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Place On Calendar

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HOUSE FILE 803

BY COMMITTEE ON COMMERCE

Passed House, Date 5-22-75 (1909) Passed Senate, Date _____
Vote: Ayes 87 Nays 0 Vote: Ayes _____ Nays _____
Approved _____

A BILL FOR

1 An Act relating to the compensation of persons suffering loss
2 as a result of medical malpractice.

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

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1 Section 1. The general assembly finds that a critical
2 situation exists because of the high cost and impending
3 unavailability of medical malpractice insurance. The purposes
4 of sections two (2) through thirteen (13) of this Act are
5 to assure that the public is adequately protected against
6 losses arising out of medical malpractice by providing licensed
7 health care providers with medical malpractice insurance
8 through the requirement that certain liability insurance
9 carriers write medical malpractice insurance for a period
10 of two years upon a finding of an emergency by the commissioner
11 of insurance that either such insurance is not available
12 through normal channels or that it is not available on a
13 reasonable basis because of lack of competition for such
14 insurance, or otherwise; to establish an association to
15 equitably spread the risks for such insurance; and to provide
16 for recoupment of losses resulting from the operation of the
17 association through a stabilization reserve fund contributed
18 to be insured, a surcharge on future liability insurance
19 policies, or a favorable premium tax treatment.

20 It is the intent of this Act to provide only an interim
21 solution to the impending unavailability of medical mal-
22 practice insurance. It is not anticipated that this Act will
23 resolve the underlying causes of the unavailability and high
24 cost which extend beyond the insurance mechanism. It is
25 anticipated that future legislation will be required to deal
26 on a more permanent basis with the underlying causes of the
27 current situation.

28 Sec. 2. NEW SECTION. DEFINITIONS. As used in this Act,
29 unless the context otherwise requires:

30 1. "Association" means the joint underwriting association
31 established pursuant to sections two (2) through thirteen
32 (13) of this Act.

33 2. "Commissioner" means the commissioner of insurance
34 or a designee.

35 3. "Medical malpractice insurance" means insurance coverage

1 against the legal liability of the insured and against loss,
2 damage, or expense incident to a claim arising out of the
3 death or injury of any person as the result of negligence
4 or malpractice in rendering professional service by any
5 licensed physician, hospital, or other licensed health care
6 provider.

7 4. "Net direct premiums" means gross direct premiums
8 written on liability insurance as reported in the annual
9 statements filed by the insurers with the commissioner,
10 including the liability component of multiple peril package
11 policies as computed by the commissioner, less return premiums
12 for the unused or unabsorbed portions of premium deposits.

13 Sec. 3. NEW SECTION. TEMPORARY JOINT UNDERWRITING ASSO-
14 CIATION.

15 1. A temporary joint underwriting association is created,
16 consisting of all insurers authorized to write and engaged
17 in writing on a direct basis within this state liability
18 insurance, including insurers covering such peril in multiple
19 peril policies. Every such insurer shall be a member of the
20 association and shall remain a member as a condition of its
21 authority to continue to write such insurance in this state.

22 2. The purpose of the association shall be to provide,
23 for a period not exceeding two years, a market for medical
24 malpractice insurance on a self-supporting basis without
25 subsidy from its members.

26 3. The association shall not commence underwriting opera-
27 tions for health care providers until the commissioner, after
28 notice and opportunity for hearing, has determined that medi-
29 cal malpractice insurance is not available at a reasonable
30 cost for a specific type of licensed health care provider
31 in the voluntary market. Upon such determination the
32 association shall be authorized to issue policies of medical
33 malpractice insurance for such specific type of health care
34 provider but need not be the exclusive agency through which
35 such insurance may be written on a primary basis in this

1 state.

2 If the commissioner determines at any time that medical
3 malpractice insurance can be made available in the voluntary
4 market for any specific type of licensed health care provider,
5 the association shall thereby cease underwriting medical mal-
6 practice insurance for that type of licensed health care pro-
7 vider.

8 4. The association shall, subject to the terms and condi-
9 tions of sections two (2) through thirteen (13) of this Act,
10 have and exercise the following powers on behalf of its
11 members:

12 a. To issue, or to cause to be issued, policies of in-
13 surance to applicants, including incidental coverages and
14 subject to limits as specified in the plan of operation but
15 not to exceed one million dollars for each claimant under
16 one policy and three million dollars for all claimants under
17 one policy in any one year.

18 b. To underwrite such insurance and to adjust and pay
19 losses with respect thereto, or to appoint service companies
20 to perform those functions.

21 c. To assume reinsurance from its members.

22 d. To cede reinsurance.

23 Sec. 4. NEW SECTION. PLAN OF OPERATION.

24 1. The association shall submit a plan of operation to
25 the commissioner, together with any amendments necessary or
26 suitable to assure the fair, reasonable, and equitable
27 administration of the association consistent with sections
28 two (2) through thirteen (13) of this Act. The plan of
29 operation and any amendments thereto shall become effective
30 upon approval in writing by the commissioner.

31 If the association fails to submit a suitable plan of
32 operation within twenty-five days following the effective
33 date of this Act or if at any time thereafter the association
34 fails to submit suitable amendments to the plan, the
35 commissioner shall, after notice and opportunity for hearing,

1 adopt rules necessary to effectuate sections two (2) through
2 thirteen (13) of this Act. Such rules shall continue in force
3 until modified by the commissioner or superseded by a plan
4 submitted by the association and approved by the commissioner.

5 2. The plan of operation shall provide for economic, fair
6 and nondiscriminatory administration, and for the prompt and
7 efficient provision of medical malpractice insurance. The
8 plan shall contain other provisions including, but not limited
9 to, preliminary assessment of all members for initial expenses
10 necessary to commence operations, establishment of necessary
11 facilities, management of the association, assessment of members
12 to defray losses and expenses, commission arrangements,
13 reasonable and objective underwriting standards, acceptance
14 and cession of reinsurance, appointment of servicing carriers
15 or other servicing arrangements and procedures for determining
16 amounts of insurance to be provided by the association.

17 3. All member insurers shall comply with the plan of
18 operation.

19 Sec. 5. NEW SECTION. POLICY FORMS AND RATES.

20 1. The rates, rating plans, rating classifications, and
21 policy forms and endorsements applicable to insurance writ-
22 ten by the association and the statistical and experience
23 data relating thereto shall be subject to sections two (2)
24 through thirteen (13) of this Act and to the provisions of
25 the general insurance code which are not inconsistent with
26 the purposes and provisions of this Act.

27 2. All policies issued by the association shall provide
28 for a continuous period of coverage beginning with their
29 respective effective dates and terminating automatically at
30 12:01 a.m. on July 1, 1977, unless sooner terminated in ac-
31 cordance with sections two (2) through thirteen (13) of this
32 Act. All policies shall be issued subject to the group
33 retrospective rating plan and the stabilization reserve fund
34 authorized by this Act. No policy form shall be used by the
35 association unless it has been filed with and approved by

1 the commissioner.

2 3. The commissioner shall specify whether policy forms
3 and the rate structure shall be on a "claims-made" or "oc-
4 currence" basis and coverage shall be provided by the asso-
5 ciation only on the basis specified by the commissioner.
6 The commissioner shall specify the "claims-made" basis only
7 if the contract makes provision for residual "occurrence"
8 coverage upon the retirement, death, disability or removal
9 from this state of the insured. Provision may be made for
10 a premium charge allocable to any such residual "occurrence"
11 coverage and such premium charges for such residual coverage
12 shall be segregated and separately maintained for such pur-
13 pose which may include the reinsurance of all or a part of
14 that portion of the risk.

15 4. The rates, rating plans, rating rules, and rating
16 classifications applicable to the insurance written by the
17 association shall be on an actuarially sound basis, giving
18 due consideration to the group retrospective rating plan and
19 the stabilization reserve fund, and shall be calculated to
20 be self-supporting.

21 5. All policies issued by the association shall be sub-
22 ject to a nonprofit group retrospective rating plan to be
23 approved by the commissioner under which the final premium
24 for all policyholders of the association, as a group, will
25 be equal to the administrative expenses, loss and loss ad-
26 justment expenses and taxes, plus a reasonable allowance for
27 contingencies and servicing. Policyholders shall be given
28 full credit for all investment income, net of expenses and
29 a reasonable management fee, on policyholder supplied funds.
30 The standard premium, before retrospective adjustment, for
31 each policy issued by the association shall be established
32 for portions of the policy period coinciding with the associa-
33 tion's fiscal year on the basis of the association's rates,
34 rating plans, rating rules, and rating classifications then
35 in effect. The maximum final premium for all policyholders

1 of the association, as a group, shall be limited as provided
2 in subsection five (5) of section six (6) of this Act. Since
3 the business of the association is subject to the nonprofit
4 group retrospective rating plan required by this subsection,
5 there shall be a presumption that the rates filed and premiums
6 imposed by the association are not unreasonable or excessive.

7 6. The association shall certify to the commissioner the
8 estimated amount of any deficit remaining after the stabiliza-
9 tion reserve fund has been exhausted in payment of the maxi-
10 mum final premium for all policyholders of the association.
11 Within sixty days after that certification the commissioner
12 shall authorize the members of the association to commence
13 recoupment of their respective shares of the deficit by one
14 of the following procedures:

15 a. Applying a surcharge to be determined by the associa-
16 tion at a rate not to exceed two percent of the annual pre-
17 miums on future policies affording those kinds of insurance
18 which form the basis for their participation in the associa-
19 tion.

20 b. Deducting their share of the deficit from past or
21 future premium taxes due the state of Iowa.
22 If the commissioner fails within sixty days to authorize one
23 of the above procedures, each member of the association may
24 commence recoupment of its deficit by the premium tax offset
25 described above. The association shall amend the amount of
26 its certification of deficit to the commissioner as the values
27 of its incurred losses become finalized and the members of
28 the association shall amend their recoupment procedure
29 accordingly.

30 7. In the event that sufficient funds are not available
31 for the sound financial operation of the association, all
32 members shall contribute to the financial requirements of
33 the association in the manner provided for in section eight
34 (8) of this Act. Any contribution shall be reimbursed to
35 the members by recoupment as provided in subsection six (6)

1 of this section.

2 Sec. 6. NEW SECTION. STABILIZATION RESERVE FUND.

3 1. There is created a stabilization reserve fund. The
4 fund shall be administered by three directors, one of whom
5 shall be the commissioner. The remaining two directors shall
6 be appointed by the commissioner: One shall be a representa-
7 tive of the association and the other a representative of
8 its policyholders.

9 2. The directors shall act by majority vote with two
10 directors constituting a quorum for the transaction of any
11 business or the exercise of any power of the fund. The
12 directors shall serve without salary, but each director other
13 than the commissioner shall be reimbursed for actual and
14 necessary expenses incurred in the performance of official
15 duties as a director. The directors shall not be subject
16 to any personal liability with respect to the administration
17 of the fund for acts or decisions made in good faith pursuant
18 to the provisions of this Act.

19 3. Each policyholder shall pay to the association a
20 stabilization reserve fund charge determined by the directors
21 which shall not exceed the amount of one annual premium due
22 for insurance through the association. Such charge shall
23 be separately stated in the policy. The association shall
24 cancel the policy of any policyholder who fails to pay the
25 stabilization reserve fund charge.

26 4. The association shall promptly pay to the fund all
27 stabilization reserve fund charges which it collects from
28 its policyholders and any retrospective premium refunds payable
29 under any group retrospective rating plan approved by the
30 commissioner under the provisions of this Act.

31 5. All monies received by the fund shall be held in trust
32 by a corporate trustee selected by the directors. The
33 corporate trustee may invest the monies held in trust, subject
34 to the approval of the directors. All investment income shall
35 be credited to the fund, and all expenses of administration

1 of the fund shall be charged against the fund. The monies
2 held in trust shall be used solely for the purpose of
3 discharging when due any retrospective premium charges payable
4 by policyholders of the association under the group
5 retrospective rating plan approved by the commissioner.
6 Payment of retrospective premium charges shall be made by
7 the directors upon certification to them by the association
8 of the amount due. If all monies accruing to the fund are
9 finally exhausted in payment of retrospective premium charges,
10 all liability and obligations of the association's
11 policyholders with respect to the payment of retrospective
12 premium charges shall thereupon terminate and shall be
13 conclusively presumed to have been discharged. Any monies
14 remaining in the fund after all such retrospective premium
15 charges have been paid shall be returned to policyholders
16 pursuant to procedures authorized by the directors.

17 Sec. 7. NEW SECTION. PROCEDURES.

18 1. Upon a finding by the commissioner, after notice and
19 opportunity for hearing, that medical malpractice insurance
20 is not available at a reasonable cost for a specific type
21 of licensed health care provider in the voluntary market and
22 upon notification of that finding to the association, any
23 licensed health care provider of the type specified in the
24 commissioner's finding shall be entitled to apply to the
25 association for medical malpractice insurance coverage. The
26 application may be made on behalf of a licensed health care
27 provider by an authorized agent.

28 2. If the association determines that the applicant meets
29 the underwriting standards of the association as prescribed
30 in the plan of operation, then the association, upon receipt
31 of the premium or such portion thereof as is prescribed in
32 the plan of operation, shall cause to be issued a policy of
33 medical malpractice insurance.

34 Sec. 8. NEW SECTION. PARTICIPATION. All members of the
35 association shall participate in its writings, expenses,

1 servicing allowance, management fees and losses in the pro-
2 portion that the net direct premiums of each member, exclud-
3 ing that portion of premiums attributable to the operation
4 of the association, written during the preceding calendar
5 year bears to the aggregate net direct premiums written in
6 this state by all members of the association. Each member's
7 proportion shall be determined annually on the basis of the
8 annual statements and other reports filed by the insurer with
9 the commissioner.

