECTION. 147B.18 SETTLEMENT NOT  
20 ADMISSION.

21     If at any time the health care provider, hospital,  
22 an insurance carrier, a surety, or the fund tenders  
23 payment to the patient or a person acting on the  
24 patient's behalf of any sum for the purpose of  
25 settlement and not as an advance, the tender shall not  
26 be considered an admission of liability by the health  
27 care provider or hospital. Liability or fault is not  
28 deemed admitted as a matter of law.

29     Sec. 21. NEW SECTION. 147B.20 COSTS OF DEFENSE.

30     1. Coverage for medical malpractice under the fund  
31 and under professional liability policies or other  
32 items posted for proof of financial responsibility to  
33 comply with the requirements of this chapter shall  
34 include defense costs and allocation for loss  
35 adjustment expense. Such benefits or coverage shall  
36 not in any way reduce the coverage available to  
37 provide for payment of judgments by a health care  
38 provider or hospital to an injured party.

39     2. The administrator may employ the services of  
40 outside legal counsel to defend the fund against  
41 claims and to assist a health care provider's insurer  
42 in defending a claim.

43     3. The administrator may, by agreement with the  
44 health care provider's insurer, allow the health care  
45 provider's insurer to provide a defense for a claim  
46 against the health care provider and the fund. The  
47 administrator and the health care provider's insurer  
48 may agree to any apportionment of the costs of  
49 defense.

50     4. All actual expenses of collecting, protecting,

1 and administering the fund shall be paid from the  
2 fund, including necessary costs of outside legal  
3 counsel. The attorney general is not responsible for  
4 representation or legal defense of the fund.

5 Sec. 22. NEW SECTION. 147B.21 FAILURE TO  
6 QUALIFY.

7 1. A health care provider or hospital who fails to  
8 qualify under this chapter is not covered by this  
9 chapter and is subject to liability as provided  
10 elsewhere in statute or common law. A patient's  
11 remedies against a nonqualified health care provider  
12 or hospital shall not be affected by this chapter.

13 2. A health care provider need not be a resident  
14 of this state to be eligible for coverage under this  
15 chapter. A nonresident may submit an application to  
16 the commissioner or the commissioner's designee to  
17 qualify for coverage under the terms and conditions  
18 provided by rule. However, the fund shall not be  
19 liable for any occurrence occurring outside of this  
20 state involving a resident or nonresident health care  
21 provider, unless the commissioner has by rule reached  
22 an agreement of reciprocity with the other state.

23 Sec. 23. NEW SECTION. 147B.22 ACTION -- AMOUNT  
24 RECOVERABLE -- SETTLEMENT.

25 1. Parties commencing an action governed by the  
26 provisions of this chapter have all rights afforded to  
27 them under statute or common law unless provided  
28 otherwise, and actions shall be commenced and governed  
29 as provided for under the rules of civil procedure.

30 2. The fund shall not be a named party to any  
31 suit. However, notice of suit shall be served upon  
32 the commissioner.

33 3. Payment of policy limits by the health care  
34 provider's or hospital's professional liability  
35 carrier or surety absolves the health care provider or  
36 hospital from any additional individual liability.  
37 The payment of policy or bond limits or any portion  
38 thereof must be coordinated with the fund and shall  
39 not absolve the carrier from participation in the  
40 defense of the fund on behalf of the health care  
41 provider or hospital. The payment of policy or bond  
42 limits or any portion thereof shall not affect the  
43 injured parties' right to a jury trial.

44 4. The fund may participate in the settlement of  
45 claims prior to a health care provider's or hospital's  
46 liability carrier or surety tendering policy limits.

47 5. If multiple health care providers or hospitals  
48 are named as individual defendants, this chapter  
49 applies only to those providers or hospitals who are  
qualified under this chapter.

1       Sec. 24. NEW SECTION. 147B.23 STRUCTURED  
2 JUDGMENTS.

3       1. In a medical malpractice action against a  
4 health care provider or hospital subject to this  
5 chapter, the verdict shall be itemized to distribute  
6 the monetary damages, if any, between past loss and  
7 future loss. In a trial to the court, the court shall  
8 itemize its findings in accordance with this section.

9       2. The court, in a medical malpractice action  
10 subject to this chapter in which a damage award  
11 against all defendant health care providers and  
12 hospitals exceeds the financial responsibility of  
13 those health care providers and hospitals required  
14 under section 147B.3 and where the fund is responsible  
15 for paying damages for future injuries to a party  
16 exceeds one hundred thousand dollars and upon  
17 application of one of the parties, shall enter a  
18 judgment ordering the portion of the award to the  
19 party in excess of one hundred thousand dollars to be  
20 paid in periodic payments, subject to the limitations  
21 contained in this section. The court shall make a  
22 specific finding as to the dollar amount of regular  
23 payments which will be required to compensate the  
24 party periodically for loss of future income and  
25 future noneconomic harm, based upon the life  
26 expectancy of the party and the damages awarded. The  
27 periodic payments shall reflect interest in accordance  
28 with annuity principles. The judgment shall specify  
29 the recipient of the periodic payments, the dollar  
30 amount of each payment, the interval between payments,  
31 and the number of payments required to be made. The  
32 judgment shall specify the amount of and the purposes  
33 for which the balance of the judgment awarded for the  
34 future care and treatment of the party may be used.

35       3. Attorney fees of the party receiving an award,  
36 if payable out of the judgment, shall be applied pro  
37 rata against amounts awarded for past injuries and for  
38 future injuries. The amount determined by the court  
39 to be payable out of damages for future injuries shall  
40 be deducted by the court from the amount to be ordered  
41 paid as provided in this subsection, and shall be  
42 deducted pro rata from those amounts awarded, if any,  
43 for loss of future income, future expenses for care  
44 and treatment, and future noneconomic harm. The  
45 amount of attorney fees attributable to the award for  
46 future injuries shall be payable upon entry of  
47 judgment.

48       4. If a judgment has been entered ordering  
49 periodic payments pursuant to this section, the health  
50 care provider's or hospital's insurer shall pay to the

1 fund the amount for which the insurer is liable under  
2 this chapter, after apportionment of costs of defense,  
3 for distribution by the fund to the party receiving  
4 the award.

5 5. If a judgment has been entered ordering  
6 periodic payments pursuant to this section, the fund  
7 shall make the payments as ordered or, alternatively,  
8 the fund may purchase an annuity from an insurance  
9 company admitted to do business in this state  
10 sufficient to make the periodic payments.

11 6. If the party receiving the award dies, amounts  
12 to be paid for loss of future income are payable to  
13 those persons to whom the party receiving the award  
14 owed a duty of support. If the party receiving the  
15 award dies prior to payment of the amounts for other  
16 than loss of future income, the judgment is satisfied  
17 upon the payment of all obligations incurred up to the  
18 time of death and of the expenses of final illness and  
19 reasonable burial expenses. Amounts remaining for  
20 other than loss of future income upon satisfaction of  
21 the judgment shall remain in the fund.

22 7. Except with respect to amounts representing  
23 loss of future income, a judgment for future injuries  
24 is a contingent award, and the right to payment vests  
25 only at such times and in such amounts as accrue  
26 pursuant to the order specifying the amount of  
27 periodic payments and the interval of those payments.

28 8. The district court shall retain jurisdiction of  
29 a medical malpractice action in which the judgment in  
30 the action orders periodic payments, and upon the  
31 death of the party receiving the award in the case of  
32 an award for loss of future income, the dependents of  
33 the decedent or any other interested party to the  
34 action or a representative of an interested party, may  
35 petition the court for a modification of the judgment  
36 and for a redesignation of the recipient of the  
37 payments, in accordance with the rights of persons  
38 established by this section. Unless otherwise  
39 ordered, the redesignated recipients of payments for  
40 loss of future income shall be paid in those amounts  
41 and at those intervals specified in the original  
42 judgment. Payments shall continue until the remaining  
43 amounts designated for that purpose have been paid, or  
44 until the death of those dependents, whichever occurs  
45 first. If the last surviving dependent dies prior to  
46 depletion of the amount specified for loss of future  
47 income, the judgment is deemed satisfied upon payment  
48 of amounts accrued up to the time of that death.  
49 Amounts remaining for loss of future income upon  
50 satisfaction of the judgment shall remain in the fund.

1       Sec. 25. NEW SECTION. 147B.24 MEDIATION SYSTEM.

2       The commissioner shall establish a mediation system  
3 which consists of mediation panels to assist in the  
4 resolution of disputes, regarding medical malpractice  
5 between an injured party and a health care provider or  
6 hospital.

7       Sec. 26. NEW SECTION. 147B.25 REQUEST FOR  
8 MEDIATION.

9       1. An injured party who may have a cause of action  
10 against a health care provider or hospital as a result  
11 of an injury alleged to have occurred as a result of  
12 medical malpractice may file a request for mediation.  
13 However, if the injured party has filed a court action  
14 claiming a cause of action against a health care  
15 provider or hospital as a result of an injury alleged  
16 to have occurred as a result of medical malpractice,  
17 the injured party shall file a request for mediation  
18 within fifteen days after the date of filing.

19       2. A request for mediation must be in writing and  
20 must include all of the following:

21       a. The name and address of all injured parties.

22       b. The name and address of the injured patient, if  
23 not included in paragraph "a".

24       c. The name and address of all health care  
25 providers and hospitals alleged to have committed  
26 medical malpractice resulting in the injury.

27       d. The condition or disease for which the health  
28 care provider or hospital was treating the injured  
29 party when the alleged medical malpractice occurred.

30       e. A brief description of the injury alleged to  
31 have been caused by the health care provider or  
32 hospital.

33       3. a. A request for mediation shall be delivered  
34 to the commissioner in person or by certified mail.  
35 The injured party requesting mediation and all health  
36 care providers and hospitals named in the request for  
37 mediation shall participate in the mediation.

38       b. An injured party shall pay a filing fee of  
39 twenty dollars at the time the request is filed with  
40 the commissioner, to be deposited in the patient  
41 catastrophic injury fund created pursuant to section  
42 147B.6.

43       4. If a court action has not been commenced at the  
44 time the request for mediation is filed with the  
45 commissioner, any applicable statute of limitations is  
46 tolled on the date the commissioner receives the  
47 request for mediation if delivered in person or on the  
48 date of mailing if sent by certified mail and remains  
49 tolled until thirty days after the last day of the  
50 mediation period. A court action shall not be

1 commenced unless a request for mediation has been  
2 filed and the mediation period has expired. An  
3 injured party who has filed a request for mediation  
4 and commences a court action after the expiration of  
5 the mediation period shall notify the commissioner  
6 that a court action has been filed.

7 5. If a court action has been commenced prior to  
8 the time the request for mediation is filed with the  
9 commissioner, any applicable statute of limitations is  
10 tolled during the mediation period.

11 Sec. 27. NEW SECTION. 147B.26 NOTICE TO HEALTH  
12 CARE PROVIDERS AND HOSPITALS.

13 The commissioner shall serve notice upon all health  
14 care providers and hospitals named in the request for  
15 mediation by certified mail within seven days after  
16 the commissioner receives the request if delivered in  
17 person or within ten days after the date of mailing of  
18 the request to the commissioner if sent by certified  
19 mail.

20 Sec. 28. NEW SECTION. 147B.27 MEDIATION PANELS.

21 1. The commissioner shall appoint the members of a  
22 mediation panel and send notice to the claimant and  
23 all respondents by certified mail. The notice shall  
24 inform the claimant and all respondents of the names  
25 of the members appointed to the mediation panel and  
26 the date, time, and place of the first mediation  
27 session. The commissioner may change the date, time,  
28 or place of the mediation session as necessary to  
29 accommodate the parties, but the session shall be held  
30 before the expiration of the mediation period.

31 2. A mediation panel shall consist of the  
32 following members appointed by the commissioner:

33 a. One public member who is neither an attorney  
34 nor a health care provider and who is selected from a  
35 list of ten public member mediators appointed by the  
36 commissioner every two years. A member on the list  
37 may be reappointed to the list.

38 b. One attorney who is licensed to practice law in  
39 this state.

40 c. One health care provider as follows:

41 (1) Except as provided in subparagraphs (4) and  
42 (5), if all respondents named in the request for  
43 mediation are health care providers licensed under  
44 chapter 148 or 150A, a health care provider who is  
45 licensed to practice in this state and who is selected  
46 from a list prepared by the board of medical  
47 examiners.

48 (2) Except as provided in subparagraphs (4) and  
49 (5), if none of the respondents named in the request  
50 for mediation is a health care provider licensed under

1 chapter 148 or 150A, a health care provider who is  
2 licensed to practice in this state in the same health  
3 care field as the respondent and who is selected from  
4 a list prepared by the examining board that regulates  
5 health care providers in that health care field.

6 (3) Except as provided in subparagraphs (4) and  
7 (5), if more than one respondent is named in the  
8 request for mediation at least one of whom is a health  
9 care provider and one of whom is a hospital, a health  
10 care provider who is licensed to practice in this  
11 state and who is selected from a list under  
12 subparagraph (1) or (2), as determined by the  
13 commissioner.

14 (4) If the commissioner determines that a list  
15 under subparagraph (1) or (2) is inadequate to permit  
16 the selection of an appropriate health care provider,  
17 a health care provider who is licensed to practice in  
18 this state and who is selected from an additional list  
19 prepared by the commissioner.

20 (5) If the commissioner determines that the lists  
21 under subparagraph (1) or (2) and subparagraph (4) are  
22 inadequate to permit the selection of an appropriate  
23 health care provider for a particular dispute, a  
24 health care provider who is licensed to practice in  
25 this state and is selected by the commissioner.

26 3. If a person appointed to a panel resigns from  
27 or is unable to serve on the mediation panel, the  
28 commissioner shall appoint a replacement selected  
29 pursuant to subsection 2.

30 4. A person shall not serve on a mediation panel  
31 if the person has a professional or personal interest  
32 in the dispute.

33 5. Each member of the mediation panel is entitled  
34 to one hundred fifty dollars per diem plus actual and  
35 necessary expenses for each day of mediation  
36 conducted. The amounts provided for under this  
37 subsection shall be paid from the patient catastrophic  
38 injury fund created pursuant to section 147B.6.

39 6. A person serving as a mediator is immune from  
40 civil liability for any good faith act or omission  
41 within the scope of the mediator's powers and duties  
42 under this chapter.

43 Sec. 29. NEW SECTION. 147B.28 MEDIATION PERIOD.

44 The period for mediation shall expire ninety days  
45 after the commissioner receives a request for  
46 mediation if delivered in person or within ninety-  
47 three days after the date of mailing the request to  
48 the commissioner by certified mail, or within a longer  
49 period agreed to by the claimant and all respondents  
50 and specified by them in writing.

1 Sec. 30. NEW SECTION. 147B.29 PROCEDURE.

2 The mediation shall be conducted without record or  
3 transcript and all parties shall be in attendance  
4 unless excused by the panel. Discovery is not  
5 allowed, and no witnesses may be subpoenaed and no  
6 oaths may be administered during the mediation period.  
7 However, the mediation panel or any member of the  
8 panel may consult with any expert, and upon  
9 authorization of the commissioner, the expert may be  
10 compensated out of the patient catastrophic injury  
11 fund created pursuant to section 147B.6.

12 All patient health care records in the possession  
13 of a mediation panel shall be kept confidential by all  
14 members of the mediation panel and all other persons  
15 participating in the mediation. Any finding,  
16 statement, or opinion made in the course of mediation  
17 is not admissible in any court action.

18 Any person participating in mediation may be  
19 represented by counsel authorized to act for the  
20 person.

21 Sec. 31. NEW SECTION. 147B.30 MEDIATION SYSTEM  
22 EXPENSES AND REPORT.

23 The administrative expenses of the mediation system  
24 established in this chapter shall be paid out of the  
25 patient catastrophic injury fund created pursuant to  
26 section 147B.6.

27 The commissioner shall submit a report on the  
28 operation of the mediation system and on the status of  
29 the mediation system expenses on or before March 1 of  
30 each year to the majority leader and minority leader  
31 of the senate, and the speaker, majority leader, and  
32 minority leader of the house of representatives.

33 Sec. 32. Section 258A.4, subsection 1, paragraph  
34 i, unnumbered paragraph 2, Code 1987, is amended to  
35 read as follows:

36 The commissioner of insurance shall by rule in  
37 consultation with the licensing boards enumerated in  
38 section 258A.1 and the department of public health,  
39 require insurance carriers which insure professional  
40 and occupational licensees or hospitals licensed  
41 pursuant to chapter 135B for acts or omissions which  
42 constitute negligence, careless acts or omissions in  
43 the practice of a profession or occupation or patient  
44 care to file reports with the commissioner of  
45 insurance within sixty days following final  
46 disposition of each malpractice claim settled or  
47 adjudicated. If the licensee or hospital is not  
48 insured by an insurance carrier admitted in this  
49 state, the licensee or hospital shall file the report.  
50 The reports shall include information-pertaining-to

1 ~~incidents-by-a-licensee-which-may-affect-the-licensee~~  
2 ~~as-defined-by-rule, involving an insured of the~~  
3 ~~insurer the following:~~

4 (1) The nature of the claim and date of  
5 occurrence.

6 (2) The alleged injury and the damages asserted.

7 (3) Attorney's fees and expenses incurred in  
8 connection with the claim or defense.

9 (4) The amount of any settlement or judgment.

10 (5) The name and address of the licensee or  
11 hospital. The commissioner of insurance shall forward  
12 reports pursuant to this section to the appropriate  
13 licensing board or to the department of public health.  
14 Reports of a settlement shall at the request of any  
15 party to the settlement be confidential and not a  
16 public record.

17 Sec. 33. NEW SECTION. 258A.9A DUTIES OF CERTAIN  
18 MEDICAL LICENSEES.

19 1. As used in this section, unless the context  
20 otherwise requires, "licensee" means a person subject  
21 to the authority of a board specified in section  
22 258A.1, subsection 1, paragraph "j", "l", or "m", or  
23 subject to chapter 135B.

24 2. A licensee shall make a report within seven  
25 days to the appropriate licensing authority of any act  
26 which the licensee knows or should reasonably know  
27 constitutes malpractice, unauthorized practice, or  
28 professional misconduct. Where a hospital is a  
29 licensee, the hospital administrator shall make a  
30 report within ten days of any such acts by a person  
31 licensed under chapters 148, 150A, 152, or 153.  
32 Reports required under this section shall, where  
33 applicable, be coordinated with a report required  
34 under section 147.135, subsection 3. Failure to make  
35 the report is grounds for licensee discipline and a  
36 civil penalty of not less than five hundred dollars  
37 nor more than five thousand dollars. Fines collected  
38 pursuant to this section shall be transferred to the  
39 patient catastrophic injury fund created in section  
40 147B.6 for use as authorized in chapter 147B.

41 3. A report received pursuant to this section is  
42 confidential and shall not be released by the  
43 licensing board except where an action against the  
44 health care provider or hospital has been commenced  
45 and the release is pursuant to a court order. In no  
46 case shall the identity of the licensee making the  
47 report under subsection 2 be disclosed. Upon receipt  
48 of a report pursuant to this section, the licensing  
49 board shall investigate and take action as appropriate  
50 and within the authority provided in this chapter.

1 4. The duties in this section are in addition to  
2 any other duties of licensees and licensing boards  
3 contained elsewhere in this chapter.

4 Sec. 34. NEW SECTION. 515A.31 REGIONAL PRICING -  
5 - AUTHORIZATION TO COMMISSIONER -- PROCEDURE.

6 1. The commissioner of insurance shall conduct an  
7 examination of insurance rating practices relating to  
8 the use of nonstate specific experience in the setting  
9 of rates in this state, and shall take or recommend  
10 such action as necessary to maximize the impact which  
11 state experience has on the setting of rates in this  
12 state.

13 2. For purposes of such action, the commissioner  
14 may do all of the following:

15 a. Determine which lines of insurance necessary to  
16 the public welfare and safety are presently not price  
17 competitive.

18 b. Determine the lines of insurance which have  
19 sufficient state experience and permit the use of only  
20 state experience for ratemaking purposes.

21 c. Determine which lines of insurance presently  
22 lack sufficient state experience credibility and allow  
23 the use of regional experience to augment present  
24 state experience for ratemaking purposes.

25 d. Determine which lines of insurance presently  
26 lack sufficient state and regional credibility and  
27 allow the use of countrywide experience to augment  
28 present state and regional experience for ratemaking  
29 purposes.

30 e. Determine which states, jurisdictions, or  
31 rating areas are excessively dissimilar to this state,  
32 and suggesting the prohibition of their inclusion in  
33 any countrywide experience used for ratemaking  
34 purposes in this state. For purposes of this  
35 paragraph, excessively dissimilar may be measured by  
36 evidence including, but not limited to, the following:

37 (1) The number of suits per one hundred thousand  
38 population in a covered line.

39 (2) The average size of judgments, awards, and  
40 settlements in a covered line.

41 (3) The significant differences in civil justice  
42 systems or procedures.

43 (4) The significant differences in insurance  
44 regulatory systems or procedures.

45 3. Prior to taking any action pursuant to this  
46 section, the commissioner shall publish notice of such  
47 action in the Iowa administrative bulletin not less  
48 than sixty days prior to the proposed action. Any  
49 affected insurer may request a hearing concerning the  
50 action prior to implementation.

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1 Sec. 35. NEW SECTION. 519B.1 DEFINITIONS.

2 As used in this chapter, unless the context  
3 requires otherwise:

4 1. "Commissioner" means the commissioner of  
5 insurance.

6 2. "Fund" means the Iowa medical care availability  
7 assistance trust fund.

8 3. "Hospital" means a hospital licensed pursuant  
9 to chapter 135B.

10 4. "Medical malpractice" means acts or omissions  
11 of a health care provider in the practice of the  
12 provider's profession or occupation, or acts or  
13 omissions of a hospital in patient treatment or care,  
14 including but not limited to negligence, failure to  
15 provide care, breach of contract relating to providing  
16 care, or claim based upon failure to obtain informed  
17 consent for an operation or treatment.

18 5. "Physician" means a physician and surgeon  
19 licensed pursuant to chapter 148; an osteopath  
20 licensed pursuant to chapter 150; an osteopathic  
21 physician and surgeon licensed pursuant to chapter  
22 150A; or a dentist licensed pursuant to chapter 153.

23 Sec. 36. NEW SECTION. 519B.2 TRUST FUND -- DIS-  
24 TRIBUTIONS.

25 1. The Iowa medical care availability assistance  
26 trust fund is established to be administered by the  
27 commissioner for the purposes set forth in this  
28 chapter. Distributions from the fund shall be made on  
29 an annual basis, as follows:

30 a. The commissioner shall, on July 1 of each year,  
31 distribute from the fund to each eligible physician an  
32 amount equal to the amount by which the physician's  
33 premium payments for medical liability insurance for  
34 the preceding calendar year exceeded fifteen percent  
35 of the physician's annual gross income derived from  
36 the physician's delivery of medical services for the  
37 preceding calendar year. The physician shall have the  
38 burden of establishing to the commissioner's  
39 satisfaction the gross income derived from the  
40 delivery of medical services in the preceding calendar  
41 year, the amount of premiums paid for medical  
42 liability insurance in the preceding calendar year,  
43 the medical specialty practiced by the physician  
44 during the previous calendar year, and the physician's  
45 eligibility to participate in the premium assistance  
46 plan.

47 b. If the amount in the fund is inadequate to pay  
48 in full all claims to qualified physicians, the amount  
49 paid to each eligible physician shall be prorated.

50 2. The amount of premium payments considered under

1 this section shall not be less than or exceed the  
2 premium amount necessary for the physician to obtain  
3 medical liability insurance coverage in an amount of  
4 five hundred thousand dollars per occurrence. If a  
5 physician applying for assistance is currently paying  
6 premiums for coverage in excess of five hundred  
7 thousand dollars per occurrence, the department shall  
8 determine the premium amount which would be paid if  
9 coverage were limited to five hundred thousand dollars  
10 per occurrence. If more than one policy is in effect  
11 during a calendar year for which application for  
12 assistance is made, the premium paid under each policy  
13 shall be prorated by the number of months the policy  
14 is in effect during that calendar year, and the  
15 amounts determined for each policy for that year shall  
16 constitute in total the premium paid for the calendar  
17 year.

18 If a single policy provides coverage for more than  
19 one physician, the commissioner shall determine the  
20 amount of premium to be attributed to the coverage for  
21 the applying physician.

22 3. An eligible physician entitled to a  
23 distribution under this section must file an  
24 application with the commissioner on or before May 1  
25 of the year following the year for which assistance is  
26 sought. Failure to file an application by May 1 of  
27 any year constitutes a waiver of any distribution to  
28 which the physician might have been entitled for the  
29 preceding year. The commissioner shall provide the  
30 application form.

31 4. Prior to making a distribution to an eligible  
32 physician, the commissioner shall obtain an assignment  
33 of any right the physician may have to a dividend,  
34 refund, or reimbursement of premium under the terms of  
35 the physician's medical liability insurance contract  
36 or agreement. Amounts received by the commissioner as  
37 a result of the assignment shall be deposited in the  
38 fund. The commissioner's rights under an assignment  
39 shall not exceed the amount distributed to the  
40 physician under this section.

41 Sec. 37. NEW SECTION. 519B.3 PHYSICIAN  
42 ELIGIBILITY.

43 1. A physician is eligible to receive a  
44 distribution if the physician files an application for  
45 a distribution as provided in section 519B.2, and  
46 meets the following requirements:

47 a. The physician was engaged in the active  
48 practice of medicine in Iowa during the entire  
49 preceding calendar year.

50 b. The physician was insured with an insurance

1 company admitted to this state under a policy of  
2 medical liability insurance during the entire  
3 preceding calendar year providing coverage in an  
4 amount of at least five hundred thousand dollars per  
5 occurrence.

6 c. The physician had staff privileges during the  
7 entire preceding calendar year at a hospital in this  
8 state, which had an emergency room and which required  
9 physicians with staff privileges to provide, when  
10 needed, medical care to unassigned patients entering  
11 the hospital through the emergency room. The  
12 physician has the burden of establishing to the  
13 commissioner's satisfaction that the physician was  
14 available to provide medical care to unassigned  
15 patients and that, when needed, did provide medical  
16 care to unassigned patients entering the hospital  
17 through the emergency room.