10 Sec. 9. NEW SECTION. GOVERNING BOARD.

11 1. The association shall be governed by a board of eleven
12 directors of whom three shall be appointed annually by the
13 commissioner to represent the licensed health care providers.
14 Eight members shall be elected annually, except as provided
15 in subsection two (2) of this section, by the members of the
16 association. Vacancies on the board shall be filled for the
17 remaining period of the term by majority vote of the remaining
18 directors subject to approval of the commissioner.

19 2. Within fifteen days after the effective date of this
20 Act the commissioner shall designate a time and place for
21 a meeting of the members of the association at which the eight
22 elected members serving on the first board shall be elected.
23 The commissioner shall appoint the appointive members of the
24 board on or before the date of such meeting.

25 The commissioner may, prior to the first meeting of the
26 members of the association, appoint an interim governing board
27 of the association consisting of eight member insurers and
28 three representatives of the licensed health care providers.
29 The eight member insurers of that interim governing board
30 shall serve until their successors are elected by the members
31 of the association. In appointing members of the association
32 to the interim governing board, the commissioner shall con-
33 sider among other things whether all member insurers are
34 fairly represented.

35 Sec. 10. NEW SECTION. APPEALS AND JUDICIAL REVIEW.

1 1. Any applicant or any person insured pursuant to section
2 seven (7) of this Act, or a legal representative, or any
3 affected insurer, may appeal to the commissioner within thirty
4 days after any ruling, action or decision by or on behalf
5 of the association, with respect to those items the plan of
6 operation defines as appealable matters.

7 2. All orders of the commissioner made pursuant to sections
8 two (2) through thirteen (13) of this Act shall be subject
9 to judicial review as provided in the Iowa administrative
10 procedure Act.

11 Sec. 11. NEW SECTION. ANNUAL STATEMENTS. The association
12 shall file in the office of the commissioner on or before
13 the first day of March each year, a statement as prescribed
14 by the commissioner. The statement shall contain matters
15 and information required by the commissioner including, but
16 not limited to, information with respect to its transactions,
17 condition, operations and affairs during the preceding year,
18 and shall be in a form approved by the commissioner. The
19 commissioner may, at any time, require the association to
20 furnish additional information with respect to matters
21 considered to be material to the scope, operation and
22 experience of the association.

23 Sec. 12. NEW SECTION. EXAMINATIONS. The commissioner
24 shall make an examination of the association at least annually.
25 The expenses of each examination shall be paid by the
26 association.

27 Sec. 13. NEW SECTION. PRIVILEGED COMMUNICATIONS. There
28 shall be no liability on the part of, and no cause of action
29 of any nature shall arise against the association, the commis-
30 sioner, or any other person or organization, for any statements
31 made in good faith by any of them in any report or communica-
32 tion concerning risks insured or to be insured by the associa-
33 tion, or during any proceedings within the scope of sections
34 two (2) through thirteen (13) of this Act.

35 Sec. 14. Section one hundred forty-seven point one (147.1),

1 Code 1975, is amended by adding the following new subsections:

2 NEW SUBSECTION. "Peer review" means evaluation of pro-
3 fessional services rendered by a person licensed to practice
4 a profession.

5 NEW SUBSECTION. "Peer review committee" means one or more
6 persons acting in a peer review capacity who also serve as
7 an officer, director, trustee, agent, or member of any of
8 the following:

9 a. A state or local professional society of a profession
10 for which there is peer review.

11 b. Any organization approved to conduct peer review by
12 a society as designated in paragraph a of this subsection.

13 c. The medical staff of any licensed hospital.

14 d. An examining board.

15 Sec. 15. Chapter one hundred forty-seven (147), Code 1975,
16 is amended by adding the following new section:

17 NEW SECTION. A person shall not be civilly liable as a
18 result of acts, omissions, or decisions made in connection
19 with the person's service on a peer review committee. However,
20 such immunity from civil liability shall not apply if an act,
21 omission, or decision is made with malice.

22 Sec. 16. Chapter one hundred forty-seven (147), Code 1975,
23 is amended by adding the following new section:

24 NEW SECTION. In an action for damages for personal injury
25 against a physician and surgeon, osteopath, osteopathic
26 physician and surgeon, dentist, podiatrist, optometrist,
27 chiropractor, or nurse licensed to practice that profession
28 in this state, or against a hospital licensed for operation
29 in this state, based on the alleged negligence of the
30 practitioner in the practice of the profession or occupation,
31 or upon the alleged negligence of the hospital in patient
32 care, in which liability is admitted or established, the
33 damages awarded shall not include actual economic losses
34 incurred or to be incurred in the future by the claimant by
35 reason of the personal injury, including but not limited to,

1 the cost of reasonable and necessary medical care,
2 rehabilitation services, and custodial care, and the loss
3 of services and loss of earned income, to the extent that
4 those losses are replaced or are indemnified by insurance,
5 or by governmental, employment, or service benefit programs
6 or from any other source except the assets of the claimant
7 or of the members of the claimant's immediate family.

8 Sec. 17. Chapter six hundred ten (610), Code 1975, is
9 amended by adding the following new section:

10 NEW SECTION. In any action for personal injury or wrongful
11 death against any physician and surgeon, osteopath, osteopathic
12 physician and surgeon, dentist, podiatrist, optometrist,
13 chiropractor, or nurse licensed to practice that profession
14 in this state, or a hospital licensed for operation in this
15 state, based upon the alleged negligence of the licensee in
16 the practice of that profession or occupation, or upon the
17 alleged negligence of the hospital in patient care, ~~by~~
18 contingent fee contract or arrangement between the plaintiff
19 and the plaintiff's attorney shall be disclosed to the court
20 and shall be subject to approval by the court. The court
21 shall approve a contingent fee contract only to the extent
22 the court finds it to be reasonable. No court shall find
23 a contingent fee contract or arrangement reasonable if it
24 provides for payment to an attorney of more than the sum of
25 the following:

26 a. For the first one thousand dollars recovered, fifty
27 percent;

28 b. For the next two thousand dollars recovered, forty
29 percent;

30 c. For the next forty-seven thousand dollars recovered,
31 thirty-three and one-third percent;

32 d. For the next fifty thousand dollars recovered, twenty
33 percent;

34 e. For all amounts recovered over one hundred thousand
35 dollars, ten percent;

1 In the event of appeal, the appellate court may find an
2 additional amount reasonable which is appropriate to the
3 services rendered by the attorney for the plaintiff on appeal.

4 Sec. 18. Chapter six hundred nineteen (619), Code 1975,
5 is amended by adding the following new section:

6 NEW SECTION. In an action for personal injury or wrongful
7 death against a physician and surgeon, osteopath, osteopathic
8 physician and surgeon, dentist, podiatrist, optometrist,
9 chiropractor, or nurse licensed to practice that profession
10 in this state, or against a hospital licensed for operation
11 in this state, based upon the alleged negligence of the
12 practitioner in the practice of the profession or occupation,
13 or upon the alleged negligence of the hospital in patient
14 care, the amount of money damages demanded shall not be stated
15 in the petition, or original notice, or in any counterclaim
16 or cross petition.

17 Sec. 19. NEW SECTION. MEDICAL MALPRACTICE PANELS. There
18 is established in each judicial district a medical malpractice
19 panel. The times and places for the meetings of each panel
20 and the rules governing its operation shall be established
21 by the supreme court pursuant to section six hundred eighty-
22 four point nineteen (684.19) of the Code. Each panel may
23 take jurisdiction of, review, and make findings as provided
24 in sections nineteen (19) through twenty-three (23) of this
25 Act in all medical malpractice actions pending before the
26 court in that district.

27 Sec. 20. NEW SECTION. HEARINGS TO BE SCHEDULED.

28 1. A calendar of all medical malpractice actions pending
29 on January 1, 1976, except actions which have had extensive
30 pretrial hearings, and all medical malpractice actions
31 thereafter filed, shall be prepared for each judicial dis-
32 trict, and a hearing date established for each case.

33 2. Not less than thirty days prior to the date set for
34 hearing the parties shall submit to the clerk of the dis-
35 trict court all written materials, including pleadings, bills

1 of particulars, medical and hospital reports.

2 3. The clerk of court shall prepare copies of all written
3 materials in triplicate, and shall make them available to
4 panel members in advance of the hearing date.

5 Sec. 21. NEW SECTION. HEARINGS AND FINDINGS.

6 1. Parties to a case shall be given two weeks' notice
7 of the date for hearing. Application for continuance may
8 be made by any party to the judge designated to preside at
9 the hearing, but continuances may be granted only in the case
10 of extraordinary need and for a period not to exceed two
11 weeks.

12 2. All parties may be represented at the hearing by trial
13 counsel authorized to act for their respective clients or
14 in person if counsel is not retained.

15 3. The hearing shall be informal and without a steno-
16 graphic record. The judge presiding at the hearing shall
17 not preside at the trial or hear any application in the case
18 not connected with the hearing itself. No other panel member
19 shall participate in the trial of that action as a witness,
20 or otherwise.

21 4. Each party to the action may submit written briefs
22 to the panel and may present oral argument, pursuant to rules
23 of procedure established by the supreme court. Testimony
24 shall not be presented other than in the form of depositions
25 and interrogatories.

26 5. Following the hearing, the panel members shall confer
27 for the purpose of making findings. The panel shall find
28 either that there is probable cause to believe that liability
29 for professional malpractice exists on the part of one or
30 more named defendants, or that there is no probable cause
31 to believe that liability for professional malpractice exists
32 on the part of one or more named defendants. A finding shall
33 be made for each defendant, based upon the affirmative vote
34 of two of the three panel members.

35 6. The supreme court shall prescribe the form and content

1 of written findings and conclusions which shall be prepared
2 in verified form by the panel, and which shall be admissible
3 as evidence at the trial of the action pursuant to rules
4 adopted by the supreme court. A panel member shall in no
5 case be called to testify as a witness. The findings and
6 conclusions may be rebutted or impeached only to the extent
7 provided by rules of the supreme court applicable only to
8 the findings and conclusions of the panel.

9 Sec. 22. NEW SECTION. MEMBERSHIP OF PANELS.

10 1. All hearings held pursuant to section twenty-one (21)
11 of this Act shall be before a panel of three persons consist-
12 ing of a district judge of the judicial district, and two
13 physicians, both to be designated in accordance with this
14 section.

15 2. A list of physicians regularly licensed to practice
16 medicine in the state shall be prepared by the district court
17 for each judicial district with the assistance of the various
18 medical associations of the state and any county medical
19 associations within the district. Each list shall be divided
20 into lists of physicians according to the particular specialty
21 of each. These lists shall be maintained in the office of
22 the clerk of the district court. The court shall assign to
23 the first action to be heard the doctor whose name appears
24 at the head of the list of the specialty most closely related
25 to that of one or more defendants, and the doctor whose name
26 appears at the head of a list of a specialty not closely
27 related to that of any defendant. After assignment, those
28 names shall be placed at the foot of the list. Assignment
29 to succeeding actions shall be made in the same manner.

30 3. In the event that a doctor selected to be on the panel
31 for a particular action is unable to serve on the particular
32 case or day, the next doctor appearing on the list shall be
33 substituted.

34 4. The supreme court shall adopt rules to provide that
35 state medical associations, county medical associations, or

1 representatives of each specialty of medical practice shall
2 review material submitted for each action and shall designate
3 the medical specialty involved and notify the court as to
4 that designation.

5 Sec. 23. NEW SECTION. NON-LIABILITY OF PANEL MEMBERS.

6 A person shall not be civilly liable for acts, omissions,
7 statements or decisions made in connection with the person's
8 service on the panel established pursuant to section eighteen
9 (18) of this Act. However, the immunity created by this
10 section shall not apply to any act, omission, statement or
11 decision made with malice.

12 Sec. 24. This Act, being deemed of immediate importance,
13 shall take effect and be in force from and after its publica-
14 tion in Iowa City Press-Citizen, a newspaper published in
15 Iowa City, Iowa, and in Marshalltown Times-
16 newspaper published in Marshalltown, Iowa. Republican

17 EXPLANATION

18 The first part of this bill, consisting of sections 2
19 through 13, requires that all insurers writing liability
20 insurance in this state be members of and participate in a
21 joint underwriting association for a period of two years.
22 The purpose of the association is to provide a market for
23 medical malpractice insurance to insure, on a self-support-
24 ing basis, specific types of licensed health care providers
25 where the commissioner of insurance finds after notice and
26 opportunity for hearing that such coverage is not available
27 in the voluntary market.

28 The association is governed by a board of directors repre-
29 senting member insurers and licensed health care providers.
30 The insurers serving on the governing board are elected by
31 the members of the association, and the members representing
32 the licensed health care providers are appointed by the com-
33 missioner of insurance.

34 The first part of the bill requires the association to
35 submit to the commissioner a plan of operation providing for

1 preliminary assessment of its members, management of the
2 association, reasonable underwriting standards, rating
3 procedures, and other matters. The plan of operation is
4 subject to the approval of the commissioner.

5 Policyholders are required to contribute to a stabiliza-
6 tion reserve fund created by this bill an amount not to ex-
7 ceed one annual premium payment due for insurance through
8 the association. All monies paid into the fund will be held
9 in trust, with all investment income credited to the policy-
10 holders, to be used for the payment of losses and expenses
11 of the association which are not covered by the standard
12 annual premiums for insurance through the association. Any
13 monies remaining in the fund after all obligations have been
14 satisfied shall be repaid to the policyholders.

15 If the obligations of the association, including loss and
16 loss adjustment expense, are not fully reimbursed by the
17 premiums collected from policyholders and the assets of the
18 stabilization reserve fund, the members of the association
19 may recoup their losses either by a premium surcharge not
20 to exceed two percent of the annual premiums on future policies
21 of liability insurance, or by a deduction of a member's pro
22 rata share of the loss from premium taxes due the state of
23 Iowa, subject to the approval of the insurance commissioner.