18 d. The physician has not incurred two or more  
19 claims for medical malpractice resulting in judgments,  
20 awards, or settlements exceeding one hundred twenty-  
21 five thousand dollars each in the preceding five  
22 years. Payment of a claim by an uninsured physician  
23 exceeding one hundred twenty-five thousand dollars  
24 shall be counted when determining the number of  
25 judgments, awards, or settlements under this  
26 paragraph.

27 e. The physician does not have an unsatisfied  
28 medical malpractice judgment which was entered within  
29 the preceding five years, or if one exists, the  
30 physician can show that at least two hundred fifty  
31 thousand dollars of the judgment has been satisfied.

32 2. The burden to establish eligibility under all  
33 criteria in this chapter by clear and convincing  
34 evidence is upon an applying physician.

35 3. The commissioner may waive the requirements  
36 provided in subsection 1, paragraphs "a", "b", or "c",  
37 if the physician establishes that it was not possible  
38 for the physician to meet the requirement through no  
39 fault of the physician.

40 Sec. 38. STUDY OF MEDICAL SERVICES. The division  
41 of insurance, in conjunction with the department of  
42 public health, shall conduct a study to determine  
43 where the state is experiencing a shortage of needed  
44 medical services, which shall be based on the  
45 availability of physicians by geographic area and  
46 medical specialty. The division shall consider the  
47 following factors in conducting the study:

48 1. The supply and demand for medical services and  
49 facilities.

50 2. The health of the population in a geographic

1 area, including mortality, morbidity, and births.  
2 3. Any other relevant demographic information  
3 which indicates the need for medical services and  
4 facilities.

5 The results of the study shall be reported on or  
6 before January 15, 1989, to the governor, majority and  
7 minority leaders of the senate, and the speaker and  
8 majority and minority leaders of the house of  
9 representatives.

10 Sec. 39. APPROPRIATION. There is appropriated  
11 from the general fund of the state to the division of  
12 insurance in the department of commerce for the fiscal  
13 year beginning July 1, 1988, and ending June 30, 1989,  
14 one hundred fifty thousand dollars, or as much thereof  
15 as is necessary, for services necessary for the  
16 implementation of sections 35 through 37 this Act. In  
17 addition, the commissioner shall provide an estimate  
18 of the cost of the program and shall provide that  
19 estimate to the governor, majority and minority  
20 leaders of the senate, and the speaker and majority  
21 and minority leaders of the house of representatives  
22 on or before January 15, 1989. Appropriations to the  
23 fund are not subject to reversion under section 8.33.

24 Sec. 40. Sections 1 through 31 of this Act apply  
25 only to occurrences after January 1, 1989.

26 Sec. 41. Sections 35 through 37 of this Act take  
27 effect on January 1, 1990, with the initial  
28 distribution to be made to eligible physicians  
29 commencing June 30, 1990, for the 1989 calendar year."

30 2. Title page, by striking lines 1 through 11 and  
31 inserting the following: "An Act relating to health  
32 care providers, hospitals, and patients by providing  
33 for the creation of a patient catastrophic injury fund  
34 for health care providers and hospitals, establishing  
35 a surcharge to be deposited in the fund, providing for  
36 an assessment on hospital charges, establishing  
37 qualifications for a health care provider, hospital,  
38 or patient to be protected by the fund, establishing a  
39 limitation on the liability of the fund, and a health  
40 care provider or hospital, establishing a study and  
41 certain other powers and duties of the commissioner of  
42 insurance, providing for indemnification agreements  
43 between a hospital and a health care provider,  
44 providing that the Act does not apply to certain  
45 contracts guaranteeing results, establishing certain  
46 reporting requirements, providing for the appointment  
47 of a fund administrator and for administration of the  
48 fund, providing that an advance payment or a  
49 settlement is not an admission of liability, providing  
50 for liability of defense costs in certain actions,

APRIL 8, 1988

S-5840 Page 24

1 authorizing the fund to procure reinsurance, providing  
2 for structured settlements, establishing a mediation  
3 system ensuring the availability of physicians to all  
4 citizens of this state by establishing a medical care  
5 availability assistance plan and trust fund, providing  
6 appropriations, establishing an effective date, and  
7 providing for applicability."

S-5840

Filed April 7, 1988

*Senate amended, concurred 4/8 (S. 1988)*

RECEIVED FROM THE HOUSE

SENATE FILE 484

5876

1 Amend the House amendment, S-5840, to Senate File  
2 484, as amended, passed, and reprinted by the Senate  
3 as follows:

4 1. Page 17, by inserting after line 32, the  
5 following:

6 "Sec. \_\_\_\_ . NEW SECTION. 249B.1 DEFINITNIONS.

7 As used in this chapter, unless the context  
8 otherwise requires:

9 1. "Commissioner" means the commissioner of human  
10 services.

11 2. "Medicare" means the Health Insurance for the  
12 Aged Act, Title XVIII of the federal Social Security  
13 Act.

14 3. "Medicare Assignment" means the decision of a  
15 physician to accept as patients beneficiaries of  
16 Medicare.

17 4. "Medicare intermediary" means the person  
18 contracted with by the United States government to  
19 administer the Medicare program in this state.

20 5. "Participating physician" means a physician who  
21 accepts an amount equal to the reasonable charge, as  
22 determined by the United States secretary of health  
23 and human services, as payment in full for services  
24 rendered to a beneficiary of Medicare or a physician  
25 who participates in the voluntary Medicare assignment  
26 program established in conjunction with the area  
27 agencies on aging.

28 6. "Physician" means a person licensed to practice  
29 medicine and surgery, osteopathy and surgery, or  
30 osteopathy under the laws of this state.

31 Sec. \_\_\_\_ . NEW SECTION. 249B.2 MEDICARE  
32 PARTICIPATION.

33 1. By July 1, 1989, and in each calendar quarter  
34 thereafter, at least eighty percent of the physicians  
35 in each area of specialty shall be participating  
36 physicians.

37 2. In computation of the percentage level required  
38 under subsection 1, licensed physicians employed by a  
39 medical education facility shall not be included.  
40 However, this subsection does not prohibit such a  
41 physician from choosing to be a participating  
42 physician.

43 3. If the level specified in subsection 1 is not  
44 achieved by July 1, 1989, or if the level is not  
45 maintained in any subsequent quarter, the board of  
46 medical examiners shall require as a condition of  
47 issuing a license or renewal of a license to practice  
48 as a physician, that a physician who accepts Medicare  
49 assignments also agrees to be a participating  
50 physician.

S-5876 Page 2

1 Sec. \_\_\_\_ . NEW SECTION. 249B.3 MEDICARE  
2 PARTICIPATION -- RECORDKEEPING.

3 1. A participating physician shall submit a report  
4 annually to the Medicare intermediary on the form  
5 required and provided by the Medicare intermediary.  
6 The report shall include but is not limited to the  
7 following:

8 a. The speciality of and type of license held by  
9 the physician.

10 b. The area of practice in which the physician  
11 accepts Medicare assignments.

12 c. The address of the location of the physician's  
13 practice.

14 d. The total number of Medicare beneficiaries  
15 provided services by the physician and the percentage  
16 of the physician's patients who are Medicare  
17 beneficiaries.

18 2. The Medicare intermediary shall, annually,  
19 submit a summary of the reports collected under  
20 subsection 1 to the human resources standing  
21 committees of the general assembly.

22 3. The commissioner may, in accordance with rules  
23 adopted pursuant to chapter 17A, require the inclusion  
24 of additional information in the reports submitted by  
25 participating physicians."

26 2. Page 24, line 2, by inserting after the word  
27 "settlements," the following: "providing for an  
28 established level of Medicare participation by certain  
29 physicians,".

30 3. By renumbering as necessary.

S-5876

Filed April 8, 1988

WITHDRAWN

BY AL STURGEON

(4.13.88)

SENATE FILE 484

S-5870

1 Amend amendment S-5840, to Senate File 484,  
 2 as amended, passed, and reprinted by the Senate,  
 3 as follows:  
 4 1. Page 7, line 5, by striking the word "FUND"  
 5 and inserting the words: "FUND AND FOR ENHANCED  
 6 MEDICAL SERVICES FUND".  
 7 2. Page 7, by inserting after line 34, the  
 8 following:  
 9 "4. An additional assessment of one percent  
 10 is imposed on patient billings for inpatient acute  
 11 care services and routine and surgical outpatient  
 12 services, other than those involving Medicaid or  
 13 Medicare, by hospitals beginning January 1, 1989.  
 14 The assessment shall be collected by the hospital  
 15 and the assessments received shall be remitted by  
 16 the hospital to the enhanced medical services fund  
 17 established in section 147B.31 monthly. A hospital  
 18 shall not be responsible for the collection or  
 19 remittance of assessments on billings deemed  
 20 uncollectible by the hospital."

21 3. Page 17, by inserting after line 32 the  
 22 following:

23 "Sec. 32. NEW SECTION. 147B.31. ENHANCED  
 24 MEDICAL SERVICES FUND.

25 1. There is established an enhanced medical  
 26 health services fund within the department of  
 27 human services from the fees collected under  
 28 section 147B.9, subsection 4.

29 2. The department shall use sixty percent of  
 30 the funds collected to increase the reimbursement  
 31 rate for hospitals in the state under the medical  
 32 assistance program. Such enhancement shall be in  
 33 addition to any other increases established, and  
 34 shall be made in consultation with the Iowa  
 35 hospital association.

36 3. The department shall use twenty-eight  
 37 percent of the funds collected to increase  
 38 eligibility for the elderly, blind, and disabled  
 39 below the poverty level under the medical assis-  
 40 tance program or to provide other medical assistance  
 41 to that population. The department shall develop  
 42 such expansion strictly within the funds available  
 43 from this fund, and in consultation with the  
 44 medical assistance advisory council and the general  
 45 assembly, and in addition to any other authorized expansions.

46 4. The department shall transfer two percent  
 47 of the funds collected to the department of public  
 48 health for the purposes of section 135B.33.

49 5. The department shall transfer ten percent  
 50 of the funds to the department of public health

Page 2

1 for the provision of additional assistance for  
 2 emergency medical services. Such enhancement  
 3 shall be in addition to any other funding  
 4 established for such services.

S-5870

SENATE 17  
APRIL 11, 1988

SENATE FILE 484

S-5881

1 Amend the House amendment, S-5840, to Senate File  
2 484, as amended, passed, and reprinted by the Senate,  
3 as follows:

4 1. Page 7, by inserting after line 34 the fol-  
5 lowing:

6 "Sec. \_\_\_\_ . NEW SECTION. 147B.9A MAXIMUM  
7 LIABILITY FOR NONECONOMIC DAMAGES.

8 1. In a verdict issued pursuant to this chapter,  
9 that portion of a verdict attributable to noneconomic  
10 damages including, but not limited to, damages for  
11 pain and suffering, loss of consortium, loss of  
12 chance, or punitive or exemplary damages against any  
13 one defendant shall not exceed two hundred fifty  
14 thousand dollars.

15 2. In an action pursuant to this chapter and tried  
16 to a jury, and in which noneconomic damages including,  
17 but not limited to, damages for pain and suffering,  
18 loss of consortium, loss of chance, or punitive or  
19 exemplary damages are sought or argued, the court  
20 shall, unless otherwise agreed to by all parties,  
21 instruct the jury that the portion of a verdict  
22 attributable to noneconomic damages including, but not  
23 limited to, damages for pain and suffering, loss of  
24 consortium, loss of chance, or punitive or exemplary  
25 damages against any one defendant shall not exceed two  
26 hundred fifty thousand dollars.

27 3. In an action brought pursuant to this chapter  
28 and tried to a jury, and in which noneconomic damages  
29 including, but not limited to, damages for pain and  
30 suffering, loss of consortium, loss of chance, or  
31 punitive or exemplary damages are sought or argued,  
32 the court shall, unless otherwise agreed to by all  
33 parties, require that the jury return a verdict  
34 itemizing the injuries and damages awarded pursuant to  
35 the verdict."

S-5881

Filed April 8, 1988 OUT OF ORDER BY JULIA B. GENTLEMAN

*g. 1352*

SENATE FILE 484

S-5883

1 Amend the House amendment, S-5840, to Senate File  
2 484 as amended, passed, and reprinted by the Senate,  
3 as follows:

DIV  
A

4 1. Page 3, by striking lines 35 and 36 and  
5 inserting the following: "business or a hospital  
6 which has ceased doing business or providing services  
7 if the health care provider or hospital files proof of  
8 insurance as required in subsection 1 or 2, as  
9 applicable, and pays a one-".

10 2. Page 3, line 44, by inserting after the word  
11 "business" the following: "or the hospital's ceasing  
12 to do business or providing services".

DIV  
B

13 3. Page 7, by striking lines 40 through 42 and  
14 inserting the following: "or settlement approved by  
15 the court in excess of five hundred thousand dollars,  
16 and up to five million dollars, against a health care  
17 provider or hospital qualified under this chapter with  
18 respect to an occurrence of".

19 4. Page 8, line 22, by inserting after the word  
20 "commerce," the following: "and to the legislative  
21 fiscal bureau,".

22 5. Page 8, by inserting after line 46, the  
23 following:

24 "The annual report shall also include an actuarial  
25 review of the solvency of the fund and contain  
26 appropriate recommendations relating to the protection  
27 of the solvency of the fund including, but not limited  
28 to, the need for mandatory participation by health  
29 care providers or hospitals, the need for additional  
30 revenue sources, and other recommendations deemed  
31 appropriate by the commissioner."