24 Section one of the bill states the intent in creating the
25 joint underwriting association is to provide only an interim
26 solution to the impending unavailability of medical malpractice
27 insurance. Future legislation will be required to deal on
28 a more permanent basis with the underlying causes of
29 unavailability and high cost which extend beyond the insurance
30 mechanism.

31 Sections 14 and 15 of the bill relate to slander and other
32 civil remedies, and provide that any person who participates
33 in peer review committees or other professional evaluation
34 panels relating to licensed health care providers shall be
35 immune from liability for statements made in the context of

1 those proceedings unless malice is shown.

2 The remainder of the bill relates to practices and pro-
3 cedures in actions based upon medical malpractice.

4 Section 16 provides that a person may not recover as damages
5 any amounts which have been paid through the person's own
6 medical insurance, or through other sources of whatever kind.
7 This relates to the so-called "collateral source rule" which
8 in some instances permits losses to be compensated more than
9 once.

10 Section 17 provides for limitations on the amount that
11 a plaintiff can agree to pay legal counsel out of the amounts
12 awarded by the trial jury or court. The section provides
13 a sliding scale or percentage which in effect adjusts the
14 rate at which a plaintiff's attorney can charge a contingency
15 fee, depending upon the amount of the award.

16 Section 18 provides that a person may not include in a
17 pleading the dollar amounts claimed against a defendant in
18 an action based upon medical malpractice.

19 Sections 19 through 23 of the bill create a new procedure
20 which will apply to all medical malpractice actions. These
21 sections establish in the district court, under rules promul-
22 gated by the supreme court, a medical malpractice panel com-
23 posed of a district judge and two physicians who review every
24 malpractice case filed, and who make findings and conclusions
25 which are admissible into evidence at the trial of the action.
26 The function of the panel is to determine whether or not there
27 is probable cause to believe that liability for medical
28 malpractice exists on behalf of each of the defendants in
29 the action.

30 All documents, pleadings, medical histories and other
31 relevant written documents, and written briefs shall be sub-
32 mitted to the panel, and oral arguments within the limits
33 prescribed by the supreme court, shall be examined or heard
34 by the panel, and a written list of findings and conclusions
35 shall be returned to the court as evidence to be used at the

1 trial.

2 The supreme court shall adopt rules for the use of the
3 written evidence, and shall determine to what extent the
4 evidence may be rebutted or impeached.

5 None of the members of the panel may be called as a wit-
6 ness at the trial. The medical members of the panel are
7 obtained in serial order from lists provided the court by
8 the medical associations. Each panel is required to contain
9 one member of a specialty which is most closely related to
10 that of one or more of the defendants, and a member of a
11 specialty which is not closely related to the specialty of
12 any defendant.

13 The panel members are given immunity from liability for
14 any acts or omissions taken in the context of the hearing
15 panel, except where there is a showing of malice.

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H-3924

1 Amend the Small amendment, H-3907, to House File
 2 803, at page 1, by inserting after line 2 the
 3 following:
 4 "Sec. . Section five hundred nineteen point
 5 one (519.1), Code 1975, is amended to read as follows:
 6 519.1 AUTHORIZATION. Any number of physicians,
 7 druggists, dentists, and graduate nurses, licensed
 8 to practice their profession in this state, and
 9 hospitals licensed under chapter one hundred thirty-
 10 five B (135B) of the Code, may, by complying with
 11 the provisions of this chapter and without regard
 12 to other statutory provisions, enter into contracts
 13 with each other for the purpose of protecting
 14 themselves by insurance against loss by reason of
 15 actions at law on account of their alleged error,
 16 mistake, negligence, or carelessness in the treatment
 17 and care of patients, including the performance of
 18 surgical operations, or in the prescribing and
 19 dispensing of drugs and medicines, or for loss by
 20 reason of damages in other respects, and to reimburse
 21 any member in case of such loss.
 22 Sec. . Section five hundred nineteen point two
 23 (519.2), Code 1975, is amended to read as follows:
 24 519.2 INCORPORATION--POWERS. All corporations,
 25 organized for the purpose of transacting such insurance
 26 business under the provisions of this chapter, shall
 27 incorporate under the provisions of chapter 491, and
 28 be known as mutual corporations; and are hereby
 29 empowered to collect such assessments, or premium
 30 payments, provided for in their articles of
 31 incorporation or bylaws, as are required to pay losses
 32 and expenses incurred in the conduct of their business
 33 and to cede reinsurance. Such mutual insurance
 34 corporations may issue certificates of membership,
 35 or policies; and may provide that all assessments,
 36 or premium payments, payable thereunder, be made in
 37 cash, or on the installment, or assessment plan."

H-3924 FILED, ADOPTED (1885)
 MAY 21, 1975

BY SMALL of Johnson

H-3925

1 Amend the Monroe amendment H-3795, to page 3
 2 of House File 803, as follows:
 3 Page 1, line 30, by striking the letter "h"
 4 and inserting in lieu thereof the letter "b".

H-3925 FILED, ADOPTED BY
 UNANIMOUS CONSENT (1880)
 MAY 21, 1975

BY MONROE of Des Moines

- 1 retrospective premium charges shall thereupon terminate
2 and shall be conclusively presumed to have been
3 discharged. Any monies remaining in the fund after
4 all such retrospective premium charges have been paid
5 shall be returned to policyholders pursuant to
6 procedures authorized by the directors."
7 8. By renumbering sections of the bill and
8 correcting internal references in conformity with
9 sections 1 through 7 of this amendment.
10 9. Page 4, by striking lines 12 through 19.
11 10. Page 6, line 16, by striking the word "one".
12 11. Page 6, by striking lines 17 through 28 and
13 inserting in lieu thereof the following:
14 "deducting their share of the deficit from past
15 or future premium taxes due the state of Iowa. The
16 association shall amend the amount of".
17 12. Page 15, by striking lines 16 through 20.

S-3998 FILED - *Adopted 6/5 (1781)* BY COMMITTEE ON COMMERCE
JUNE 2, 1975 LOWELL L. JUNKINS,
CHAIRMAN

FISCAL NOTE
HOUSE FILE 803

Date Prepared May 21, 1975

Requested by Representatives' Bina and Walter
Prepared in regard to the Small amendment to H.F. 803 relating to
Malpractice Insurance. Following is the fiscal effect in dollars of
the legislative proposal as required by Joint Rule 16:

No Estimate Available.

Because it is not known how many claims will be filed and how many
of these claims may go to arbitration or the actual time needed to
evaluate a claim, an accurate estimate cannot be completed.

As stated in Section 28 of the amendment, compensation and expenses
of panel members shall be taxed as costs as provided in chapter six
hundred twenty-five (625) of the Code, except as provided in sub-
section four (4) of section twenty-nine (29) of this Act.

Subsection four (4) of section twenty-nine (29) of this Act relates
to arbitration and states that the cost shall be payable out of
appropriations to the Supreme Court upon certification by the Chief
Judge of the District Court to the Court Administrator of the
Judicial Department.

The following estimate is intended to be an example of the possible
cost that could be incurred. Based on 1974 information and assuming
that 50% of all claims filed will go to arbitration, the estimated
cost per year would be approximately \$20,000.

FILED
MAY 21, 1975

GERRY D. RANKIN
Legislative Fiscal Director

1 "Sec. 6. NEW SECTION. STABILIZATION RESERVE FUND.

2 1. There is created a stabilization reserve fund.
3 The fund shall be administered by three directors,
4 one of whom shall be the commissioner. The remaining
5 two directors shall be appointed by the commissioner:
6 One shall be a representative of the association and
7 the other a representative of its policyholders.
8 2. The directors shall act by majority vote with
9 two directors constituting a quorum for the transaction
10 of any business or the exercise of any power of the
11 fund. The directors shall serve without salary, but
12 each director other than the commissioner shall be
13 reimbursed for actual and necessary expenses incurred
14 in the performance of official duties as a director.
15 The directors shall not be subject to any personal
16 liability with respect to the administration of the
17 fund for acts or decisions made in good faith pursuant
18 to the provisions of this Act.
19 3. Each policyholder shall pay to the association
20 a stabilization reserve fund charge determined by
21 the directors which shall not exceed the amount of
22 one annual premium due for insurance through the
23 association. Such charge shall be separately stated
24 in the policy. The association shall cancel the
25 policy of any policyholder who fails to pay the
26 stabilization reserve fund charge.
27 4. The association shall promptly pay to the fund
28 all stabilization reserve fund charges which it
29 collects from its policyholders and any retrospective
30 premium refunds payable under any group retrospective
31 rating plan approved by the commissioner under the
32 provisions of this Act.
33 5. All monies received by the fund shall be held
34 in trust by a corporate trustee selected by the
35 directors. The corporate trustee may invest the
36 monies held in trust, subject to the approval of the
37 directors. All investment income shall be credited
38 to the fund, and all expenses of administration of
39 the fund shall be charged against the fund. The
40 monies held in trust shall be used solely for the
41 purpose of discharging when due any retrospective
42 premium charges payable by policyholders of the
43 association under the group retrospective rating plan
44 approved by the commissioner. Payment of retrospective
45 premium charges shall be made by the directors upon
46 certification to them by the association of the amount
47 due. If all monies accruing to the fund are finally
48 exhausted in payment of retrospective premium charges,
49 all liability and obligations of the association's
50 policyholders with respect to the payment of

S-3998

1 Amend House File 803 as amended, passed and
2 reprinted by the House as follows:

3 1. Page 1, line 17, by striking the words "an
4 assessment of the policyholders" and inserting in lieu
5 thereof the words "a stabilization reserve fund
6 contributed to by insureds".

7 2. Page 5, by striking lines 15 and 16 and
8 inserting in lieu thereof the following:

9 "All policies shall be issued subject to the group
10 retrospective rating plan and the stabilization reserve
11 fund authorized by this Act. No policy".

12 3. Page 5, line 35, by inserting after the word
13 "basis," the following:

14 "giving due consideration to the group retrospective
15 rating plan and the stabilization reserve fund,".

16 4. Page 6, by striking lines 4 through 10 and
17 inserting in lieu thereof the following:

18 "ject to a nonprofit group retrospective rating
19 plan to be approved by the commissioner under which
20 the final premium for all policyholders of the
21 association, as a group, will be equal to the
22 administrative expenses, loss and loss adjustment
23 expenses and taxes, plus a reasonable allowance for
24 contingencies and servicing. Policyholders shall
25 be given full credit for all investment income, net
26 of expenses and a reasonable management fee, on
27 policyholder supplied funds. The standard premium,
28 before retrospective adjustment, for each policy
29 issued by the association shall be established for
30 portions of the policy period coinciding with the
31 association's fiscal year on the basis of the
32 association's rates, rating plans, rating rules, and
33 rating classifications then in effect. The maximum
34 final premium for all policyholders of the associa-
35 tion, as a group, shall be limited as provided in
36 subsection five (5) of section six (6) of this Act.
37 Since the business of the association is subject to
38 the nonprofit group retrospective rating plan required
39 by this subsection, there shall be a presumption that
40 the rates filed and premiums imposed by the association
41 are not unreasonable or excessive."

42 5. Page 6, line 12, by striking the word
43 "assessment".

44 6. Page 6, by striking line 13 and inserting
45 in lieu thereof the following:

46 "the stabilization reserve fund has been exhausted
47 in payment of the maximum final premium for all
48 policyholders of the association."

49 7. Page 7, by inserting after line 4 the following
50 new section:

H-3939

1 Amend House File 803 as follows:

2 1. Page 12, by striking lines 8 through 35.

3 2. Page 13, by striking lines 1 through 3 and
4 inserting in lieu thereof the following:

5 "Sec. Chapter one hundred forty-seven
6 (147), Code 1975, by adding the following new
7 section:

8 NEW SECTION. In any action for personal injury
9 or wrongful death against any health care
10 practitioner licensed under this chapter or a
11 hospital licensed for operation in this state,
12 based upon the alleged negligence of the licensee
13 in the practice of that profession or occupation,
14 or upon the alleged negligence of the hospital in
15 patient care, the court shall determine the
16 reasonableness of any contingent fee arrangement
17 between the plaintiff and the plaintiff's attorney."

H-3939 FILED, RULED GERMANE
ADOPTED (1907)
MAY 22, 1973

BY SCHOREDER of Pottawattamie
WALTER of Pottawattamie

H-3913

1 Amend the Small, Lipsky amendment H-3910, to
2 page 13 of House File 803, page 4, line 2, by
3 striking the words "writing and" and inserting in
4 lieu thereof the words "the form of written findings
5 and conclusions".

H-3913 FILED - *Adopted 5/22 (1904)*
MAY 21, 1975

BY SMALL of Johnson
LIPSKY of Linn

H-3914

1 Amend House File 803 as follows:
2 Page 11, by striking the words "or to be incurred
3 in the future" from line 34.

H-3914 FILED - *Lost 5/21 (1882)*
MAY 21, 1975

BY TAUKE of Dubuque
WALTER of Pottawattamie

H-3919

1 Amend the Small and Lipsky amendment, H-3910, to
2 page 13 of House File 803, at page 1, by striking
3 lines 38 through 42, and inserting in lieu thereof
4 the following:
5 "may be submitted to a medical evaluation panel
6 upon the written agreement of all of the parties to
7 that action. Upon the filing with the court of that
8 agreement that action shall not be scheduled for trial
9 until after a written opinion of the panel has been
10 filed with the court as provided in this Act. This
11 section shall not".

H-3919 FILED - *Lost 5/22 (1904)*
MAY 21, 1975

BY BINA of Scott
WALTER of Pottawattamie
TAUKE of Dubuque

H-3926

- 1 Amend the Monroe amendment H-3795K, to page 11
- 2 of House File 803, as follows:
- 3 Page 2, line 19, by striking the word "part"
- 4 and inserting in lieu thereof the word "past".

H-3926 FILED, ADOPTED BY BY MONROE of Des Moines
UNANIMOUS CONSENT (1381)
MAY 21, 1975

H-3929

- 1 Amend House File 803, page 13, by striking all
- 2 of lines 4 through 16.

H-3929 FILED *Lost 5/22 (1900)* BY OAKLEY of Clinton
MAY 21, 1975 TAUKE of Dubuque

H-3931

- 1 Amend the Small amendment, H-3909, to
- 2 House File 803, page 1, by striking from line 20
- 3 the word "six" and inserting the word "four"

H-3931 FILED, LOST (1900) BY BRUNOW of Appanoose
MAY 22, 1975

H-3934

- 1 Amend the Small amendment, H-3908, to page 12 of
- 2 House File 803, as follows:
- 3 Inserting after line 9 the following:
- 4 "Any fee, retainer, or hourly compensation
- 5 charged by the defendant's attorney or attorneys shall
- 6 be disclosed to the court and shall be subject to
- 7 approval by the court. The court shall approve
- 8 payment of any such fee, retainer, or hourly compensation
- 9 only to the extent the court finds it to be reasonable."

H-3934 FILED, RULED GERMANE, LOST BY GILLOON of Dubuque
MAY 22, 1975 (1903)

H-3938

- 1 Amend House File 803 as follows:
- 2 1. Page 10, by striking line 35.
- 3 2. Page 11, by striking lines 1 through 35.
- 4 3. Page 12, by striking lines 1 through 35.
- 5 4. Page 13, by striking lines 1 through 35.
- 6 5. Page 14, by striking lines 1 through 35.
- 7 6. Page 15, by striking lines 1 through 35.
- 8 7. Page 16, by striking lines 1 through 11.
- 9 8. By renumbering the remaining sections to
- 10 conform with this amendment.

H-3938 FILED, LOST (1906) BY BAKER of Buena Vista
MAY 22, 1975

H-3918

1 Amend the Small and Lipsky amendment, H-3910, to
2 page 13 of House File 803, as follows:
3 1. Page 2, by striking lines 4 through 12 and
4 inserting in lieu thereof the following:
5 "licensure. Each examining board from time to
6 time shall submit upon request to the clerk of the
7 district court a roster containing the names of fifteen
8 health care practitioners subject to examination or
9 licensure by the respective examining board. Upon
10 receipt of these rosters, the clerk of district court
11 shall prepare for use in any action for which a medical
12 evaluation panel is to be convened a list of nine
13 names selected at random by the clerk from the rosters
14 submitted by the examining boards, and containing
15 as nearly as possible an equal number of selections
16 from each roster. Members of an evaluation panel
17 shall be selected by the parties from the list prepared
18 by the clerk of court. The list prepared by the clerk
19 shall not contain the".
20 2. Page 2, by striking lines 32 and 33 and
21 inserting in lieu thereof the words "to select one
22 practitioner from the list prepared by the clerk of
23 court, and the two members thus selected".
24 3. Page 3, by inserting after line 1 the following
25 paragraph:
26 "In no event shall a panel contain more than one
27 health care practitioner who is of the same board
28 certified medical specialty or branch of the medical
29 profession as one or more of the defendants."

H-3918 FILED - *Withdrawn 5/22 (1904)* BY BINA of Scott
MAY 21, 1975 WALTER of Pottawattamie
TAUKE of Dubuque

H-3920

1 Amend the Small amendment H-3916 to House File
2 803 by striking the word "Failure" in line 18 and
3 all of lines 19 thru 21 and the word "state." in
4 line 22.

H-3920 FILED, LOST (1875) BY NIELSEN of Polk
MAY 21, 1975

H-3908

1 Amend House File 803, page 12, by inserting
2 after line 35, the following new paragraph:
3 "However, the court may approve a contingent
4 fee contract which provides for payment to the
5 attorney of a sum in excess of the maximum fee
6 permitted by this section if the attorney submits
7 to the court an affidavit establishing that the
8 attorney incurred extraordinary expenses or pro-
9 vided extraordinary services in this action."

H-3908 FILED - *Bulled out of order with* BY SMALL of Johnson
MAY 20, 1975 *rejection of 33553 5/21 (1888)* HENNESSEY of Delaware
Belkin order after 33553 reconsidered loss BROCKETT of Marshall
Adopted 5/22 (1903)

House File 803

H-3916

- 1 Amend House File 803 as follows:
- 2 1. Page 1, line 17, by striking the words "a
- 3 stabilization reserve fund contributed".
- 4 2. Page 1, line 18, by striking the words " to
- 5 be insured," and inserting in lieu thereof the words
- 6 "an assessment of the policyholders,".
- 7 3. Page 5, line 17, by striking the word
- 8 "giving".
- 9 4. Page 5, by striking line 18.
- 10 5. Page 5, line 19, by striking the words
- 11 "the stabilization reserve fund,".
- 12 6. Page 5, line 22, by striking the words "a
- 13 nonprofit group retrospective rating plan to be",
- 14 and inserting in lieu thereof the words "an annual
- 15 assessment upon the policyholders as required to
- 16 recoup any deficit sustained by the association in
- 17 any one year, such assessment not to exceed one ad-
- 18 ditional premium at the then current rate. Failure
- 19 to pay such assessment when due shall result in the
- 20 suspension of the licensed health care provider's
- 21 license to practice his or her profession in this
- 22 state."
- 23 7. Page 5, by striking all of lines 23 through
- 24 35.
- 25 8. Page 6, by striking lines 1 through 6.
- 26 9. Page 6, line 8, by striking the words "the
- 27 stabiliza-", and inserting in lieu thereof the words
- 28 "assessment of the policyholders as provided in sub-
- 29 section five (5)."
- 30 10. Page 6, by striking lines 9 and 10.
- 31 11. Page 7, by striking all of lines 2 through
- 32 35.
- 33 12. Page 8, by striking lines 1 through 16.
- 34 13. By renumbering sections of the Act as re-
- 35 quired.

H-3916 FILED, ADOPTED *as amended* BY SMALL of Johnson
MAY 21, 1975 *By 3921 (1975)*

House File 803

H-3921

- 1 Amend the Small amendment, H-3916, to House
- 2 File 803, by inserting after line 6 the following:
- 3 "____. Page 4, by striking lines 32 through
- 4 34 and inserting in lieu thereof the following:
- 5 "Act. All policies shall be subject to assess-
- 6 ment as provided in subsection (5) of this section.
- 7 No policy form shall be used by the".

H-3921 FILED, ADOPTED (1876) BY SMALL of Johnson
MAY 21, 1975

H-3907

1 Amend House File 803, page 12, by inserting after
2 line 7 the following sections:

3 "Sec. _____. Section five hundred nineteen point
4 five (519.5), Code 1975, is amended to read as follows:

5 519.5 CONDITIONS. No such certificate shall be
6 issued by the commissioner of insurance until two
7 hundred fifty applications have been received,
8 ~~representing, in the aggregate, one million dollars~~
9 ~~of insurance,~~ and until the commissioner of insurance
10 has satisfied himself that such mutual insurance
11 corporation has bona fide applications representing
12 the number of applicants ~~and the amount of insurance~~
13 ~~herein~~ required, and that there is in the possession
14 of such mutual insurance corporation cash assets
15 amounting to not less than ten ~~thousand dollars~~ times
16 the maximum single retained risk.

17 Sec. _____. Section five hundred nineteen point six
18 (519.6), Code 1975, is amended to read as follows:

19 519.6 REPORTS. Such mutual insurance corporations
20 doing business under the provisions of this chapter
21 shall, annually, ~~in the month of January~~ before the
22 first day of March, report to the commissioner of
23 insurance, upon blanks furnished by him, the same
24 facts, so far as applicable, as are required to be
25 furnished by mutual insurance associations under the
26 statutes of Iowa, which report shall be tabulated
27 by the commissioner of insurance and published by
28 him in the annual report on insurance.

29 Sec. _____. Section five hundred nineteen point
30 eight (519.8), Code 1975, is amended to read as
31 follows:

32 519.8 CANCELLATION OF POLICY. Any certificate
33 of membership, or policy, issued by such a mutual
34 insurance corporation may be canceled by the
35 corporation by giving five thirty days' written notice
36 thereof to the insured; or such cancellation may be
37 upon demand of the insured; and such cancellation,
38 when so made, either by the corporation or by the
39 insured, shall be upon a pro rata basis, and the
40 cancellation of such certificate or policy shall
41 release the member from all other future obligations
42 to such corporation.

43 Sec. _____. Section five hundred nineteen point
44 nine (519.9), Code 1975, is amended to read as follows:

45 519.9 FEES. Such a mutual insurance corporation
46 shall pay the same fees for admission into the state,
47 for annual reports, and for annual certificates of
48 authority as are required to be paid by domestic
49 mutual companies organized and doing business under
50 chapter 515; such certificate shall expire ~~March-4~~

1 May first of the year following the date of its issue.
2 Sec. . Section five hundred nineteen point
3 twelve (519.12), Code 1975, is amended to read as
4 follows:
5 519.12 FOREIGN COMPANIES. Any mutual insurance
6 association organized under the laws of any other
7 state, for the purpose of transacting the kind of
8 business described in this chapter, and which has
9 ~~been-in-business-not-less-than-one-year-and-has~~ on
10 hand ~~cash-assets-in-an-amount-of~~ surplus amounting
11 to not less than ten thousand-dollars times the maximum
12 single retained risk, and has not less than three
13 two hundred fifty members, shall may upon application,
14 be admitted to do business in this state if the
15 commissioner finds such admission is in the public
16 interest; and shall thereafter make all reports and
17 be subject to taxation, examination, and supervision
18 by the commissioner of insurance to the same extent
19 and in the same manner as are domestic corporations
20 organized under the provisions of this chapter."

H-3907 FILED - *Adopted as amended by* BY SMALL of Johnson
MAY 20, 1975 *3924 5/21 (1976)*

H-3909

1 Amend House File 803, page 13, by inserting
2 after line 3 the following:
3 "Sec. . Section six hundred fourteen point
4 one (614.1), Code 1975, is amended by adding the
5 following new subsection:
6 NEW SUBSECTION. MALPRACTICE. Those founded on
7 injuries to the person or wrongful death against
8 any physician and surgeon, osteopath, osteopathic
9 physician and surgeon, dentist, podiatrist,
10 optometrist, chiropractor, or nurse, licensed under
11 chapter one hundred forty-seven (147) of the Code,
12 or a hospital licensed under chapter one hundred
13 thirty-five B (135B) of the Code, arising out of
14 patient care, within two years after the date on
15 which the claimant knew, or through the use of
16 reasonable diligence should have known, or received
17 notice in writing of the existence of, the injury
18 or death for which damages are sought in the action,
19 whichever of the dates occurs first, but in no event
20 shall any action be brought more than six years after
21 the date on which occurred the act or omission or
22 occurrence alleged in the action to have been the
23 cause of the injury or death unless a foreign object
24 unintentionally left in the body caused the injury
25 or death."

H-3909 FILED - *Adopted 5/22 (1975)* BY SMALL of Johnson
MAY 20, 1975

H-3911

1 Amend House File 803, page 12, by inserting after
2 line 7 the following:

3 "Sec. _____. Chapter one hundred forty-seven (147),
4 Code 1975, is amended by adding the following new
5 sections:

6 NEW SECTION. DEFINITIONS. As used in this Act
7 unless the context otherwise requires:

8 1. "Medical profession examining board" means and
9 includes the following boards:

- 10 a. Board of medical examiners.
11 b. Board of podiatry examiners
12 c. Board of chiropractic examiners.
13 d. Board of dental examiners
14 e. Board of optometry examiners.

15 2. "Continuing education" means that education which
16 is obtained by a medical profession licensee in order
17 to maintain, improve, or expand skills and knowledge
18 or to develop new and relevant skills and knowledge.

19 NEW SECTION. CONTINUING EDUCATION REQUIRED.

20 Each medical profession examining board shall
21 promulgate rules pursuant to chapter seventeen A (17A)
22 of the Code for the continuing education of each
23 medical profession licensee subject to examination or
24 licensure by that examining board. The general purpose
25 of continuing education shall be to improve the quality
26 of the profession for the ultimate goal of safeguarding
27 and improving the health, safety and welfare of the
28 citizens of this state.

29 NEW SECTION. RULE-MAKING AUTHORITY.

30 1. Each medical profession examining board is
31 delegated the authority to create, by rule, pursuant to
32 chapter seventeen A (17A) of the Code, continuing educa-
33 tion requirements as a condition to license renewal or
34 reinstatement.

35 2. Rules may create continuing education requirements
36 and additionally may establish continuing education
37 programs to assist a licensee in meeting continuing
38 education requirements. Such rules shall:

39 a. Give due consideration to the effect of continuing
40 education requirements on interstate and international
41 practice.

42 b. Place the responsibility for arrangement of
43 financing continuing education on the licensee, while
44 allowing the board or a continuing education provider
45 to receive available funds or resources that aid in
46 supporting continuing education programs.

47 c. Attempt to express continuing education require-
48 ments in terms of uniform and recognized measurement
49 units.

50 d. Establish guidelines, including guidelines in

MAY 21, 1975

Page 2
H-3911

1 regard to the monitoring of licensee participation,
2 for the approval of continuing education programs that
3 qualify under the continuing education requirements
4 prescribed.

5 e. Not be implemented for the purpose of limiting
6 the size of the profession or occupation.