32 6. Page 8, by inserting after line 47 the  
33 following:

34 "The legislative fiscal bureau shall have the  
35 authority to retain an actuary, upon the approval of  
36 the legislative council, to examine and report on the  
37 patient catastrophic injury fund."

38 7. Page 11, by striking lines 33 through 35 and  
39 inserting the following: "3."

40 8. Page 12, line 16, by striking the words  
41 "exceeds one hundred" and inserting the following:  
42 "which exceed two hundred fifty".

43 9. Page 12, line 18, by inserting after the word  
44 "award" the following: "where the fund is responsible  
45 for paying damages for future injuries".

46 10. Page 12, line 19, by striking the words "one  
47 hundred thousand dollars" and inserting the following:  
48 "two hundred fifty thousand dollars, including any  
49 amount for future damages to be paid by the health  
50 care provider or hospital in excess of the limits of

1 the fund,".

2 11. Page 13, by striking lines 11 through 50.

3 12. Page 17, line 38, by inserting after the  
4 figure "258A.1" the following: "the department of  
5 inspections and appeals,".

6 13. Page 17, line 45, by inserting after the word  
7 "insurance" the following: "and to the legislative  
8 fiscal bureau".

9 14. Page 18, by striking line 13 and inserting  
10 the following: "licensing board authority of the  
11 health care provider or hospital."

12 15. Page 18, line 31, by inserting after the  
13 figure "153" the following: ", except where such acts  
14 also involve disciplinary actions against a health  
15 care provider by the hospital, reports shall be made".

16 16. Page 18, by striking lines 32 and 33.

17 17. Page 19, lines 30 and 31, by striking the  
18 words ", jurisdictions, or rating areas".

19 18. Page 20, by striking lines 6 and 7 and  
20 inserting the following:

21 "2. "Fund" means the patient catastrophic injury  
22 fund established in section 147B.6."

23 19. Page 20, by striking lines 23 through 30 and  
24 inserting the following:

25 "Sec.     . NEW SECTION. 519B.2 INSURANCE PREMIUM  
26 DISTRIBUTIONS.

27 The commissioner shall, on July 1 of each year,".

28 20. Page 20, by striking lines 47 through 49.

29 21. Page 23, by striking lines 10 through 23 and  
30 inserting the following:

31 "Sec.     . An amount not to exceed one hundred  
32 thousand dollars shall be paid out of the patient  
33 catastrophic injury fund to the board of medical  
34 examiners established under chapter 147 for the  
35 purpose of enhancing the board's administration and  
36 enforcement of the provisions of law relating to those  
37 licensed to practice medicine and surgery, osteopathic  
38 medicine and surgery, and osteopathy."

39 22. Page 23, lines 39 and 40, by striking the  
40 words "and a health care provider or hospital,".

41 23. Page 23, line 46, by inserting after the word  
42 "requirements" the following: "regarding claims".

43 24. Page 24, by striking lines 3 through 7 and  
44 inserting the following: "system to assist in the  
45 resolution of disputes, establishing certain mandatory  
46 reporting requirements for health care providers  
47 regarding acts which may constitute malpractice,  
48 providing for regional pricing of insurance,  
49 establishing a system for the reimbursement of certain  
50 amounts paid for medical liability insurance to ensure

DIV  
A

S-5883 Page 3

DIV  
A

1 the availability of physicians to all citizens of this  
2 state, establishing a study to determine where the  
3 state is experiencing a shortage of needed medical  
4 services, establishing an effective date, providing  
5 for applicability and establishing penalties."  
6 25. By renumbering as necessary.

S-5883 DIV A - ADOPTED  
Filed April 8, 1988 DIV B - ADOPTED BY DONALD DOYLE  
(88-1331-24) BILL HUTCHINS

SENATE FILE 484

S-5889

1 Amend the House amendment, S-5840, to Senate File  
2 484, as amended, passed and reprinted by the Senate as  
3 follows:

4 1. Page 10, by inserting after line 28 the  
5 following:

6 "Sec. \_\_\_\_ . NEW SECTION. 147B.19 FRIVOLOUS  
7 ACTIONS.

8 In all cases against a health care provider or  
9 hospital under this chapter, the court may, in its  
10 discretion, upon application by the prevailing party  
11 and in an amount determined by the court, charge  
12 reasonable attorney fees as costs payable to the  
13 prevailing party, if the court finds that the losing  
14 party did not have a reasonable likelihood of recovery  
15 or a reasonable likelihood of a successful defense.  
16 The charging of costs under this section is the sole  
17 responsibility of the named parties and shall not in  
18 any way be considered a cost of defense or reduce in  
19 any manner insurance coverage provided to either party  
20 thereby reducing the amount of coverage available for  
21 the payment of any judgment rendered against that  
22 party."

S-5889

Filed April 8, 1988

OUT OF ORDER

BY JULIA GENTLEMAN

(p. 1382)

FILED APR 08 1988

STATE OF IOWA

FISCAL NOTE

LSB No. 2860S.3  
Staff ID. JEM

SENATE FILE 484 AS AMENDED BY S-5870

In compliance with a written request received April 8, 1988, a fiscal note for SENATE FILE 484 AS AMENDED BY S-5870 is hereby submitted pursuant to Joint Rule 17. Data used in developing this fiscal note are available from the Legislative Fiscal Bureau to members of the Legislature upon request.

Senate File 484 as amended by S 5870 creates additional revenue for indigent patient care by assessing a one percent charge on patient billings for inpatient acute care services and routine surgical services. Billings involving Medicaid or Medicare are excluded. This assessment would be in addition to the one percent assessment that would fund the patient compensation injury fund. Revenues generated from the assessment would be used by the Department of Human Services and the Department of Public Health to provide medical assistance by: increasing eligibility for the elderly, blind, and disabled people, providing planning to ensure access to hospital services in rural areas, and for additional assistance for emergency medical assistance.

**FISCAL EFFECT**

1. Approximately \$6.5 million annually could be generated from a one percent assessment of hospital billings. This amendment has an effective date that is in the middle of the 1989 fiscal year and therefore approximately \$3.25 million would be available.
2. The Department of Human services would use 60% of the funds collected or \$1.95 million in FY 1989 and \$3.9 million in FY 1990 to enhance the reimbursement rate for hospitals. This would result in additional revenues of approximately \$3.2 million in FY 1989 and \$6.4 million in FY 1990 and beyond.
3. The Department of Human Services would use 28% of the funds collected or \$910,000 in FY 1989 and \$1.82 million in FY 1990 to expand medical assistance eligibility. This would result in additional federal revenue of approximately \$1.5 million in FY 1989 and \$3.0 million in FY 1990 and beyond.
4. The Department of Public Health would use 2% of the funds collected or \$65,000 in FY 1989 and \$130,000 in FY 1990 for planning assistance to local boards to ensure access to hospital services in rural areas.
5. The Department of Public Health would use 10% of the funds collected or \$325,000 in FY 1989 and \$650,000 in FY 1990 for additional assistance for emergency medical services.

Source: The Insurance Division.

(LSB 2860S.3, JEM)

*Renee Proerty*  
Fiscal Director

Legislative Fiscal Bureau

Date: 4/8/88

STATE OF IOWA

FILED APR 08 1988

FISCAL NOTE

LSB No. 2880s.2  
Staff ID. JEM

SENATE FILE 484 AS AMENDED BY THE HOUSE

In compliance with a written request received April 7, 1988, a fiscal note for SF 484 AS AMENDED BY HOUSE is hereby submitted pursuant to Joint Rule 17. Data used in developing this fiscal note are available from the Legislative Fiscal Bureau to members of the Legislature upon request.

Senate File 484 as amended by S 5985 creates an excess liability fund for health care providers, establishes a surcharge to be deposited into the fund, establishing qualifications for a health care provider or a patient to be protected by the fund, establishing a maximum limitation on the liability of the fund, creation of a compensation review board, authorization of the fund to procure reinsurance to protect the fund, authorization of the fund to provide claim payments for medical malpractice awards, and to create structured settlements for health care professionals and insurance companies.

Explanation

The patient compensation injury fund is expected to reduce insurance premiums by establishing a fund that would exempt health care providers from certain limits of liability. The fund would effectively reduce the amount of liability for which a health care provider could be liable. The fund would be financed by a 1% charge on hospital billings for inpatient acute care services and an annual surcharge based on premiums paid by health care providers for liability coverage. The fund will pay malpractice awards from \$500,000 to \$3 million, and a health care professional and hospitals shall provide coverage for awards under \$500,000.

A mediation service is established that would require an injured party to request mediation within fifteen days after filing a court action. Persons who have not filed a court action may also participate in mediation, however, it is mandatory. Mediation services will be funded by imposing an \$20.00 filing fee for mediation hearings.

The amendment establishes a Iowa Medical Care Availability Assistance Trust Fund for physicians who cannot afford their medical malpractice premiums. Physicians are eligible to receive compensation from the fund if their annual gross income derived from delivery of medical services.

The commissioner of insurance shall conduct an examination of insurance rating practices relating to the use of nonstate specific experience in the setting of rates in the state, (regional pricing).

The commissioner of insurance shall discount liability premiums for those health providers who are free of any civil or criminal claims for a five year period.

Fiscal Effect

1. The Patient Compensation Fund is estimated to produce approximately \$6.5 million annually. It is unknown what amount would be paid out of the fund for claims within the established limits. However, the commissioner of insurance shall determine when health care providers and hospitals would no longer have to pay into the fund, but would also require the gener-

STATE OF IOWA

FISCAL NOTE

SENATE FILE 484 AS AMENDED BY THE HOUSE

LSB No. 2860s.2  
Staff ID. JEM

fund to be liable for any awards that could not be covered by the amount in the Patient Compensation Fund.

- 2. A mediation fund is established by charging a \$20.00 filing fee on the number of malpractice cases brought before the courts. It is unknown how much will be generated as a result of the filing fee, as it depends upon the number of malpractice cases filed.
- 3. The Insurance Division shall distribute from funds appropriated from the general fund to physicians an amount equal to the amount by which the physicians premium payments for medical liability insurance exceed 15% of the physician's annual gross income. The bill appropriates \$150,000 to the Iowa Medical Care Availability Assistance Trust Fund.
- 4. Section 35 of the amendment requires the Insurance Division of the Department of Commerce to conduct a study to determine where the state has a shortage of needed medical services. No additional funds or staff are needed.
- 5. Approximately \$250,000 is anticipated in revenues from the one time application fee required from hospitals and health care providers. Money collected as a result of the application fee would be used by the insurance division to implement and administer the Patient Compensation Fund.

Source: The Insurance Division  
Department of Commerce

(LSB 2860s.2, JEM)

*Henry Probst*  
\_\_\_\_\_  
Fiscal Director

Legislative Fiscal Bureau

Date: 4/8/88

SENATE AMENDMENT TO HOUSE AMENDMENT TO  
SENATE FILE 484

H-6353

- 1 Amend the House amendment, S-5840, to Senate File  
2 484 as amended, passed, and reprinted by the Senate,  
3 as follows:
- 4 1. Page 3, by striking lines 35 and 36 and  
5 inserting the following: "business or a hospital  
6 which has ceased doing business or providing services  
7 if the health care provider or hospital files proof of  
8 insurance as required in subsection 1 or 2, as  
9 applicable, and pays a one-".
- 10 2. Page 3, line 44, by inserting after the word  
11 "business" the following: "or the hospital's ceasing  
12 to do business or providing services".
- 13 3. Page 7, by striking lines 40 through 42 and  
14 inserting the following: "or settlement approved by  
15 the court in excess of five hundred thousand dollars,  
16 and up to five million dollars, against a health care  
17 provider or hospital qualified under this chapter with  
18 respect to an occurrence of".
- 19 4. Page 8, line 22, by inserting after the word  
20 "commerce," the following: "and to the legislative  
21 fiscal bureau,".
- 22 5. Page 8, by inserting after line 46, the  
23 following:  
24 "The annual report shall also include an actuarial  
25 review of the solvency of the fund and contain  
26 appropriate recommendations relating to the protection  
27 of the solvency of the fund including, but not limited  
28 to, the need for mandatory participation by health  
29 care providers or hospitals, the need for additional  
30 revenue sources, and other recommendations deemed  
31 appropriate by the commissioner."
- 32 6. Page 8, by inserting after line 47 the  
33 following:  
34 "The legislative fiscal bureau shall have the  
35 authority to retain an actuary, upon the approval of  
36 the legislative council, to examine and report on the  
37 patient catastrophic injury fund."
- 38 7. Page 11, by striking lines 33 through 36 and  
39 inserting the following: "3."
- 40 8. Page 12, line 16, by striking the words  
41 "exceeds one hundred" and inserting the following:  
42 "which exceed two hundred fifty".
- 43 9. Page 12, line 18, by inserting after the word  
44 "award" the following: "where the fund is responsible  
45 for paying damages for future injuries".
- 46 10. Page 12, line 19, by striking the words "one  
47 hundred thousand dollars" and inserting the following:  
48 "two hundred fifty thousand dollars, including any  
49 amount for future damages to be paid by the health  
50 care provider or hospital in excess of the limits of