7 f. Define the statuses of active licensure and
8 reinstatement, and establish appropriate guidelines
9 for the reinstatement of persons previously licensed.

10 g. Be promulgated solely for the purpose of assur-
11 ing that a licensee maintain or improve professional
12 skills and knowledge directly related to and commensurate
13 with the level of competency which is generally
14 recognized as appropriate and acceptable in the
15 licensee's profession or board certified specialty.
16 Rules shall be amended from time to time as necessary
17 in order to reflect changes in the state of the art.

18 NEW SECTION. FAILURE TO COMPLY--PENALTY. A
19 licensee who fails to comply with applicable continu-
20 ing education requirements established by rule of
21 an examining board commits a violation of this chapter
22 and shall be subject to disciplinary action including
23 suspension or revocation of the license to practice
24 that profession.

H-3911 FILED *Revised not germane 5/21 (1987)* BY
MAY 20, 1975

LIPSKY of Linn
SMALL of Johnson
BINA of Scott
BROCKETT of Marshall
HENNESSEY of Delaware

H-3910

1 Amend House File 803, page 13 by striking lines
2 17 through 35, pages 14 and 15 by striking lines 1
3 through 35, and page 16 by striking lines 1 through
4 11, and inserting in lieu thereof the following:

5 "Sec. 19. Chapter six hundred five (605), Code
6 1975, is amended by adding sections twenty (20) through
7 twenty-nine (29) of this Act.

8 Sec. 20. NEW SECTION. DEFINITIONS. As used in
9 this Act, unless the context otherwise requires:

10 1. "Examining board" means and includes each of
11 the agencies responsible by law for the examination
12 or licensure of health care providers.

13 2. "Health care practitioner" means and includes
14 every licensed health care provider, except a hospital
15 and except a person licensed only to engage in a
16 limited practice of a profession under the supervision
17 of another licensed person.

18 3. "Health care provider" means and includes
19 hospitals subject to licensing under chapter one
20 hundred thirty-five B (135B) of the Code, and persons
21 subject to licensing under chapter one hundred forty-
22 seven (147) of the Code as physicians, surgeons,
23 osteopaths, osteopathic physicians and surgeons,
24 dentists, podiatrists, optometrists, chiropractors
25 or nurses, including students or other persons licensed
26 to exercise limited functions within one of those
27 professions under the supervision of another licensed
28 person.

29 4. "Medical evaluation panel" means each of the
30 panels of health care practitioners created by this
31 Act and charged with the review of medical malpractice
32 actions.

33 Sec. 21. NEW SECTION. MEDICAL EVALUATION PANEL.
34 There are established in the district court medical
35 evaluation panels to review as provided in this Act
36 all claims of malpractice against health care
37 providers. An action against a health care provider
38 alleging malpractice shall not be brought to trial
39 in a court in this state until the claimant's
40 allegations have been submitted to a medical evaluation
41 panel and a decision has been rendered by that panel
42 and filed with the court. This section shall not
43 apply to any action commenced prior to January 1,
44 1976.

45 Sec. 22. NEW SECTION. MEMBERSHIP OF PANELS.

46 1. A medical evaluation panel shall consist of
47 three health care practitioners and one attorney to
48 be selected as provided in this section. The attorney
49 shall act in an advisory capacity and as chairman
50 of the panel, but shall have no vote.

1 2. All health care practitioners licensed in this
2 state shall be subject to selection for service on
3 a medical evaluation panel as a condition of retaining
4 licensure. An examining board shall submit upon
5 request to the clerk of the district court having
6 jurisdiction of the action a list containing the names
7 of nine health care practitioners who are of the same
8 or related board certified medical specialities as
9 one or more of the defendants in the action. Members
10 of the medical evaluation panel shall be selected
11 from the list submitted to the clerk of court. The
12 list submitted to the court shall not contain the
13 name of any health care practitioner who engages in
14 professional practice in the same locality as any
15 of the defendants, or, if any defendant is a hospital,
16 the list shall not contain the name of any practi-
17 tioner affiliated with or having privileges in that
18 hospital.

19 3. A health care practitioner actually selected
20 for service on a medical evaluation panel may be
21 excused from service for good cause shown, and only
22 upon submission of an affidavit by that practitioner
23 to the district court specifying facts establishing
24 that service at that time would constitute an
25 unreasonable burden or an undue hardship. A person
26 who actually serves on an evaluation panel shall not
27 be subject to service for a period of one year
28 thereafter unless circumstances exist whereby other
29 practitioners are not available for service on a
30 panel.

31 4. Each party to the action shall have the right
32 to select one practitioner from the list submitted
33 to the clerk of court, the two members thus selected
34 shall select the third panel member from the names
35 remaining on the list. However, if there are two
36 or more parties appearing as plaintiffs or as
37 defendants then each side shall have the right to
38 select one panel member who shall be chosen by
39 agreement of those parties. In the event that multiple
40 parties on a side cannot agree on a selection, they
41 shall so inform the court and the court shall submit
42 to those parties three names which remain on the list
43 after the other side has made its selection. The
44 parties shall then strike two names and the remaining
45 person shall serve on the evaluation panel.

46 If the two panel members chosen by the parties
47 are unable to agree on a third panel member, they
48 shall so inform the court, and the parties shall then
49 strike three names each in alternative fashion, the
50 plaintiff striking the first, from the list and the

1 remaining person shall serve as the third panel member.
2 5. The attorney member of the panel shall be
3 selected from a list of five attorneys submitted to
4 the clerk of court by the clerk of the supreme court.
5 The attorney member may be selected by agreement of
6 the parties. In the absence of an agreement each
7 side alternately shall strike two names, the plaintiff
8 striking the first, and the remaining person shall
9 serve on the evaluation panel. An attorney who
10 actually serves on a panel shall not serve on another
11 panel for a period of one year thereafter. The supreme
12 court shall provide for the compiling of the lists
13 of attorneys, which shall not include any attorney
14 who is not experienced in trial practice.

15 Sec. 23. NEW SECTION. HEARINGS AND EVIDENCE.

16 1. The chairman of the medical evaluation panel
17 shall convene the panel for a hearing of the claims
18 in the action assigned to that panel as soon as is
19 practicable after the selection of the panel. The
20 hearing shall be held within the jurisdiction of the
21 court, and at a place and time convenient to the
22 parties, subject to any rules of the court. The
23 chairman shall preside at hearings.

24 2. The evidence to be considered shall be in
25 written form only, and may consist of medical charts,
26 X-rays, laboratory tests, excerpts of treatises,
27 depositions or interrogatories of witnesses including
28 parties, and any other type of evidence allowed by
29 the panel. The chairman of the panel shall advise
30 the panel on legal questions involved in the
31 proceeding, but a hearing shall be informal and shall
32 not be subject to strict rules of evidence.

33 3. The panel shall have the right and duty to
34 request and obtain all necessary information. The
35 panel may consult with medical authorities at any
36 time, and may obtain, introduce and examine other
37 evidence not submitted by the parties when necessary
38 to fully inform itself regarding the issues to be
39 decided. All parties shall be given full access to
40 any material submitted to or considered by the panel.

41 4. A party or legal counsel shall have the right
42 to ask questions of and to address the panel concerning
43 any matters relevant to issues before the panel.
44 The panel may limit the duration of questioning and
45 statements when necessary to preserve order.

46 Sec. 24. NEW SECTION. OPINION OF PANEL.

47 1. The panel shall have the sole duty to express
48 its expert opinion respecting the issues charged in
49 the complaint. Within thirty days following the con-
50 clusion of the hearing the panel shall render one

1 or more of the following expert opinions respecting
2 each defendant which shall be in writing and signed
3 by each of the panelists:

4 a. That the evidence supports the conclusion that
5 the defendant failed to comply with the appropriate
6 standard of care as charged in the complaint.

7 b. That the evidence does not support the conclu-
8 sion that the defendant failed to meet the applicable
9 standard of care as charged in the complaint.

10 c. That there is a material issue of fact, not
11 requiring expert opinion, bearing on liability for
12 consideration by the court or jury.

13 d. That the conduct complained of was or was not
14 a cause of the resultant damages.

15 e. Whether the plaintiff suffered any disability
16 and the extent and duration of the disability, and
17 whether the plaintiff suffered any permanent impairment
18 and the percentage of the impairment.

19 2. The chairman of the panel shall have the duty
20 to prepare the written opinion of the panel and to
21 submit the opinion to the court. The clerk of court
22 shall file the opinion in the action and shall mail
23 a copy of the opinion to each party. Concurring and
24 dissenting opinions shall not be separately submitted,
25 but any absence of unanimity in the opinion respecting
26 any finding or conclusion expressed in the opinion
27 shall be identified as to both the panel members and
28 the issues involved.

29 3. In a separate written opinion the panel shall
30 have the duty to express its opinion as to whether
31 or not the claim warrants arbitration. The opinion
32 also shall be filed by the clerk of court and mailed
33 to the parties, but shall not be admissible as evi-
34 dence.

35 4. The clerk of court shall forward a certified
36 copy of the opinion filed pursuant to subsection two
37 (2) of this section to the state department of health
38 for review. No fee shall be imposed by the clerk
39 for the certification of the opinion.

40 Sec. 25. NEW SECTION. EVIDENCE AT TRIAL--PROOF-
41 COSTS.

42 1. At any subsequent trial of the action, the
43 expert opinion rendered by the medical evaluation
44 panel shall be admissible as evidence. The opinion
45 shall not be conclusive and either party shall have
46 the right to call a member of the panel and other
47 experts as witnesses at that party's expense. If
48 called as a witness a medical evaluation panel member
49 shall be required to appear and testify.

50 2. In the event that the expert opinion of the

1 panel is unanimous respecting all issues material
2 to the controversy, the party in whose favor the
3 opinion was rendered shall be entitled, upon being
4 awarded a verdict or judgment, to recover the actual
5 total costs expended by that party in proving those
6 issues at trial, notwithstanding any limitations on
7 recoverable witness fees or expenses otherwise provided
8 by law.

9 Sec. 26. NEW SECTION. COURT RULES.

10 1. The district court shall provide by local rule
11 for the convening of a pretrial conference in each
12 malpractice action for the purposes of the selection
13 of the panel, the scheduling of discovery prior to
14 hearing by the panel, and the general scheduling of
15 panel hearings.

16 2. The district court shall provide for the
17 swearing in of panel members prior to the convening
18 of any panel.

19 3. The supreme court shall adopt rules from time
20 to time to implement and administer the operation
21 of medical evaluation panels. The panels and the
22 procedures relating to their use shall be subject
23 to the superintending and administrative control of
24 the supreme court. The supreme court shall promulgate
25 an oath which shall be undertaken by each person
26 serving on a medical evaluation panel.

27 Sec. 27. NEW SECTION. IMMUNITY. A member of
28 a medical evaluation panel shall have absolute immu-
29 nity from civil liability for all communications,
30 findings, opinions and conclusions made in the course
31 and scope of duties prescribed by this Act.

32 Sec. 28. NEW SECTION. COMPENSATION. Each member
33 of a medical evaluation panel shall be paid a per
34 diem of forty dollars for each day of service per-
35 formed as a member of the panel, and shall be reim-
36 bursed for necessary and reasonable expenses actually
37 incurred; provided that this section shall not apply
38 to appearances of a panel member when called as a
39 witness. Compensation and expenses of panel members
40 shall be taxed as costs as provided in chapter six
41 hundred twenty-five (625) of the Code, except as
42 provided in subsection four (4) of section twenty-
43 nine (29) of this Act.

44 Sec. 29. NEW SECTION. ARBITRATION.

45 1. In the event that a majority of the medical
46 evaluation panel recommends arbitration pursuant to
47 subsection three (3) of section twenty-four (24) of
48 this Act, the action may be resubmitted to that panel
49 upon the written agreement of the parties. Any
50 arbitration agreed to shall be subject to the following

1 conditions:

2 a. The parties shall submit to arbitration all
3 of the issues involved in the action.

4 b. No party shall have the power to revoke the
5 agreement, either with or without the consent of the
6 other parties.

7 c. Upon filing with the court of an arbitration
8 agreement the court immediately shall mail a notice
9 of arbitration to the chairman and each member of
10 the medical evaluation panel. The panel shall
11 reconvene not later than thirty days thereafter for
12 the purpose of taking further proceedings in that
13 action. Witnesses shall be sworn before offering
14 evidence. The chairman shall be authorized to place
15 a person upon oath. Questions previously decided
16 relating to liability shall not be reconsidered in
17 arbitration.

18 d. An award of the panel shall be filed with the
19 court not later than sixty days following the date
20 the notice of arbitration was mailed by the clerk
21 of court.

22 2. The provisions of chapter six hundred seventy-
23 nine (679) of the Code shall be applicable to
24 arbitration pursuant to this section to the extent
25 not inconsistent with this section, and in the event
26 of conflict the provisions of this section shall
27 supercede the provisions of that chapter.

28 3. Each member of the panel shall receive com-
29 pensation and reimbursement for expenses for ser-
30 vices in arbitration in the amounts and to the extent
31 provided in section twenty-eight (28) of this Act.

32 4. In the event any action is submitted to arbi-
33 tration as provided in this section, the amounts
34 otherwise taxable as costs pursuant to section twenty-
35 five (25) of this Act and the amounts paid to the
36 panel for service in arbitration as provided in this
37 section shall be paid by the state and the parties
38 to the agreement shall be exempted from any payment
39 thereof. The costs shall be payable out of
40 appropriations to the supreme court upon certification
41 by the chief judge of the district court to the court
42 administrator of the judicial department.

43 Sec. 30. Section one hundred thirty-five B point
44 seven (135B.7), Code 1975, is amended by adding the
45 following new unnumbered paragraph:

46 NEW UNNUMBERED PARAGRAPH. The state department
47 of health shall review every opinion of a medical
48 evaluation panel received from the clerk of the
49 district court which relates to an action in which
50 a hospital was a party defendant. If the opinion

1 indicates noncompliance with rules or standards
2 established by the department, proceedings for the
3 suspension or revocation of the license of that hos-
4 pital may be commenced as provided in this chapter.
5 If there has not been any failure to comply with rules
6 or standards, the department shall review the opinion
7 for the purpose of determining whether or not changes
8 in rules or standards are needed to accomplish the
9 purposes of this chapter. The annual report of the
10 department shall include discussion of the actions
11 and inactions of the department with respect to this
12 paragraph.

13 Sec. 31. Section one hundred forty-seven point
14 fifty-five (147.55), subsection two (2), Code 1975,
15 is amended to read as follows:

16 2. Incompetency in the practice of his or her
17 profession, including but not limited to the pro-
18 vision of services which are unnecessarily harmful
19 to the patient or which are of grossly inferior
20 quality, or the repeated use of surgery or other
21 modalities of treatment not reasonably necessary to
22 the health and well-being of patients.

23 Sec. 32. Section one hundred forty-seven point
24 eighty-seven (147.87), Code 1975, is amended by adding
25 the following new unnumbered paragraph:

26 NEW UNNUMBERED PARAGRAPH. The department shall
27 review every opinion of a medical evaluation panel
28 received from the clerk of the district court which
29 relates to a person subject to licensure under this
30 chapter, and shall cause a copy of each opinion to
31 be delivered to the chairman of the examining board
32 for the profession involved. If the opinion indicates
33 a violation of this chapter the department, either
34 independently or in conjunction with the examining
35 board, may initiate proceedings for the suspension
36 or revocation of the license involved, or may initiate
37 such other proceedings as are provided by this chapter
38 or this title for violations.

39 Sec. 33. Chapter one hundred forty-seven (147),
40 Code 1975, is amended by adding sections thirty-four
41 (34) through thirty-seven (37) of this Act.

42 Sec. 34. NEW SECTION. REVOCATION OF LICENSES.

43 1. In addition to the provisions of sections one
44 hundred forty-seven point fifty-eight (147.58) to
45 one hundred forty-seven point seventy-one (147.71)
46 of the Code, an examining board after due notice and
47 hearing may direct the commissioner of health to issue
48 an order to revoke or suspend a license to practice,
49 or to discipline a person licensed to practice for
50 any of the grounds set forth in sections one hundred

1 forty-seven point fifty-five (147.55) and one hundred
2 forty-seven point fifty-six (147.56) of the Code or
3 if, after a hearing, the examining board determines
4 that a person licensed to practice is guilty of any
5 of the following acts or offenses:

6 a. Knowingly making misleading, deceptive, untrue
7 or fraudulent representation in the practice of his
8 or her profession.

9 b. Being convicted of a felony in the courts of
10 this state or another state, territory, or country.
11 Conviction as used in this paragraph shall include
12 a conviction of an offense which if committed in this
13 state would be deemed a felony without regard to its
14 designation elsewhere, or a criminal proceeding in
15 which a finding or verdict of guilt is made or
16 returned, but the adjudication of guilt is either
17 withheld or not entered. A certified copy of the
18 final order or judgment of conviction or plea of
19 guilty in this state or in another state shall be
20 conclusive evidence.

21 c. Violating a statute or law of this state,
22 another state, or the United States, without regard
23 to its designation as either felony or misdemeanor,
24 which statute or law relates to the practice of a
25 medically related profession.

26 d. Having his or her license to practice revoked
27 or suspended, or having other disciplinary action
28 taken by a licensing authority of another state,
29 territory, or country. A certified copy of the record
30 or order of suspension, revocation, or disciplinary
31 action is conclusive or prima facie evidence.

32 e. Knowingly aiding, assisting, procuring, or
33 advising a person to unlawfully practice a medically
34 related profession.

35 f. Being adjudged mentally incompetent by a court
36 of competent jurisdiction. Such adjudication shall
37 automatically suspend a license for the duration of
38 the license unless the board orders otherwise.

39 g. Being guilty of a willful or repeated departure
40 from, or the failure to conform to, the minimal
41 standard of acceptable and prevailing practice of
42 the profession for which licensed in which proceeding
43 actual injury to a patient need not be established;
44 or the committing by the licensed person of an act
45 contrary to honesty, justice, or good morals, whether
46 the same is committed in the course of practice or
47 otherwise, and whether committed within or without
48 this state.

49 h. Inability to practice with reasonable skill
50 and safety by reason of illness, drunkenness, excessive

1 use of drugs, narcotics, chemicals, or other type
 2 of material or as a result of a mental or physical
 3 condition. The examining board shall, upon probable
 4 cause, have authority to compel a licensed person
 5 to submit to a mental or physical examination by
 6 designated physicians. Failure to submit to an
 7 examination shall constitute admission to the
 8 allegations made against the licensed person and the
 9 finding of fact and decision of the examining board
 10 may be entered without the taking of testimony or
 11 presentation of evidence. At reasonable intervals,
 12 the person shall be afforded an opportunity to
 13 demonstrate that he or she can resume the competent
 14 practice of the profession with reasonable skill and
 15 safety to patients.

16 A person licensed to practice who makes application
 17 for the renewal of his or her license, as required
 18 by section one hundred forty-seven point ten (147.10)
 19 of the Code gives consent to submit to a mental or
 20 physical examination as provided by this paragraph
 21 when directed in writing by the examining board.
 22 All objections shall be waived as to the admissibility
 23 of the examining physicians' testimony or examination
 24 reports on the grounds that they constitute privileged
 25 communication. The medical testimony or examination
 26 reports shall not be used against a person in another
 27 proceeding and shall be confidential, except for other
 28 actions filed against the person to revoke or suspend
 29 his or her license.

30 i. Willful or repeated violation of lawful rule
 31 or regulation promulgated by the examining board or
 32 violating a lawful order of the board, previously
 33 entered by the board in a disciplinary hearing.

34 Sec. 35. NEW SECTION. DISCIPLINARY PROCEEDINGS.

35 1. A proceeding for the revocation or suspension
 36 of a license to practice or to discipline a person
 37 licensed to practice shall be substantially in accord
 38 with the procedure provided in this section.

39 2. The examining board may, upon their own motion
 40 or upon verified complaint in writing, and shall,
 41 if such complaint is filed by the commissioner of
 42 public health, issue an order fixing the time and
 43 place for hearing thereon. A written notice of the
 44 time and place of the hearing together with a statement
 45 of the charges shall be served upon the licensee at
 46 least ten days before said hearing in the manner
 47 required for the service of notice of the commencement
 48 of an ordinary action.

49 3. If the licensee has absented or removed himself
 50 from the state, the notice and statement of the charges

1 shall be so served at least twenty days before the
 2 date of the hearing, wherever he or she may be found.
 3 If the whereabouts of the licensee is unknown, service

4 may be had by publication as provided in the rules
5 of civil procedure upon filing the affidavit required
6 by said rules. In case the licensee fails to appear,
7 either in person or by counsel at the time and place
8 designated in said notice, the examining board shall
9 proceed with the hearing as hereinafter provided.

10 4. The hearing shall be before a member or members
11 designated by the board or before a hearing officer
12 appointed by the board. The presiding board member
13 or hearing officer is empowered to issue subpoenas,
14 administer oaths and take or cause depositions to
15 be taken in connection with the hearing. He or she
16 shall issue subpoenas at the request and on behalf
17 of the licensee. The hearing shall be open to the
18 public.

19 The hearing officer shall be vested with full
20 authority of the board to schedule and conduct
21 hearings. The hearing officer shall prepare and file
22 with the board of examiners findings of fact and
23 conclusions of law, together with a complete written
24 transcript of all testimony and evidence introduced
25 at the hearing and all exhibits, pleas, motions,
26 objections and rulings of the hearing officer.

27 5. A stenographic record of the proceedings shall
28 be kept. The licensee shall have the opportunity
29 to appear personally and by counsel, with the right
30 to produce evidence in his or her own behalf, to
31 examine and cross-examine witnesses and to examine
32 documentary evidence produced against him or her.

33 6. If a person refuses to obey a subpoena issued
34 by the presiding member or hearing officer or to
35 answer a proper question put to him or her during
36 the hearing, the presiding member or hearing officer
37 may invoke the aid of a court of competent jurisdiction
38 or judge of this court in requiring the attendance
39 and testimony of such person and the production of
40 papers. A failure to obey such order of the court
41 may be punished by the court as a civil contempt may
42 be punished.

43 7. Unless the hearing is before the entire board,
44 a transcript of the proceeding, together with exhibits
45 presented, shall be considered by the entire board
46 at the earliest practicable time. The licensee and
47 counsel shall have the opportunity to appear personally
48 to present the licensee's position and arguments to
49 the board. The board shall determine the charge or
50 charges upon the merits on the basis of the evidence

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1 in the record before it.

2 8. If a majority of the members of the board vote
3 in favor of finding the licensee guilty of an act
4 or offense specified in section one hundred forty-
5 seven point fifty-five (147.55) or one hundred forty-
6 seven point fifty-six (147.56) of the Code or section
7 thirty-four (34) of this Act, the board shall prepare
8 written findings of fact and its decision imposing
9 one or more of the following disciplinary measures:

10 a. Suspend the person's license to practice his
11 or her profession for a period to be determined by
12 the board.
13 b. Revoke the person's license to practice his
14 or her profession.
15 c. Suspend or revoke the privilege of the person
16 to engage in specified activities or practices within
17 the profession as a condition of permitting the person
18 otherwise to retain his or her privilege to practice.
19 d. Suspend imposition of judgment and penalty
20 or impose the judgment and penalty, but suspend
21 enforcement and place the person on probation. The
22 probation ordered may be vacated upon noncompliance.
23 The examining board may direct the commissioner of
24 health to restore and reissue a license to practice
25 but may impose a disciplinary or corrective measure
26 which it originally might have imposed. Such findings
27 of fact and decision shall be filed with the
28 commissioner of public health who shall within ten
29 days from such filing enter an order revoking or sus-
30 pending the license to practice or discipline the
31 person as directed by the board in its decision.
32 A copy of the commissioner's order shall immediately
33 be sent by registered mail to the licensee's last
34 known post-office address accompanied by a copy of
35 the board's findings of fact and decision.
36 9. Judicial review of an examining board's action
37 may be sought in accordance with the terms of the
38 Iowa administrative procedure Act.
39 10. The commissioner's order revoking or suspending
40 a license to practice or to discipline a licensee
41 shall remain in force and effect until the appeal
42 is finally determined and disposed of upon its merits.
43 Sec. 36. NEW SECTION. VOLUNTARY SURRENDER OF
44 LICENSE. The commissioner of public health is hereby
45 authorized to accept the voluntary surrender of a
46 license if accompanied by a written statement of
47 intention. Such voluntary surrender, when so accepted,
48 shall have the same force and effect as an order of
49 revocation.
50 Sec. 37. NEW SECTION. REINSTATEMENT. Any person

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1 whose license has been suspended, revoked or placed
2 on probation may apply to the appropriate examining
3 board for reinstatement at any time and the board
4 may hold hearings on any such petition and may order
5 reinstatement and impose terms and conditions thereof
6 and issue a certificate of reinstatement to the
7 commissioner of public health who shall thereupon
8 issue a license as directed by the board.

9 Sec. 38. Section one hundred forty-eight point
10 seven (148.7), subsection seven (7), Code 1975, is
11 amended by adding the following new paragraph:

12 NEW PARAGRAPH. d. Suspend or revoke the privilege
13 of the person to engage in specified activities or
14 practices within the profession as a condition of
15 the person's retaining his or her license to practice."

H-3910 FILED *a - Amended by 3912 and* BY SMALL of Johnson
MAY 20, 1975 *withdrawn 5/22 (1905)* LIPSKY of Linn
B - Withdrawn 5/22 (1903)

H-3864

- 1 Amend House File 803 as follows:
- 2 1. Page 5, line 25, by inserting after the word
- 3 "administrative" the following: "and underwriting".
- 4 2. Page 6, by striking the word "one" in line 13,
- 5 by striking lines 14 through 19.
- 6 3. Page 6, line 20, by striking the words "b.
- 7 Deducting", and inserting in lieu thereof the word
- 8 "deducting".
- 9 4. Page 6, by striking lines 22 through 24 and by
- 10 striking the words "described above." on line 25.
- 11 5. Page 6, line 28, by striking the word
- 12 "procedure".

H-3864 FILED - *Ruled out of order 5/21 (1880)* BY KREAMER of Polk
MAY 15, 1975

H-3865

- 1 Amend House File 803, page 7, line 19, by strik-
- 2 ing the word "a" and inserting in lieu thereof the
- 3 words "an annual".

H-3865 FILED - *Ruled out of order with* BY KREAMER of Polk
MAY 15, 1975 *adoption of 3916 5/21 (1877)*

H-3866

- 1 Amend House File 803 as follows:
- 2 1. Page 1, line 8, by striking the word "liability". *B*
- 3 2. Page 1, by striking lines 18 and 19 and insert- *A*
- 4 ing in lieu thereof the following: "to by the insured
- 5 and through the participation of the insurance carriers,
- 6 whose deficits would be deductible from premium taxes."
- 7 3. Page 2, by striking lines 7 through 12 and insert- *B*
- 8 ing in lieu thereof the following:
- 9 "4. "Net direct premiums" means net taxable insurance
- 10 premiums as reported in the annual premium tax returns
- 11 filed by the insurers with the commissioner in compliance
- 12 with chapter four hundred thirty-two (432) of the Code."
- 13 4. Page 2, by striking lines 15 through 19 and insert-
- 14 ing in lieu thereof the following:
- 15 "1. A temporary joint underwriting association is
- 16 created, consisting of all insurers required to file
- 17 premium tax returns with the commissioner in compliance with
- 18 chapter four hundred thirty-two (432) of the Code. Every
- 19 such insurer shall be a member of the".
- 20 5. Page 2, line 21 by striking the word "such".
- 21 6. Page 9, line 8, by striking "statements and other *A*
- 22 reports" and inserting "premium tax returns".