H-6353

Page 2

- 1 the fund,".
- 2 11. Page 13, by striking lines 11 through 50.
- 3 12. Page 17, line 38, by inserting after the
- 4 figure "258A.1" the following: "the department of
- 5 inspections and appeals,".
- 6 13. Page 17, line 45, by inserting after the word
- 7 "insurance" the following: "and to the legislative
- 8 fiscal bureau".
- 9 14. Page 18, by striking line 13 and inserting
- 10 the following: "licensing board authority of the
- 11 health care provider or hospital."
- 12 15. Page 18, line 31, by inserting after the
- 13 figure "153" the following: ", except where such acts
- 14 also involve disciplinary actions against a health
- 15 care provider by the hospital, reports shall be made".
- 16 16. Page 18, by striking lines 32 and 33.
- 17 17. Page 19, lines 30 and 31, by striking the
- 18 words ", jurisdictions, or rating areas".
- 19 18. Page 20, by striking lines 6 and 7 and
- 20 inserting the following:
- 21 "2. "Fund" means the patient catastrophic injury
- 22 fund established in section 147B.6."
- 23 19. Page 20, by striking lines 23 through 30 and
- 24 inserting the following:
- 25 "Sec. \_\_\_\_\_. NEW SECTION. 519B.2 INSURANCE PREMIUM
- 26 DISTRIBUTIONS.
- 27 The commissioner shall, on July 1 of each year,".
- 28 20. Page 20, by striking lines 47 through 49.
- 29 21. Page 23, by striking lines 10 through 23 and
- 30 inserting the following:
- 31 "Sec. \_\_\_\_\_. An amount not to exceed one hundred
- 32 thousand dollars shall be paid out of the patient
- 33 catastrophic injury fund to the board of medical
- 34 examiners established under chapter 147 for the
- 35 purpose of enhancing the board's administration and
- 36 enforcement of the provisions of law relating to those
- 37 licensed to practice medicine and surgery, osteopathic
- 38 medicine and surgery, and osteopathy."
- 39 22. Page 23, lines 39 and 40, by striking the
- 40 words "and a health care provider or hospital,".
- 41 23. Page 23, line 46, by inserting after the word
- 42 "requirements" the following: "regarding claims".
- 43 24. Page 24, by striking lines 3 through 7 and
- 44 inserting the following: "system to assist in the
- 45 resolution of disputes, establishing certain mandatory
- 46 reporting requirements for health care providers
- 47 regarding acts which may constitute malpractice,
- 48 providing for regional pricing of insurance,
- 49 establishing a system for the reimbursement of certain
- 50 amounts paid for medical liability insurance to ensure

H-6353

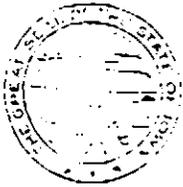
Page 3

1 the availability of physicians to all citizens of this  
2 state, establishing a study to determine where the  
3 state is experiencing a shortage of needed medical  
4 services, establishing an effective date, providing  
5 for applicability and establishing penalties."  
6 25. By renumbering as necessary.

RECEIVED FROM THE SENATE

H-6353 FILED APRIL 11, 1988

*House concurred 4/12 (p. 1793)*



OFFICE OF THE GOVERNOR

STATE CAPITOL

DES MOINES, IOWA 50319

515 281-5211

TERRY E. BRANSTAD  
GOVERNOR

May 13, 1988

The Honorable Elaine Baxter  
Secretary of State  
State Capitol Building  
L O C A L

Dear Madam Secretary:

Senate File 484, an act relating to health care providers, hospitals, and patients by providing for the creation of a patient catastrophic injury fund for health care providers and hospitals, establishing a surcharge to be deposited in the fund, providing for an assessment on hospital charges, establishing qualifications for a health care provider, hospital, or patient to be protected by the fund, establishing a limitation on the liability of the fund, establishing a study and certain other powers and duties of the commissioner of insurance, providing for indemnification agreements between a hospital and a health care provider, providing that the act does not apply to certain contracts guaranteeing results, establishing certain reporting requirements regarding claims, providing for the appointment of a fund administrator and for administration of the fund, providing that an advance payment or a settlement is not an admission of liability, providing for liability of defense costs in certain actions, authorizing the fund to procure reinsurance, providing for structured settlements, establishing a mediation system to assist in the resolution of disputes, establishing certain mandatory reporting requirements for health care providers regarding acts which may constitute malpractice, providing for regional pricing of insurance, establishing a system for the reimbursement of certain amounts paid for medical liability insurance to ensure the availability of physicians to all citizens of this state, establishing a study to determine where the state is experiencing a shortage of needed medical services, establishing an effective date, providing for applicability and establishing penalties, is hereby transmitted to you in accordance with Article III, Section 16, of the Constitution of the State of Iowa.

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Senate File 484 puts the state in the medical malpractice insurance business by establishing a patient compensation fund for recoveries of up to \$5 million. The first \$1 million worth of coverage is effectively paid for by the doctor or hospital with the remaining \$4 million worth of coverage supplied by a one percent tax on hospital billings and, if needed, the state's general fund.

Senate File 484 is a so-called tort reform bill. However, even some of the strongest proponents of this bill admit that the bill does not reform our tort liability system. Instead, proponents argue that it will provide a reduction in the cost of reinsurance for some doctors and hospitals in our state and will maintain and possibly even enhance the ability of plaintiffs in medical malpractice actions to receive recoveries. However, in this effort to provide reassurance to some physicians and hospitals and to protect the plaintiffs in malpractice cases, the legislature apparently forgot about one important player in this process -- the taxpayer. Indeed, Senate File 484 is simply bad public policy. It is fiscally unsound; its potential long term impacts are frightening; and it forfeits the chance to obtain meaningful tort liability reform at this time and for the foreseeable future. For those reasons, I cannot approve Senate File 484.

It is no understatement to say that the medical malpractice system in the state of Iowa is in a state of crisis. Consider, for example, that malpractice premiums in Iowa have risen by 366 percent since 1981. And, an Iowa Supreme Court's study found that the number of medical malpractice cases filed in Iowa doubled from 1981 to 1986. The size of the awards also increased significantly.

This medical malpractice crisis has resulted in a loss of access to and an increase in cost of quality medical care. For example, a 1987 survey of physicians in Iowa found that 57 percent of them were less likely to provide services to high risk patients than in 1981. Moreover, between 1981 and 1987 the state lost one-third of its practicing obstetric physicians and one-half of those who quit practiced in rural areas. In fact, today in some parts of Iowa, a mother must travel up to 60 miles to give birth to her baby.

This malpractice crisis also has added to health care cost inflation. The same survey found that two-thirds of the doctors were more likely to require additional laboratory tests in order to practice defensive medicine. And, there can be little doubt that the additional malpractice insurance premiums required to be paid by doctors, at least in part, have been passed on in higher costs to health care consumers.

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Now, there are some who say that the medical malpractice crisis is simply an insurance company conspiracy. However, the facts do not bear that out. In fact, approximately 600 companies have the ability to write medical malpractice insurance in Iowa. However, in 1987, only six insurers wrote 90 percent of the market. The reason for the small number of insurers is clear: medical malpractice insurance has not been significantly profitable in the past few years. Moreover, the loss ratio for companies insuring medical malpractice in Iowa has gotten significantly worse with Iowa's largest medical malpractice insurer's loss ratio exceeding 120 percent in one year.

What is needed to resolve this serious problem? It is clear there must be some cap placed on medical malpractice recoveries. I recommended a \$250,000 cap on non-economic losses -- similar caps are presently in place in 21 other states. In addition, the medical profession itself must do an even better job of policing its profession to ensure that physicians who are not up to standard are not allowed to practice.

But Senate File 484 does not significantly address the issue of improving the quality of physicians and hospitals and does not put in place reasonable limitations on recoveries. Instead, this bill simply shifts the cost from doctors, plaintiffs and their attorneys to the public. I acknowledge that Senate File 484 does provide reinsurance for the 40 percent of doctors who need greater than a million dollars worth of coverage. However, the reduction in malpractice costs for those individuals comes at too high a price.

First, I have deep philosophical concerns about the state being involved in this type of insurance business. Five of the ten states that are involved in the medical malpractice insurance business have funds that are actuarially insolvent. The reason is simple. The political process resists efforts to put funds away for potential losses in the future. Instead, the temptation among state governments is to provide funds on a cash flow basis only. That temptation may look good in the short run, but in the long term, it can cause a severe financial crisis for the state.

Second, Senate File 484 is fiscally unwise. It puts in place a \$7 million tax on health care on hospital consumers to help pay for medical malpractice claims. This is, in effect, a general tax increase in order to fund the problem we have not taken action to solve. Moreover, careful actuarial reviews of the bill have been conducted for the Insurance Division for the Department of Commerce and the Iowa Medical Society. Review was difficult

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to do since the bill contains significant ambiguous language, i.e., the determination of whether coverage is per occurrence or per defendant is not clear. Moreover, the actuarial firm has indicated that state taxpayers could eventually be forced to pay excess liability costs of between \$426,000 to \$4 million per year. Given the tight fiscal conditions existing in the state, it would be difficult for the state to absorb these additional costs. Regardless of the actual size of the state liability, I believe that it is unwise for the state fiscal policy to have the taxpayers exposed to significant liability resulting from medical malpractice claims.

Third, I believe the bill could, in the long term, make the medical malpractice crisis even worse. This bill could actually result in increased medical malpractice claims above present levels. Senate File 484 provides for up to \$5 million of coverage for all doctors and hospitals in the state. Currently, 60 to 70 percent of doctors have coverage of only \$1 million. The additional availability of \$4 million of insurance would certainly be an attractive target for plaintiff attorneys in malpractice cases to shoot at. And higher claims will only make the current malpractice crisis even worse.

Fourth, I believe Senate File 484, if signed, would significantly reduce the chances for meaningful tort reform for the future. In effect, this bill relieves some of the pressures for medical malpractice reform. Since health care consumers and taxpayers would be paying for higher levels of coverage, there may be reduced interest among the affected physicians and hospitals to push for meaningful malpractice reform for the future. As a result, the likelihood of reform in future is significantly diminished.

In summary, I am aware that the proponents of this legislation indicate that it protects medical malpractice plaintiffs and will provide some reinsurance for some medical practitioners. However, these marginal benefits are clearly outweighed by the fact that the legislature, in passing this bill, forgot about the taxpayer. The health care consumer and the state's general fund would be forced to absorb the probable increase in medical malpractice awards. I believe that is bad public policy and fiscally unwise. And it significantly reduces our chance to obtain meaningful tort reform in the future.

Moreover, I have deep philosophical reservations about having the state enter into the insurance business and believe it should only be done on rare occasions when the potential exposure to the state is slim and public policy reasons for offering of such

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insurance are overwhelming. In addition, I believe it is inappropriate for the state to enter that type of business when the result is to mask the root cause of the medical malpractice crisis. Indeed, we should not push this problem on to the public. As public policymakers, our role is to protect the public, not to make them the ultimate absorbers of excess risk.

I pledge to work with the legislature, the affected interests, and representatives of public to develop a meaningful medical malpractice and tort liability reform in the future. It will require compromise from all parties and commitment to protect the public interest in available and affordable health care.

For the above reasons, I hereby respectfully disapprove Senate File 484.

Sincerely,



Terry E. Branstad  
Governor

TEB/ps

cc: Secretary of the Senate  
Chief Clerk of the House

Veto

SENATE FILE 484

AN ACT

RELATING TO HEALTH CARE PROVIDERS, HOSPITALS, AND PATIENTS BY PROVIDING FOR THE CREATION OF A PATIENT CATASTROPHIC INJURY FUND FOR HEALTH CARE PROVIDERS AND HOSPITALS, ESTABLISHING A SURCHARGE TO BE DEPOSITED IN THE FUND, PROVIDING FOR AN ASSESSMENT ON HOSPITAL CHARGES, ESTABLISHING QUALIFICATIONS FOR A HEALTH CARE PROVIDER, HOSPITAL, OR PATIENT TO BE PROTECTED BY THE FUND, ESTABLISHING A LIMITATION ON THE LIABILITY OF THE FUND, ESTABLISHING A STUDY AND CERTAIN OTHER POWERS AND DUTIES OF THE COMMISSIONER OF INSURANCE, PROVIDING FOR INDEMNIFICATION AGREEMENTS BETWEEN A HOSPITAL AND A HEALTH CARE PROVIDER, PROVIDING THAT THE ACT DOES NOT APPLY TO CERTAIN CONTRACTS GUARANTEEING RESULTS, ESTABLISHING CERTAIN REPORTING REQUIREMENTS REGARDING CLAIMS, PROVIDING FOR THE APPOINTMENT OF A FUND ADMINISTRATOR AND FOR ADMINISTRATION OF THE FUND, PROVIDING THAT AN ADVANCE PAYMENT OR A SETTLEMENT IS NOT AN ADMISSION OF LIABILITY, PROVIDING FOR LIABILITY OF DEFENSE COSTS IN CERTAIN ACTIONS, AUTHORIZING THE FUND TO PROCURE REINSURANCE, PROVIDING FOR STRUCTURED SETTLEMENTS, ESTABLISHING A MEDIATION SYSTEM TO ASSIST IN THE RESOLUTION OF DISPUTES, ESTABLISHING CERTAIN MANDATORY REPORTING REQUIREMENTS FOR HEALTH CARE PROVIDERS REGARDING ACTS WHICH MAY CONSTITUTE MALPRACTICE, PROVIDING FOR REGIONAL PRICING OF INSURANCE, ESTABLISHING A SYSTEM

FOR THE REIMBURSEMENT OF CERTAIN AMOUNTS PAID FOR MEDICAL LIABILITY INSURANCE TO ENSURE THE AVAILABILITY OF PHYSICIANS TO ALL CITIZENS OF THIS STATE, ESTABLISHING A STUDY TO DETERMINE WHERE THE STATE IS EXPERIENCING A SHORTAGE OF NEEDED MEDICAL SERVICES, ESTABLISHING AN EFFECTIVE DATE, PROVIDING FOR APPLICABILITY AND ESTABLISHING PENALTIES.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. FINDINGS -- PURPOSE. The general assembly finds that access to high quality medical and hospital services at reasonable costs is in the public interest and is necessary to ensure the health, safety, and welfare of Iowa citizens.

The general assembly finds that the increasing costs and decreasing availability of adequate medical liability insurance for health care providers and hospitals threaten the public access to high quality medical and hospital services at reasonable costs.

The general assembly finds that it has become necessary to take legislative action to achieve the public interest and assure the health, safety, and welfare of Iowa citizens, such action to include the balancing of interests between an individual's right of recovery for injuries and society's need for necessary services.

It is the purpose of this Act to maintain and increase the public's access to high quality medical and hospital services at reasonable costs, thereby protecting the health, safety, and welfare of the citizens of this state. To effectuate this purpose, it is the intent of the general assembly that the provisions of this Act be construed liberally to achieve the following:

1. An increase in the availability and affordability of medical liability insurance for health care providers and hospitals.
2. To maximize an individual's right to redress for injuries within the confines of the broader purpose of protecting the health, safety, and welfare of all citizens.

3. To obtain such data as is necessary to develop long-term solutions to the problems related to these findings.
4. To decrease the incidence of medical malpractice.
5. To provide such incentives as are necessary to retain medical and hospital services in all parts of this state.
6. To increase the resolution of medical liability actions by more cost-efficient means than traditional litigation.
7. To insure that the costs of medical liability insurance accurately reflect the exposure to risk.

Sec. 2. NEW SECTION. 147B.1 SHORT TITLE.

This chapter shall be known as the "Health Care Provider and Patient Assistance Act."

Sec. 3. NEW SECTION. 147B.2 DEFINITIONS.

As used in this chapter, unless the context requires otherwise:

1. "Administrator" means the compensation fund administrator appointed pursuant to section 147B.15, or the administrator's designee.
2. "Commissioner" means the commissioner of insurance.
3. "Fund" means the patient catastrophic injury fund established in section 147B.6.
4. "Future injuries" means all legal harm relating to an injury which the trier of fact determines will be incurred by the injured party subsequent to the entry of judgment.
5. "Health care provider" means a person licensed or certified in this state under chapter 148, 150, 150A, 152, or 153 to provide professional health care services to an individual during that individual's medical care, treatment, or confinement.
6. "Health services" means clinically related diagnostic, curative, or rehabilitative services, and includes alcoholism, drug abuse, and mental health services.
7. "Hospital" means a hospital licensed pursuant to chapter 135B.
8. "Injured person" means the person during whose medical treatment or care the acts or omissions of medical malpractice are determined to have occurred.

9. "Injured party" means a party plaintiff to a medical malpractice action or other person not a party to the action but who may have a cause of action against a health care provider or hospital as a result of an injury alleged to have occurred as a result of medical malpractice, and includes the injured person.

10. "Injury" means a legal harm for which damages are recoverable in an action arising under this chapter.

11. "Medical malpractice" means acts or omissions of a health care practitioner in the practice of the practitioner's profession or occupation, or acts or omissions of a hospital in patient treatment or care, including but not limited to negligence, failure to provide care, breach of contract relating to providing care, or claim based upon failure to obtain informed consent for an operation or treatment.

Sec. 4. NEW SECTION. 147B.3 QUALIFIED PROVIDER - PATIENT.

1. A health care provider is qualified to participate under this chapter if the health care provider does the following:
  - a. Files with the commissioner proof that the health care provider is insured with an insurance company admitted to do business in this state under a policy of medical liability insurance providing a minimum of five hundred thousand dollars per occurrence in coverage.
  - b. Pays a surcharge levied on the health care provider pursuant to section 147B.6.
2. A hospital is qualified to participate under this chapter if the hospital does the following:
  - a. Files with the commissioner proof of financial responsibility in an amount of five hundred thousand dollars per occurrence. The hospital is qualified as long as the required proof of financial responsibility remains effective. Financial responsibility is proven by providing a certified copy of a professional liability insurance policy currently in force, with annual proof of policy renewal required; a notarized letter from the professional liability insurance

carrier stating that the hospital is covered by a policy of professional liability insurance, with annual proof of policy renewal required; the posting of a bond; or the payment of cash to the commissioner. If proof of financial responsibility is by professional liability insurance the hospital shall provide information evidencing the policy period, amount of coverage, premium paid, claim form of policy, and any reservation of rights by the carrier.

b. Pays a surcharge levied on the hospital pursuant to section 147B.6.

3. The commissioner may permit qualification of a health care provider who has retired or ceased doing business or a hospital which has ceased doing business or providing services if the health care provider or hospital files proof of insurance as required in subsection 1 or 2, as applicable, and pays a one-time surcharge as may be determined to be appropriate by the commissioner. The amount of the surcharge shall not exceed the cost of five hundred thousand dollars of medical liability coverage above the initial five hundred thousand dollars of medical liability coverage for the period subsequent to the health care provider's retirement or ceasing to do business or the hospital's ceasing to do business or providing services. The commissioner shall adopt rules to implement this subsection.

4. A claim or cause of action against a health care provider or hospital shall not be denied as a result of the health care provider or hospital not being qualified at the time the action is instituted if the health care provider or hospital was qualified at the time of the alleged occurrence. A health care provider or hospital not qualified at the time of the alleged occurrence is not qualified under this chapter by filing proof of financial responsibility and making payment of the required surcharge subsequent to the occurrence giving rise to the claim.

Sec. 5. NEW SECTION. 147B.4 NOTICE -- APPLICATION FEE.

1. Prior to consideration for qualification pursuant to this chapter, a health care provider shall give notice to the

commissioner of the provider's intention to qualify. The notice of intention shall be accompanied by a one-time application fee of fifty dollars for health care practitioners and five hundred dollars for hospitals.

2. Fees received by the commissioner pursuant to subsection 1 shall only be expended for purposes of payment of the reasonable expenses incurred or to be incurred in the implementation of this chapter.

3. To the extent that fees received pursuant to subsection 1 are in excess of the expenses of implementation of this chapter, the commissioner shall transfer the excess fees to the fund.

4. Notice and application fees received subsequent to the implementation of this chapter shall be placed in the fund upon receipt.

Sec. 6. NEW SECTION. 147B.5 EXPRESS CONTRACT ASSURING RESULTS.

Liability shall not be imposed upon a health care provider or hospital as a result of an alleged breach of an express or implied contract assuring results to be obtained by any procedure undertaken in the course of health care unless the contract is expressly set forth in writing and is signed by the health care provider or hospital or by an authorized agent of the health care provider or hospital. The only exception to the written requirement shall be when the health care provider or hospital expressly represents to the patient in the presence of an employee of the health care provider or hospital the results to be obtained from a procedure undertaken. This section does not exempt a health care provider or hospital from the standard of due care in administering any procedure undertaken.

Sec. 7. NEW SECTION. 147B.6 PATIENT CATASTROPHIC INJURY FUND.

1. A patient catastrophic injury fund is created for the purposes stated in this chapter. The fund and income from the fund shall be deposited with the treasurer of state to be used for the payment of qualifying claims under this chapter and

administrative expenses of the mediation system established pursuant to section 147B.24, and the fund is appropriated for those purposes. Appropriations to the fund are not subject to reversion under section 8.33.

The fund shall be wholly responsible for paying settlements or judgments in excess of the amount of the combined financial responsibility required under section 147B.3. If more than one health care provider or hospital, or both, are liable on a claim, the combined financial responsibility amounts shall be primary coverage, and the fund shall constitute secondary coverage.

2. An annual surcharge shall be levied on all health care providers and hospitals qualifying under section 147B.3. The surcharge for a health care provider or hospital is determined by the commissioner subject to the following limitations:

a. The annual surcharge shall not exceed the difference of the premium amount which the health care provider or hospital would pay annually to maintain a policy of medical liability insurance providing one million dollars of coverage less the premium amount which the health care provider or hospital pays or would pay to maintain a policy of medical liability insurance providing five hundred thousand dollars of coverage.

b. The amount of the surcharge shall not exceed the amount necessary to assure that the fund is actuarially sound.

3. The surcharge required for qualification under section 147B.3 is due and payable at the time the health care provider or hospital qualifies pursuant to section 147B.3, and is payable annually thereafter in amounts as determined by the commissioner.

4. If the annual premium surcharge required for qualification under section 147B.3 is not paid within the time specified in subsection 3, the qualification of the health care provider or hospital shall be suspended until the annual premium surcharge is paid. The suspension shall not be effective as to patients claiming against the health care provider or hospital unless, at least thirty days before the effective date of the suspension, a written notice giving the

date upon which the suspension becomes effective has been provided by the commissioner to the health care provider or hospital.

Sec. 8. NEW SECTION. 147B.7 LIMITATION OF LIABILITY.

A health care provider or hospital qualified under this chapter determined to be liable for an occurrence, to which this chapter applies, resulting in an injury or death of a patient arising out of medical malpractice shall be liable for all amounts due under a judgment or settlement recoverable by an injured party in excess of any amount for which the fund is liable under section 147B.11.

Sec. 9. NEW SECTION. 147B.8 COVERAGE BY FUND.

1. The fund shall provide coverage to the health care provider or hospital on the same basis as the underlying professional liability insurance or other proof of financial responsibility maintained by the health care provider or hospital.

2. If at any time prior to the health care provider's or hospital's qualification under this chapter, the health care provider or hospital had acquired coverage under an occurrence form policy of medical liability insurance for an occurrence of alleged medical malpractice occurring during the term that policy was in effect, the fund shall provide coverage only for claims for alleged medical malpractice covered under the policy to the extent that a judgment or settlement exceeds the limits of the policy.

3. The fund shall not provide coverage for a medical malpractice claim against a health care provider or hospital qualified under this chapter if the medical malpractice claim was made against that health care provider or hospital prior to the time of the health care provider's or hospital's qualification under this chapter.

4. The fund may provide coverage for an alleged occurrence of medical malpractice by a health care provider or hospital which occurred prior to the health care provider's or hospital's qualification under this chapter if the health care provider or hospital had not received notice and the health

care provider or hospital had a claims made policy of medical liability insurance in effect immediately prior to the health care provider's or hospital's qualification under this chapter. A health care provider or hospital may be required to pay a surcharge for such coverage as determined by the commissioner to be appropriate if the prior claims made policy was not mature.

Sec. 10. NEW SECTION. 147B.9 REINSURANCE.

The commissioner may cause all or any part of the potential liability of the fund to be reinsured, if reinsurance is available on a fair and reasonable basis. The cost of the reinsurance shall be paid by the fund and the fact of the reinsurance shall be taken into account in determining the surcharge.

Sec. 11. NEW SECTION. 147B.10 SOURCE OF FUNDING FOR PATIENT CATASTROPHIC INJURY FUND.

1. An assessment of one percent is imposed on patient billings for inpatient acute care services and routine and surgical outpatient services, other than those involving Medicaid or Medicare, by hospitals beginning January 1, 1989. This assessment shall be collected by the hospital and the assessments received shall be remitted by the hospital to the patient catastrophic injury fund monthly. A hospital shall not be responsible for the collection or remittance of assessments on billings deemed uncollectible by the hospital.

2. The assessment created by this section shall be charged to and paid in full by the primary payor and shall be considered a covered benefit for purposes of third-party reimbursement. A primary payor's obligations under this section shall not be altered by contract or agreement.

3. The assessment pursuant to subsection 1 shall be implemented on January 1, 1989, and shall only continue in force and effect until the patient catastrophic injury fund is found to be actuarially sound. The determination that the fund is actuarially sound shall be made by the commissioner. The assessment shall only be reinstated upon order of the commissioner based upon evidence that the reinstatement of the

assessment is necessary to maintain actuarial soundness of the fund. The order shall only be made following notice and hearing to interested parties.

Sec. 12. NEW SECTION. 147B.11 LIABILITY OF PATIENT CATASTROPHIC INJURY FUND -- STANDING APPROPRIATION.

The patient catastrophic injury fund is liable for all sums to be paid under a judgment, verdict, award, or settlement approved by the court in excess of five hundred thousand dollars, and up to five million dollars, against a health care provider or hospital qualified under this chapter with respect to an occurrence of medical malpractice in this state.

There is appropriated from the general fund of the state to the patient catastrophic injury fund each fiscal year an amount sufficient to pay any amounts outstanding for which the fund is liable when all moneys deposited in the fund for that year have been expended.