H-3866 FILED - *Lost 5/21 (1874)* BY KREAMER of Polk
MAY 15, 1975 KRAUSE of Palo Alto

H-3892

- 1 Amend House File 803, page 3, line 4 by inserting
- 2 after the word "market" the words "at a reasonable price".

H-3892 FILED - *Adopted 5/21 (1879)* BY BROCKETT of Marshall
MAY 20, 1975 EVANS of Grundy

H-3895

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Amend House File 803, page 16 as follows:

1. By inserting the following new section:

"Sec. _____ NEW SECTION. LIMIT ON LIABILITY.

In an action for damages for personal injury or death against a physician and surgeon, osteopath, osteopathic physician and surgeon, dentist, podiatrist, optometrist, chiropractor or nurse licensed to practice their profession in this state, or against a hospital licensed for operation in this state, based on the alleged negligence of the practitioner in the practice of the profession or occupation, or upon the alleged negligence of the hospital in patient care in which liability is admitted or established, the limit of total liability shall be five hundred thousand dollars."

2. By numbering section to conform to this amendment.

H-3895 FILED - *Withdrawn 5/22 (1988)* BY BROCKETT of Marshall
MAY 20, 1975 EVANS of Grundy

H-3896

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Amend House File 803 as follows:

1. Page 6, line 13, by striking the word "one".

2. Page 6, by striking all of line 14, all of lines 15 through 24, and through the period in line 25 and inserting in lieu thereof the following:

"the following procedure:

a. Deducting their share of the deficit from past or future premium taxes due the state of Iowa."

H-3896 FILED - *Repealed 5/21 (1880)* BY BROCKETT of Marshall
MAY 20, 1975 EVANS of Grundy

House File 803

H-3905

1 Amend the Jesse, et al. amendment, H-3855, to House
2 File 803, page 2, by inserting in line 14 after the
3 word "death" the words "unless a foreign object
4 unintentionally left in the body caused the injury
5 or death".

H-3905 FILED - *Ruled out of order with adoption of 3909 5/22 (1900)* BY WALTER of Pottawattamie
MAY 20, 1975 TAUKE of Dubuque
SCHROEDER of Pottawattamie
HIGGINS of Scott
JOCHUM of Dubuque
CRAWFORD of Story
DOYLE of Woodbury
HARVEY of Scott
PAVICH of Pottawattamie
WEST of Marshall
BINA of Scott

H-3855

1 Amend House File 803 as follows:

2 1. Page 12, by adding the following new section
3 after line 7:

4 "Sec. ____ Chapter one hundred forty-seven (147),
5 Code 1975, is amended by adding thereto the follow-
6 ing new section:

7 NEW SECTION. A consent in writing to any medical
8 or surgical procedure or course of procedures in
9 patient care which meets the requirements of this
10 section shall be conclusively presumed to be valid
11 and effective, in the absence of clear proof that
12 execution of the consent was induced by fraudulent
13 misrepresentation of material facts. Unless fraud-
14 ulent misrepresentation of material facts is es-
15 tablished, no evidence shall be admissible to im-
16 peach, modify or limit the authorization for per-
17 formance of the procedure or procedures set forth
18 in that written consent. A consent in writing meets
19 the requirements of this section if it:

20 1. Sets forth in general terms the nature and
21 purpose of the procedure or procedures, together
22 with the known risks, if any, of death, brain damage,
23 quadriplegia, paraplegia, the loss or loss of func-
24 tion of any organ or limb, or disfiguring scars
25 associated with such procedure or procedures, with
26 the probability of each such risk if reasonably
27 determinable.

28 2. Acknowledges that the disclosure of that
29 information has been made and that all questions
30 asked about the procedure or procedures have been
31 answered in a satisfactory manner.

32 3. Is signed by the patient for whom the procedure
33 is to be performed, or if the patient for any reason
34 lacks legal capacity to consent, is signed by a per-
35 son who has legal authority to consent on behalf of
36 that patient in those circumstances."

37 2. Page 12, line 17, by striking the word "any". B

38 3. Page 12, by striking lines 18 through 35 and
39 inserting in lieu thereof the words "the court shall
40 have jurisdiction over any contingent fee contract
41 between the plaintiff and the plaintiff's attorney."

42 4. Page 13, by striking lines 1 through 3. C

43 5. Page 13, by adding the following new section
44 after line 3:

45 "Sec. ____ Section six hundred fourteen point one
46 (614.1), Code 1975, is amended by adding the follow-
47 ing new subsection:

48 NEW SUBSECTION. MALPRACTICE. Those founded on
49 injuries to the person or wrongful death against any
50 physician and surgeon, osteopath, osteopathic physician

- 1 and surgeon, dentist, podiatrist, optometrist, chiro-
- 2 practor, or nurse, licensed under chapter one hundred
- 3 forty-seven (147) of the Code, or a hospital licensed
- 4 under chapter one hundred thirty-five B (135B) of
- 5 the Code, arising out of patient care, within two
- 6 years after the date on which the claimant knew, or
- 7 through the use of reasonable diligence should have
- 8 known, or received notice in writing of the existence
- 9 of, the injury or death for which damages are sought
- 10 in the action, whichever of the dates occurs first,
- 11 but in no event shall any action be brought more
- 12 than four years after the date on which occurred
- 13 the act or omission or occurrence alleged in the
- 14 action to have been the cause of the injury or death."
- 15 6. Page 13, by striking lines 17 through 35.
- 16 7. By striking all of pages 14 and 15.
- 17 8. Page 16, by striking lines 1 through 11.

H-3855 FILED
MAY 14, 1975

BY JESSE of Polk
 BINA of Scott
 WEST of Marshall
 DRAKE of Muscatine
 MIDDLETON of Black Hawk
 BYERLY of Polk
 PELLETT of Cass
 MILLEN of Van Buren
 NIELSEN of Polk
 BRUNOW of Appanoose
 VARLEY of Adair
 HARPER of Davis
 STROMER of Hancock
 SCHROEDER of Pottawattamie
 KREAMER of Polk
 HORN of Linn
 HUSAK of Tama
 WYCKOFF of Benton
 HULLINGER of Decatur
 DIELEMAN of Marion
 CAFFREY of Polk
 NEWHARD of Jones
 MCELROY of Fremont
 DUNTON of Keokuk

A. Adopted 5/21 (1883)
B. Adopted 5/21 (1882) Motion to
reconsider filed 5/21 (1889)
prevailed 5/22 - B. Lost (1902)
C. Pulled out of order by adoption
of 3909 5/22 (1900)
D. Adopted 5/22 (1908)

H-3855 FILED, *a, B, C adopted*
MAY 14, 1975

H-3795

1	Amend House File 803 as follows:	
2	1. Page 2, line 21, by striking the word "such"	
3	and inserting in lieu thereof the word "liability".	A
4	2. Page 2, line 23, by striking the words "not	
5	exceeding" and inserting in lieu thereof the words	B
6	"of at least".	
7	3. Page 3, line 3, by striking the words "can	
8	be made" and inserting in lieu thereof the word "is".	C
9	4. Page 3, line 4, by inserting after the word	
10	"market" the words "on a competitive basis".	D
11	5. Page 3, line 5, by striking the word "shall"	
12	and inserting in lieu thereof the word "may".	B
13	6. Page 3, line 7, by inserting after the period	
14	the following:	E
15	"A determination of the commissioner pursuant to	
16	this paragraph shall be promulgated by rule, which	
17	in the discretion of the commissioner may become	
18	effective immediately upon filing with the secretary	
19	of state pursuant to subparagraph one (1) of paragraph	
20	b of subsection two (2) of section seventeen A point	
21	five (17A.5) of the Code."	
22	7. Page 3, by striking line 30, and by inserting	
23	in lieu thereof the following:	F
24	"only after promulgation of the plan or amendment	
25	by the commissioner as a rule pursuant to section	
26	seventeen A point four (17A.4) of the Code: Provided	
27	that the initial plan may in the discretion of the	
28	commissioner become effective immediately upon filing	
29	with the secretary of state pursuant to subparagraph	
30	one (1) of paragraph h of subsection two (2) of section	
31	seventeen A point five (17A.5) of the Code."	
32	8. Page 3, line 32, by striking the word "twenty-	
33	five" and inserting in lieu thereof the word "sixty".	G
34	9. Page 3, line 35, by striking the words ", after	
35	notice and opportunity for hearing,".	F
36	10. Page 4, by inserting after line 4 the	
37	following:	
38	"Any initial plan adopted by the commissioner	
39	pursuant to this paragraph shall be exempt from the	
40	provisions of section seventeen A point four (17A.4)	
41	of the Code, and may, in the discretion of the	
42	commissioner, become effective upon filing with the	
43	secretary of state pursuant to subparagraph one (1)	
44	of paragraph b of subsection two (2) of section	
45	seventeen A point five (17A.5) of the Code."	
46	11. Page 4, line 29, by striking the words	
47	"automatically at" and inserting in lieu thereof the	
48	words "not sooner than".	B
49	12. Page 4, line 32, by inserting after the word	
50	"Act" the words ", or unless terminated because of	H

1 failure of the policyholder to pay any premium or
2 stabilization reserve fund charge or portion of either
3 when due".

4 13. Page 6, line 2, by striking the word "Since",
5 and by striking lines 3 through 6.

6 14. Page 6, line 13, by striking the word "one".

7 15. Page 6, by striking line 14.

8 16. Page 6, line 15, by striking the words "a.
9 Applying" and inserting in lieu thereof the word
10 "applying".

11 17. Page 6, by striking lines 20 through 29.

12 18. Page 8, line 20, by striking the word
13 "reasonable" and inserting in lieu thereof the word
14 "competitive".

15 19. Page 11, line 26, by inserting after the word
16 "optometrist," the word "pharmacist,".

17 20. Page 11, line 33, by inserting after the word
18 "include" the words "any amount representing loss
19 of earned income, whether part or future, in excess
20 of five hundred thousand dollars, and the damages
21 awarded shall not include".

22 21. Page 12, line 12, by inserting after the word
23 "optometrist," the word "pharmacist,".

24 22. Page 13, line 8, by inserting after the word
25 "optometrist," the word "pharmacist,".

H-3795 FILED
MAY 7, 1975

*A-adopted; B-lost, C as d, withdrawn, E-lost f-amended by 3925 and adopted 5/21
G-withdrawn, H-adopted J-w.d, K-adopted 5/21 (1888)
R-lost 5/21 (1884)
adopted - A, 7 (as amended by 3925), K, J 5/21*

BY MONROE of Des Moines

Sen. Commerce 5/28 - Without Recommendation 5/30

HOUSE FILE 803

By COMMITTEE ON COMMERCE
(As Amended and Passed by the House)

Passed House, ^{as amended by Senate} Date 6-9-75 (2271) Passed Senate, Date 6-5-75 (1786)
Vote: Ayes 84 Nays 2 Vote: Ayes 44 Nays 1
Approved 6-30

A BILL FOR

1 An Act relating to the compensation of persons suffering loss
2 as a result of medical malpractice.
3 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

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House Amendments _____

1 Section 1. The general assembly finds that a critical
2 situation exists because of the high cost and impending
3 unavailability of medical malpractice insurance. The purposes
4 of sections two (2) through twelve (12) of this Act are
5 to assure that the public is adequately protected against
6 losses arising out of medical malpractice by providing licensed
7 health care providers with medical malpractice insurance
8 through the requirement that certain liability insurance
9 carriers write medical malpractice insurance for a period
10 of two years upon a finding of an emergency by the commissioner
11 of insurance that either such insurance is not available
12 through normal channels or that it is not available on a
13 reasonable basis because of lack of competition for such
14 insurance, or otherwise; to establish an association to
15 equitably spread the risks for such insurance; and to provide
16 for recoupment of losses resulting from the operation of the
17 association through an assessment of the policyholders,
18 a surcharge on future liability insurance
19 policies, or a favorable premium tax treatment.

20 It is the intent of this Act to provide only an interim
21 solution to the impending unavailability of medical mal-
22 practice insurance. It is not anticipated that this Act will
23 resolve the underlying causes of the unavailability and high
24 cost which extend beyond the insurance mechanism. It is
25 anticipated that future legislation will be required to deal
26 on a more permanent basis with the underlying causes of the
27 current situation.

28 Sec. 2. NEW SECTION. DEFINITIONS. As used in this Act,
29 unless the context otherwise requires:

30 1. "Association" means the joint underwriting association
31 established pursuant to sections two (2) through twelve
32 (12) of this Act.

33 2. "Commissioner" means the commissioner of insurance
34 or a designee.

35 3. "Medical malpractice insurance" means insurance coverage

1 against the legal liability of the insured and against loss,
2 damage, or expense incident to a claim arising out of the
3 death or injury of any person as the result of negligence
4 or malpractice in rendering professional service by any
5 licensed physician, hospital, or other licensed health care
6 provider.

7 4. "Net direct premiums" means gross direct premiums
8 written on liability insurance as reported in the annual
9 statements filed by the insurers with the commissioner,
10 including the liability component of multiple peril package
11 policies as computed by the commissioner, less return premiums
12 for the unused or unabsorbed portions of premium deposits.