However, the fund is liable for the repayment to the general fund for any amounts expended for payment of any claims under this chapter. These amounts shall be repaid out of any amounts collected pursuant to this chapter in subsequent years which are in excess of the amount determined by the commissioner necessary to maintain the fund in an actuarially sound manner.

Sec. 13. NEW SECTION. 147B.12 FUND NOT PART OF THE IOWA INSURANCE GUARANTY ASSOCIATION.

The fund is not an insurance company or insurer under the laws of this state and shall not be a member of, nor be entitled to file a claim against, the Iowa insurance guaranty association created under chapter 515B.

Sec. 14. NEW SECTION. 147B.13 ANNUAL REPORT.

The commissioner shall, pursuant to rules issued by the commissioner, on or before the first day of February of each year, provide to the chairpersons, vice chairpersons, and ranking members of the senate standing committees on judiciary and commerce, and the house of representatives standing committees on judiciary and law enforcement, and small business and commerce, and to the legislative fiscal bureau, a

report regarding claims filed against the fund and claims closed involving the fund for the previous calendar year. However, the report shall not include any confidential information regarding a claim currently being litigated or which will be litigated, or a claim where the parties have entered into or will enter into discussions intended to result in a settlement of the claim, if the release of the information may impede settlement negotiations or adversely affect either party to the negotiations or litigation. The report shall contain to the extent the information is available the following information:

1. Parties to the claims.
2. Causes of action.
3. Amounts reserved or paid per claim, including the present value for structured settlements or awards.
4. Legal fees, expert witness fees, court costs, or other associated costs of judgments or decrees per claim.
5. Allocated loss adjustment expense.
6. Administrative costs.
7. Other claims information as deemed necessary by the commissioner.

The annual report shall also include an actuarial review of the solvency of the fund and contain appropriate recommendations relating to the protection of the solvency of the fund including, but not limited to, the need for mandatory participation by health care providers or hospitals, the need for additional revenue sources, and other recommendations deemed appropriate by the commissioner.

The report is a public record.

The legislative fiscal bureau shall have the authority to retain an actuary, upon the approval of the legislative council, to examine and report on the patient catastrophic injury fund.

Sec. 15. NEW SECTION. 147B.14 PROFESSIONAL LIABILITY PREMIUM DISCOUNT.

Every insurer providing a policy of professional liability insurance to a health care provider in Iowa on or after

January 1, 1989, shall review the health care provider's civil and criminal record for a period of not less than five years prior to the effective date of any new or renewed policy of insurance.

If the record establishes that the health care provider is claim-free for the period, the insurer shall do one of the following according to rules established by the commissioner:

1. Discount the provider's premium by an amount to be determined annually by the commissioner.
2. Issue the health care provider a policy based upon a preferred risk selection program, if the insurer has previously established such a program.
3. Specifically provide within the policy a review of the underwriting considerations accounting for the fact that the provider has had no claims within the last five years. However, the policy may be reviewed by the commissioner for reasonableness of underwriting considerations, and the commissioner may order that the underwriting considerations be replaced by a discount in the minimum amount provided in subsection 1.

Sec. 16. NEW SECTION. 147B.15 CATASTROPHIC INJURY FUND ADMINISTRATOR.

The commissioner may appoint an administrator to perform all duties and responsibilities pursuant to this chapter. The administrator shall serve at the pleasure of the commissioner. The salary and expenses of the administrator shall be paid from the fund.

Sec. 17. NEW SECTION. 147B.16 ADMINISTRATION.

The commissioner shall provide staff services necessary for the implementation of this chapter, or may contract with an insurance company licensed to do business in this state, or both, to perform any administrative duties of the commissioner pursuant to this chapter. The commissioner shall retain supervisory control over all services for which a contract is entered into. All reasonable costs and charges incurred in the administration of this chapter shall be paid from the fund.

The administrator and all persons employed or contracted with to provide staff services necessary for the operation of this chapter are employees of the state for purposes of chapter 25A, but for no other purposes.

Sec. 18. NEW SECTION. 147B.17 RULES.

The commissioner shall adopt rules pursuant to chapter 17A for the efficient administration of this chapter in accordance with its terms and intent.

Sec. 19. NEW SECTION. 147B.18 ADVANCE PAYMENT NOT ADMISSION.

A payment made by a health care provider or hospital or the health care provider's or hospital's insurer or surety to or for the patient or any other person on the patient's behalf in advance of a final determination of liability shall not be construed as an admission of liability for injuries or damages suffered in a medical malpractice action. In the event of an advance payment, the court shall reduce the judgment to the plaintiff by the amount of the advance payment. If the advance payment exceeds the liability of the defendant, the court shall order any adjustment necessary to equalize the amount under which each defendant is obligated to pay and in no case shall an advance in excess of the amount found to be due be repayable to the health care provider or hospital or the insurer or surety making the payment.

Sec. 20. NEW SECTION. 147B.19 SETTLEMENT NOT ADMISSION.

If at any time the health care provider, hospital, an insurance carrier, a surety, or the fund tenders payment to the patient or a person acting on the patient's behalf of any sum for the purpose of settlement and not as an advance, the tender shall not be considered an admission of liability by the health care provider or hospital. Liability or fault is not deemed admitted as a matter of law.

Sec. 21. NEW SECTION. 147B.20 COSTS OF DEFENSE.

1. Coverage for medical malpractice under the fund and under professional liability policies or other items posted for proof of financial responsibility to comply with the requirements of this chapter shall include defense costs and

allocation for loss adjustment expense. Such benefits or coverage shall not in any way reduce the coverage available to provide for payment of judgments by a health care provider or hospital to an injured party.

2. The administrator may employ the services of outside legal counsel to defend the fund against claims and to assist a health care provider's insurer in defending a claim.

3. The administrator may, by agreement with the health care provider's insurer, allow the health care provider's insurer to provide a defense for a claim against the health care provider and the fund. The administrator and the health care provider's insurer may agree to any apportionment of the costs of defense.

4. All actual expenses of collecting, protecting, and administering the fund shall be paid from the fund, including necessary costs of outside legal counsel. The attorney general is not responsible for representation or legal defense of the fund.

Sec. 22. NEW SECTION. 147B.21 FAILURE TO QUALIFY.

1. A health care provider or hospital who fails to qualify under this chapter is not covered by this chapter and is subject to liability as provided elsewhere in statute or common law. A patient's remedies against a nonqualified health care provider or hospital shall not be affected by this chapter.

2. A health care provider need not be a resident of this state to be eligible for coverage under this chapter. A nonresident may submit an application to the commissioner or the commissioner's designee to qualify for coverage under the terms and conditions provided by rule. However, the fund shall not be liable for any occurrence occurring outside of this state involving a resident or nonresident health care provider, unless the commissioner has by rule reached an agreement of reciprocity with the other state.

Sec. 23. NEW SECTION. 147B.22 ACTION -- AMOUNT RECOVERABLE -- SETTLEMENT.

1. Parties commencing an action governed by the provisions of this chapter have all rights afforded to them under statute or common law unless provided otherwise, and actions shall be commenced and governed as provided for under the rules of civil procedure.

2. The fund shall not be a named party to any suit. However, notice of suit shall be served upon the commissioner.

3. The payment of policy or bond limits or any portion thereof must be coordinated with the fund and shall not absolve the carrier from participation in the defense of the fund on behalf of the health care provider or hospital. The payment of policy or bond limits or any portion thereof shall not affect the injured parties' right to a jury trial.

4. The fund may participate in the settlement of claims prior to a health care provider's or hospital's liability carrier or surety tendering policy limits.

5. If multiple health care providers or hospitals are named as individual defendants, this chapter applies only to those providers or hospitals who are qualified under this chapter.

Sec. 24. NEW SECTION. 147B.23 STRUCTURED JUDGMENTS.

1. In a medical malpractice action against a health care provider or hospital subject to this chapter, the verdict shall be itemized to distribute the monetary damages, if any, between past loss and future loss. In a trial to the court, the court shall itemize its findings in accordance with this section.

2. The court, in a medical malpractice action subject to this chapter in which a damage award against all defendant health care providers and hospitals exceeds the financial responsibility of those health care providers and hospitals required under section 147B.3 and where the fund is responsible for paying damages for future injuries to a party which exceed two hundred fifty thousand dollars and upon application of one of the parties, shall enter a judgment ordering the portion of the award where the fund is responsible for paying damages for future injuries to the

party in excess of two hundred fifty thousand dollars, including any amount for future damages to be paid by the health care provider or hospital in excess of the limits of the fund, to be paid in periodic payments, subject to the limitations contained in this section. The court shall make a specific finding as to the dollar amount of regular payments which will be required to compensate the party periodically for loss of future income and future noneconomic harm, based upon the life expectancy of the party and the damages awarded. The periodic payments shall reflect interest in accordance with annuity principles. The judgment shall specify the recipient of the periodic payments, the dollar amount of each payment, the interval between payments, and the number of payments required to be made. The judgment shall specify the amount of and the purposes for which the balance of the judgment awarded for the future care and treatment of the party may be used.

3. Attorney fees of the party receiving an award, if payable out of the judgment, shall be applied pro rata against amounts awarded for past injuries and for future injuries. The amount determined by the court to be payable out of damages for future injuries shall be deducted by the court from the amount to be ordered paid as provided in this subsection, and shall be deducted pro rata from those amounts awarded, if any, for loss of future income, future expenses for care and treatment, and future noneconomic harm. The amount of attorney fees attributable to the award for future injuries shall be payable upon entry of judgment.

4. If a judgment has been entered ordering periodic payments pursuant to this section, the health care provider's or hospital's insurer shall pay to the fund the amount for which the insurer is liable under this chapter, after apportionment of costs of defense, for distribution by the fund to the party receiving the award.

5. If a judgment has been entered ordering periodic payments pursuant to this section, the fund shall make the payments as ordered or, alternatively, the fund may purchase

an annuity from an insurance company admitted to do business in this state sufficient to make the periodic payments.

Sec. 25. NEW SECTION. 147B.24 MEDIATION SYSTEM.

The commissioner shall establish a mediation system which consists of mediation panels to assist in the resolution of disputes, regarding medical malpractice between an injured party and a health care provider or hospital.

Sec. 26. NEW SECTION. 147B.25 REQUEST FOR MEDIATION.

1. An injured party who may have a cause of action against a health care provider or hospital as a result of an injury alleged to have occurred as a result of medical malpractice may file a request for mediation. However, if the injured party has filed a court action claiming a cause of action against a health care provider or hospital as a result of an injury alleged to have occurred as a result of medical malpractice, the injured party shall file a request for mediation within fifteen days after the date of filing.

2. A request for mediation must be in writing and must include all of the following:

- a. The name and address of all injured parties.
- b. The name and address of the injured patient, if not included in paragraph "a".
- c. The name and address of all health care providers and hospitals alleged to have committed medical malpractice resulting in the injury.
- d. The condition or disease for which the health care provider or hospital was treating the injured party when the alleged medical malpractice occurred.
- e. A brief description of the injury alleged to have been caused by the health care provider or hospital.

3. a. A request for mediation shall be delivered to the commissioner in person or by certified mail. The injured party requesting mediation and all health care providers and hospitals named in the request for mediation shall participate in the mediation.

b. An injured party shall pay a filing fee of twenty dollars at the time the request is filed with the

commissioner, to be deposited in the patient catastrophic injury fund created pursuant to section 147B.6.

4. If a court action has not been commenced at the time the request for mediation is filed with the commissioner, any applicable statute of limitations is tolled on the date the commissioner receives the request for mediation if delivered in person or on the date of mailing if sent by certified mail and remains tolled until thirty days after the last day of the mediation period. A court action shall not be commenced unless a request for mediation has been filed and the mediation period has expired. An injured party who has filed a request for mediation and commences a court action after the expiration of the mediation period shall notify the commissioner that a court action has been filed.

5. If a court action has been commenced prior to the time the request for mediation is filed with the commissioner, any applicable statute of limitations is tolled during the mediation period.

Sec. 27. NEW SECTION. 147B.26 NOTICE TO HEALTH CARE PROVIDERS AND HOSPITALS.

The commissioner shall serve notice upon all health care providers and hospitals named in the request for mediation by certified mail within seven days after the commissioner receives the request if delivered in person or within ten days after the date of mailing of the request to the commissioner if sent by certified mail.

Sec. 28. NEW SECTION. 147B.27 MEDIATION PANELS.

1. The commissioner shall appoint the members of a mediation panel and send notice to the claimant and all respondents by certified mail. The notice shall inform the claimant and all respondents of the names of the members appointed to the mediation panel and the date, time, and place of the first mediation session. The commissioner may change the date, time, or place of the mediation session as necessary to accommodate the parties, but the session shall be held before the expiration of the mediation period.

2. A mediation panel shall consist of the following members appointed by the commissioner:

a. One public member who is neither an attorney nor a health care provider and who is selected from a list of ten public member mediators appointed by the commissioner every two years. A member on the list may be reappointed to the list.

b. One attorney who is licensed to practice law in this state.

c. One health care provider as follows:

(1) Except as provided in subparagraphs (4) and (5), if all respondents named in the request for mediation are health care providers licensed under chapter 148 or 150A, a health care provider who is licensed to practice in this state and who is selected from a list prepared by the board of medical examiners.

(2) Except as provided in subparagraphs (4) and (5), if none of the respondents named in the request for mediation is a health care provider licensed under chapter 148 or 150A, a health care provider who is licensed to practice in this state in the same health care field as the respondent and who is selected from a list prepared by the examining board that regulates health care providers in that health care field.

(3) Except as provided in subparagraphs (4) and (5), if more than one respondent is named in the request for mediation at least one of whom is a health care provider and one of whom is a hospital, a health care provider who is licensed to practice in this state and who is selected from a list under subparagraph (1) or (2), as determined by the commissioner.

(4) If the commissioner determines that a list under subparagraph (1) or (2) is inadequate to permit the selection of an appropriate health care provider, a health care provider who is licensed to practice in this state and who is selected from an additional list prepared by the commissioner.

(5) If the commissioner determines that the lists under subparagraph (1) or (2) and subparagraph (4) are inadequate to permit the selection of an appropriate health care provider

for a particular dispute, a health care provider who is licensed to practice in this state and is selected by the commissioner.

3. If a person appointed to a panel resigns from or is unable to serve on the mediation panel, the commissioner shall appoint a replacement selected pursuant to subsection 2.

4. A person shall not serve on a mediation panel if the person has a professional or personal interest in the dispute.

5. Each member of the mediation panel is entitled to one hundred fifty dollars per diem plus actual and necessary expenses for each day of mediation conducted. The amounts provided for under this subsection shall be paid from the patient catastrophic injury fund created pursuant to section 147B.6.

6. A person serving as a mediator is immune from civil liability for any good faith act or omission within the scope of the mediator's powers and duties under this chapter.

Sec. 29. NEW SECTION. 147B.28 MEDIATION PERIOD.

The period for mediation shall expire ninety days after the commissioner receives a request for mediation if delivered in person or within ninety-three days after the date of mailing the request to the commissioner by certified mail, or within a longer period agreed to by the claimant and all respondents and specified by them in writing.

Sec. 30. NEW SECTION. 147B.29 PROCEDURE.

The mediation shall be conducted without record or transcript and all parties shall be in attendance unless excused by the panel. Discovery is not allowed, and no witnesses may be subpoenaed and no oaths may be administered during the mediation period. However, the mediation panel or any member of the panel may consult with any expert, and upon authorization of the commissioner, the expert may be compensated out of the patient catastrophic injury fund created pursuant to section 147B.6.

All patient health care records in the possession of a mediation panel shall be kept confidential by all members of the mediation panel and all other persons participating in the

mediation. Any finding, statement, or opinion made in the course of mediation is not admissible in any court action.

Any person participating in mediation may be represented by counsel authorized to act for the person.

Sec. 31. NEW SECTION. 147B.30 MEDIATION SYSTEM EXPENSES AND REPORT.

The administrative expenses of the mediation system established in this chapter shall be paid out of the patient catastrophic injury fund created pursuant to section 147B.6.

The commissioner shall submit a report on the operation of the mediation system and on the status of the mediation system expenses on or before March 1 of each year to the majority leader and minority leader of the senate, and the speaker, majority leader, and minority leader of the house of representatives.

Sec. 32. Section 258A.4, subsection 1, paragraph i, unnumbered paragraph 2, Code 1987, is amended to read as follows:

The commissioner of insurance shall by rule in consultation with the licensing boards enumerated in section 258A.1, the department of inspections and appeals, and the department of public health, require insurance carriers which insure professional and occupational licensees or hospitals licensed pursuant to chapter 135B for acts or omissions which constitute negligence, careless acts or omissions in the practice of a profession or occupation or patient care to file reports with the commissioner of insurance and to the legislative fiscal bureau within sixty days following final disposition of each malpractice claim settled or adjudicated. If the licensee or hospital is not insured by an insurance carrier admitted in this state, the licensee or hospital shall file the report. The reports shall include information ~~pertaining to incidents by a licensee which may affect the licensee as defined by rule involving an insured of the insurer~~ the following:

- (1) The nature of the claim and date of occurrence.
- (2) The alleged injury and the damages asserted.

(3) Attorney's fees and expenses incurred in connection with the claim or defense.

(4) The amount of any settlement or judgment.

(5) The name and address of the licensee or hospital. The commissioner of insurance shall forward reports pursuant to this section to the appropriate licensing board authority of the health care provider or hospital. Reports of a settlement shall at the request of any party to the settlement be confidential and not a public record.

Sec. 33. NEW SECTION. 258A.9A DUTIES OF CERTAIN MEDICAL LICENSEES.

1. As used in this section, unless the context otherwise requires, "licensee" means a person subject to the authority of a board specified in section 258A.1, subsection 1, paragraph "j", "l", or "m", or subject to chapter 135B.

2. A licensee shall make a report within seven days to the appropriate licensing authority of any act which the licensee knows or should reasonably know constitutes malpractice, unauthorized practice, or professional misconduct. Where a hospital is a licensee, the hospital administrator shall make a report within ten days of any such acts by a person licensed under chapter 148, 150A, 152, or 153, except where such acts also involve disciplinary actions against a health care provider by the hospital, reports shall be made under section 147.135, subsection 3. Failure to make the report is grounds for licensee discipline and a civil penalty of not less than five hundred dollars nor more than five thousand dollars. Fines collected pursuant to this section shall be transferred to the patient catastrophic injury fund created in section 147B.6 for use as authorized in chapter 147B.

3. A report received pursuant to this section is confidential and shall not be released by the licensing board except where an action against the health care provider or hospital has been commenced and the release is pursuant to a court order. In no case shall the identity of the licensee making the report under subsection 2 be disclosed. Upon receipt of a report pursuant to this section, the licensing

board shall investigate and take action as appropriate and within the authority provided in this chapter.

4. The duties in this section are in addition to any other duties of licensees and licensing boards contained elsewhere in this chapter.

Sec. 34. NEW SECTION. 515A.31 REGIONAL PRICING -- AUTHORIZATION TO COMMISSIONER -- PROCEDURE.

1. The commissioner of insurance shall conduct an examination of insurance rating practices relating to the use of nonstate specific experience in the setting of rates in this state, and shall take or recommend such action as necessary to maximize the impact which state experience has on the setting of rates in this state.

2. For purposes of such action, the commissioner may do all of the following:

a. Determine which lines of insurance necessary to the public welfare and safety are presently not price competitive.

b. Determine the lines of insurance which have sufficient state experience and permit the use of only state experience for ratemaking purposes.

c. Determine which lines of insurance presently lack sufficient state experience credibility and allow the use of regional experience to augment present state experience for ratemaking purposes.

d. Determine which lines of insurance presently lack sufficient state and regional credibility and allow the use of countrywide experience to augment present state and regional experience for ratemaking purposes.

e. Determine which states are excessively dissimilar to this state, and suggesting the prohibition of their inclusion in any countrywide experience used for ratemaking purposes in this state. For purposes of this paragraph, excessively dissimilar may be measured by evidence including, but not limited to, the following:

(1) The number of suits per one hundred thousand population in a covered line.

(2) The average size of judgments, awards, and settlements in a covered line.

(3) The significant differences in civil justice systems or procedures.

(4) The significant differences in insurance regulatory systems or procedures.

3. Prior to taking any action pursuant to this section, the commissioner shall publish notice of such action in the Iowa administrative bulletin not less than sixty days prior to the proposed action. Any affected insurer may request a hearing concerning the action prior to implementation.

Sec. 35. NEW SECTION. 519B.1 DEFINITIONS.

As used in this chapter, unless the context requires otherwise:

1. "Commissioner" means the commissioner of insurance.

2. "Fund" means the patient catastrophic injury fund established in section 147B.6.

3. "Hospital" means a hospital licensed pursuant to chapter 135B.

4. "Medical malpractice" means acts or omissions of a health care provider in the practice of the provider's profession or occupation, or acts or omissions of a hospital in patient treatment or care, including but not limited to negligence, failure to provide care, breach of contract relating to providing care, or claim based upon failure to obtain informed consent for an operation or treatment.

5. "Physician" means a physician and surgeon licensed pursuant to chapter 148; an osteopath licensed pursuant to chapter 150; an osteopathic physician and surgeon licensed pursuant to chapter 150A; or a dentist licensed pursuant to chapter 153.

Sec. 36. NEW SECTION. 519B.2 INSURANCE PREMIUM DISTRIBUTIONS.

1. The commissioner shall, on July 1 of each year, distribute from the fund to each eligible physician an amount equal to the amount by which the physician's premium payments for medical liability insurance for the preceding calendar

year exceeded fifteen percent of the physician's annual gross income derived from the physician's delivery of medical services for the preceding calendar year. The physician shall have the burden of establishing to the commissioner's satisfaction the gross income derived from the delivery of medical services in the preceding calendar year, the amount of premiums paid for medical liability insurance in the preceding calendar year, the medical specialty practiced by the physician during the previous calendar year, and the physician's eligibility to participate in the premium assistance plan.

2. The amount of premium payments considered under this section shall not be less than or exceed the premium amount necessary for the physician to obtain medical liability insurance coverage in an amount of five hundred thousand dollars per occurrence. If a physician applying for assistance is currently paying premiums for coverage in excess of five hundred thousand dollars per occurrence, the department shall determine the premium amount which would be paid if coverage were limited to five hundred thousand dollars per occurrence. If more than one policy is in effect during a calendar year for which application for assistance is made, the premium paid under each policy shall be prorated by the number of months the policy is in effect during that calendar year, and the amounts determined for each policy for that year shall constitute in total the premium paid for the calendar year.

If a single policy provides coverage for more than one physician, the commissioner shall determine the amount of premium to be attributed to the coverage for the applying physician.

3. An eligible physician entitled to a distribution under this section must file an application with the commissioner on or before May 1 of the year following the year for which assistance is sought. Failure to file an application by May 1 of any year constitutes a waiver of any distribution to which the physician might have been entitled for the preceding year. The commissioner shall provide the application form.

4. Prior to making a distribution to an eligible physician, the commissioner shall obtain an assignment of any right the physician may have to a dividend, refund, or reimbursement of premium under the terms of the physician's medical liability insurance contract or agreement. Amounts received by the commissioner as a result of the assignment shall be deposited in the fund. The commissioner's rights under an assignment shall not exceed the amount distributed to the physician under this section.

Sec. 37. NEW SECTION. 519B.3 PHYSICIAN ELIGIBILITY.

1. A physician is eligible to receive a distribution if the physician files an application for a distribution as provided in section 519B.2, and meets the following requirements:

a. The physician was engaged in the active practice of medicine in Iowa during the entire preceding calendar year.

b. The physician was insured with an insurance company admitted to this state under a policy of medical liability insurance during the entire preceding calendar year providing coverage in an amount of at least five hundred thousand dollars per occurrence.

c. The physician had staff privileges during the entire preceding calendar year at a hospital in this state, which had an emergency room and which required physicians with staff privileges to provide, when needed, medical care to unassigned patients entering the hospital through the emergency room. The physician has the burden of establishing to the commissioner's satisfaction that the physician was available to provide medical care to unassigned patients and that, when needed, did provide medical care to unassigned patients entering the hospital through the emergency room.

d. The physician has not incurred two or more claims for medical malpractice resulting in judgments, awards, or settlements exceeding one hundred twenty-five thousand dollars each in the preceding five years. Payment of a claim by an uninsured physician exceeding one hundred twenty-five thousand dollars shall be counted when determining the number of judgments, awards, or settlements under this paragraph.

e. The physician does not have an unsatisfied medical malpractice judgment which was entered within the preceding five years, or if one exists, the physician can show that at least two hundred fifty thousand dollars of the judgment has been satisfied.

2. The burden to establish eligibility under all criteria in this chapter by clear and convincing evidence is upon an applying physician.

3. The commissioner may waive the requirements provided in subsection 1, paragraph "a", "b", or "c", if the physician establishes that it was not possible for the physician to meet the requirement through no fault of the physician.

Sec. 38. STUDY OF MEDICAL SERVICES. The division of insurance, in conjunction with the department of public health, shall conduct a study to determine where the state is experiencing a shortage of needed medical services, which shall be based on the availability of physicians by geographic area and medical specialty. The division shall consider the following factors in conducting the study:

1. The supply and demand for medical services and facilities.
2. The health of the population in a geographic area, including mortality, morbidity, and births.
3. Any other relevant demographic information which indicates the need for medical services and facilities.

The results of the study shall be reported on or before January 15, 1989, to the governor, majority and minority leaders of the senate, and the speaker and majority and minority leaders of the house of representatives.

Sec. 39. An amount not to exceed one hundred thousand dollars shall be paid out of the patient catastrophic injury fund to the board of medical examiners established under chapter 147 for the purpose of enhancing the board's administration and enforcement of the provisions of law relating to those licensed to practice medicine and surgery, osteopathic medicine and surgery, and osteopathy.

Sec. 40. Sections 1 through 31 of this Act apply only to occurrences after January 1, 1989.

Sec. 41. Sections 35 through 37 of this Act take effect on January 1, 1990, with the initial distribution to be made to eligible physicians commencing June 30, 1990, for the 1989 calendar year.

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JO ANN ZIMMERMAN  
President of the Senate

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DONALD D. AVENSON  
Speaker of the House

I hereby certify that this bill originated in the Senate and is known as Senate File 484, Seventy-second General Assembly.

*John P. Dwyer*  
Approved May 13, 1988

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JOHN P. DWYER  
Secretary of the Senate

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TERRY E. BRANSTAD  
Governor