13 Sec. 3. NEW SECTION. TEMPORARY JOINT UNDERWRITING ASSO-
14 CIATION.

15 1. A temporary joint underwriting association is created,
16 consisting of all insurers authorized to write and engaged
17 in writing on a direct basis within this state liability
18 insurance, including insurers covering such peril in multiple
19 peril policies. Every such insurer shall be a member of the
20 association and shall remain a member as a condition of its
21 authority to continue to write liability insurance in this state.

22 | 2. The purpose of the association shall be to provide,
23 for a period not exceeding two years, a market for medical
24 malpractice insurance on a self-supporting basis without
25 subsidy from its members.

26 3. The association shall not commence underwriting opera-
27 tions for health care providers until the commissioner, after
28 notice and opportunity for hearing, has determined that medi-
29 cal malpractice insurance is not available at a reasonable
30 cost for a specific type of licensed health care provider
31 in the voluntary market. Upon such determination the
32 association shall be authorized to issue policies of medical
33 malpractice insurance for such specific type of health care
34 provider but need not be the exclusive agency through which
35 such insurance may be written on a primary basis in this

1 state.

2 If the commissioner determines at any time that medical
3 malpractice insurance can be made available in the voluntary
4 market at a reasonable price
5 for any specific type of licensed health care provider,
6 the association shall thereby cease underwriting medical mal-
7 practice insurance for that type of licensed health care pro-
8 vider.

9 4. The association shall, subject to the terms and condi-
10 tions of sections two (2) through twelve (12) of this Act,
11 have and exercise the following powers on behalf of its
12 members:

13 a. To issue, or to cause to be issued, policies of in-
14 surance to applicants, including incidental coverages and
15 subject to limits as specified in the plan of operation but
16 not to exceed one million dollars for each claimant under
17 one policy and three million dollars for all claimants under
18 one policy in any one year.

19 b. To underwrite such insurance and to adjust and pay
20 losses with respect thereto, or to appoint service companies
21 to perform those functions.

22 c. To assume reinsurance from its members.

23 d. To cede reinsurance.

24 Sec. 4. NEW SECTION. PLAN OF OPERATION.

25 1. The association shall submit a plan of operation to
26 the commissioner, together with any amendments necessary or
27 suitable to assure the fair, reasonable, and equitable
28 administration of the association consistent with sections
29 two (2) through twelve (12) of this Act. The plan of
30 operation and any amendments thereto shall become effective
31 only after promulgation of the plan or amendment by the
32 commissioner as a rule pursuant to section seventeen A point
33 four (17A.4) of the Code: Provided that the initial plan may
34 in the discretion of the commissioner become effective
35 immediately upon filing with the secretary of state pursuant

1 to subparagraph one (1) of paragraph b of subsection two (2)
2 of section seventeen A point five (17A.5) of the Code.

3 If the association fails to submit a suitable plan of
4 operation within twenty-five days following the effective
5 date of this Act or if at any time thereafter the association
6 fails to submit suitable amendments to the plan, the
7 commissioner shall
8 adopt rules necessary to effectuate sections two (2) through
9 twelve (12) of this Act. Such rules shall continue in force
10 until modified by the commissioner or superseded by a plan
11 submitted by the association and approved by the commissioner.

12 Any initial plan adopted by the commissioner pursuant
13 to this paragraph shall be exempt from the provisions
14 of section seventeen A point four (17A.4) of the Code,
15 and may, in the discretion of the commissioner, become
16 effective upon filing with the secretary of state
17 pursuant to subparagraph one (1) of paragraph b of
18 subsection two (2) of section seventeen A point five
19 (17A.5) of the Code.

20 2. The plan of operation shall provide for economic, fair
21 and nondiscriminatory administration, and for the prompt and
22 efficient provision of medical malpractice insurance. The
23 plan shall contain other provisions including, but not limited
24 to, preliminary assessment of all members for initial expenses
25 necessary to commence operations, establishment of necessary
26 facilities, management of the association, assessment of members
27 to defray losses and expenses, commission arrangements,
28 reasonable and objective underwriting standards, acceptance
29 and cession of reinsurance, appointment of servicing carriers
30 or other servicing arrangements and procedures for determining
31 amounts of insurance to be provided by the association.

32 3. All member insurers shall comply with the plan of
33 operation.

34 Sec. 5. NEW SECTION. POLICY FORMS AND RATES.

35 1. The rates, rating plans, rating classifications, and

1 policy forms and endorsements applicable to insurance writ-
2 ten by the association and the statistical and experience
3 data relating thereto shall be subject to sections two (2)
4 through twelve (12) of this Act and to the provisions of
5 the general insurance code which are not inconsistent with
6 the purposes and provisions of this Act.

7 2. All policies issued by the association shall provide
8 for a continuous period of coverage beginning with their
9 respective effective dates and terminating automatically at
10 12:01 a.m. on July 1, 1977, unless sooner terminated in ac-
11 cordance with sections two (2) through twelve (12) of this
12 Act, or unless terminated because of failure of the
13 policyholder to pay any premium or stabilization reserve
14 fund charge or portion of either when due.

15 All policies shall be subject to assessment as
16 provided in subsection (5) of this section. No policy
17 form shall be used by the
18 association unless it has been filed with and approved by
19 the commissioner.

20 3. The commissioner shall specify whether policy forms
21 and the rate structure shall be on a "claims-made" or "oc-
22 currence" basis and coverage shall be provided by the asso-
23 ciation only on the basis specified by the commissioner.
24 The commissioner shall specify the "claims-made" basis only
25 if the contract makes provision for residual "occurrence"
26 coverage upon the retirement, death, disability or removal
27 from this state of the insured. Provision may be made for
28 a premium charge allocable to any such residual "occurrence"
29 coverage and such premium charges for such residual coverage
30 shall be segregated and separately maintained for such pur-
31 pose which may include the reinsurance of all or a part of
32 that portion of the risk.

33 4. The rates, rating plans, rating rules, and rating
34 classifications applicable to the insurance written by the
35 association shall be on an actuarially sound basis,

1 and shall be calculated to
2 be self-supporting.

3 5. All policies issued by the association shall be sub-
4 ject to an annual assessment upon the policyholders as required
5 to recoup any deficit sustained by the association in any one
6 year, such assessment not to exceed one additional premium
7 at the then current rate. Failure to pay such assessment
8 when due shall result in the suspension of the licensed
9 health care provider's license to practice his or her profession
10 in this state.

11 6. The association shall certify to the commissioner the
12 estimated amount of any deficit remaining after assessment
13 of the policyholders as provided in subsection five (5).
14 Within sixty days after that certification the commissioner
15 shall authorize the members of the association to commence
16 recoupment of their respective shares of the deficit by one
17 of the following procedures:

18 a. Applying a surcharge to be determined by the associa-
19 tion at a rate not to exceed two percent of the annual pre-
20 miums on future policies affording those kinds of insurance
21 which form the basis for their participation in the associa-
22 tion.

23 b. Deducting their share of the deficit from past or
24 future premium taxes due the state of Iowa.
25 If the commissioner fails within sixty days to authorize one
26 of the above procedures, each member of the association may
27 commence recoupment of its deficit by the premium tax offset
28 described above. The association shall amend the amount of
29 its certification of deficit to the commissioner as the values
30 of its incurred losses become finalized and the members of
31 the association shall amend their recoupment procedure
32 accordingly.

33 7. In the event that sufficient funds are not available
34 for the sound financial operation of the association, all
35 members shall contribute to the financial requirements of

1 the association in the manner provided for in section seven
2 (7) of this Act. Any contribution shall be reimbursed to
3 the members by recoupment as provided in subsection six (6)
4 of this section.

5 Sec. 6. NEW SECTION. PROCEDURES.

6 1. Upon a finding by the commissioner, after notice and
7 opportunity for hearing, that medical malpractice insurance
8 is not available at a reasonable cost for a specific type
9 of licensed health care provider in the voluntary market and
10 upon notification of that finding to the association, any
11 licensed health care provider of the type specified in the
12 commissioner's finding shall be entitled to apply to the
13 association for medical malpractice insurance coverage. The
14 application may be made on behalf of a licensed health care
15 provider by an authorized agent.

16 2. If the association determines that the applicant meets
17 the underwriting standards of the association as prescribed
18 in the plan of operation, then the association, upon receipt
19 of the premium or such portion thereof as is prescribed in
20 the plan of operation, shall cause to be issued a policy of
21 medical malpractice insurance.

22 Sec. 7. NEW SECTION. PARTICIPATION. All members of the
23 association shall participate in its writings, expenses,
24 servicing allowance, management fees and losses in the pro-
25 portion that the net direct premiums of each member, exclud-
26 ing that portion of premiums attributable to the operation
27 of the association, written during the preceding calendar
28 year bears to the aggregate net direct premiums written in
29 this state by all members of the association. Each member's
30 proportion shall be determined annually on the basis of the
31 annual statements and other reports filed by the insurer with
32 the commissioner.

33 Sec. 8. NEW SECTION. GOVERNING BOARD.

34 1. The association shall be governed by a board of eleven
35 directors of whom three shall be appointed annually by the

1 commissioner to represent the licensed health care providers.
2 Eight members shall be elected annually, except as provided
3 in subsection two (2) of this section, by the members of the
4 association. Vacancies on the board shall be filled for the
5 remaining period of the term by majority vote of the remaining
6 directors subject to approval of the commissioner.

7 2. Within fifteen days after the effective date of this
8 Act the commissioner shall designate a time and place for
9 a meeting of the members of the association at which the eight
10 elected members serving on the first board shall be elected.
11 The commissioner shall appoint the appointive members of the
12 board on or before the date of such meeting.

13 The commissioner may, prior to the first meeting of the
14 members of the association, appoint an interim governing board
15 of the association consisting of eight member insurers and
16 three representatives of the licensed health care providers.
17 The eight member insurers of that interim governing board
18 shall serve until their successors are elected by the members
19 of the association. In appointing members of the association
20 to the interim governing board, the commissioner shall con-
21 sider among other things whether all member insurers are
22 fairly represented.

23 Sec. 9. NEW SECTION. APPEALS AND JUDICIAL REVIEW.

24 1. Any applicant or any person insured pursuant to section
25 six (6) of this Act, or a legal representative, or any
26 affected insurer, may appeal to the commissioner within thirty
27 days after any ruling, action or decision by or on behalf
28 of the association, with respect to those items the plan of
29 operation defines as appealable matters.

30 2. All orders of the commissioner made pursuant to sections
31 two (2) through twelve (12) of this Act shall be subject
32 to judicial review as provided in the Iowa administrative
33 procedure Act.

34 Sec. 10. NEW SECTION. ANNUAL STATEMENTS. The association
35 shall file in the office of the commissioner on or before

1 the first day of March each year, a statement as prescribed
2 by the commissioner. The statement shall contain matters
3 and information required by the commissioner including, but
4 not limited to, information with respect to its transactions,
5 condition, operations and affairs during the preceding year,
6 and shall be in a form approved by the commissioner. The
7 commissioner may, at any time, require the association to
8 furnish additional information with respect to matters
9 considered to be material to the scope, operation and
10 experience of the association.

11 Sec. 11. NEW SECTION. EXAMINATIONS. The commissioner
12 shall make an examination of the association at least annually.
13 The expenses of each examination shall be paid by the
14 association.

15 Sec. 12. NEW SECTION. PRIVILEGED COMMUNICATIONS. There
16 shall be no liability on the part of, and no cause of action
17 of any nature shall arise against the association, the commis-
18 sioner, or any other person or organization, for any statements
19 made in good faith by any of them in any report or communica-
20 tion concerning risks insured or to be insured by the associa-
21 tion, or during any proceedings within the scope of sections
22 two (2) through twelve (12) of this Act.

23 Sec. 13. Section one hundred forty-seven point one (147.1),
24 Code 1975, is amended by adding the following new subsections:

25 NEW SUBSECTION. "Peer review" means evaluation of pro-
26 fessional services rendered by a person licensed to practice
27 a profession.

28 NEW SUBSECTION. "Peer review committee" means one or more
29 persons acting in a peer review capacity who also serve as
30 an officer, director, trustee, agent, or member of any of
31 the following:

32 a. A state or local professional society of a profession
33 for which there is peer review.

34 b. Any organization approved to conduct peer review by
35 a society as designated in paragraph a of this subsection.

- 1 c. The medical staff of any licensed hospital.
2 d. An examining board.

3 Sec. 14. Chapter one hundred forty-seven (147), Code 1975,
4 is amended by adding the following new section:

5 NEW SECTION. A person shall not be civilly liable as a
6 result of acts, omissions, or decisions made in connection
7 with the person's service on a peer review committee. However,
8 such immunity from civil liability shall not apply if an act,
9 omission, or decision is made with malice.

10 Sec. 15. Chapter one hundred forty-seven (147), Code 1975,
11 is amended by adding the following new section:

12 NEW SECTION. In an action for damages for personal injury
13 against a physician and surgeon, osteopath, osteopathic
14 physician and surgeon, dentist, podiatrist, optometrist,
15 pharmacist,

16 chiropractor, or nurse licensed to practice that profession
17 in this state, or against a hospital licensed for operation
18 in this state, based on the alleged negligence of the
19 practitioner in the practice of the profession or occupation,
20 or upon the alleged negligence of the hospital in patient
21 care, in which liability is admitted or established, the
22 damages awarded shall not include actual economic losses
23 incurred or to be incurred in the future by the claimant by
24 reason of the personal injury, including but not limited to,
25 the cost of reasonable and necessary medical care,
26 rehabilitation services, and custodial care, and the loss
27 of services and loss of earned income, to the extent that
28 those losses are replaced or are indemnified by insurance,
29 or by governmental, employment, or service benefit programs
30 or from any other source except the assets of the claimant
31 or of the members of the claimant's immediate family.

32 Sec. 16. Chapter one hundred forty-seven (147), Code 1975,
33 is amended by adding thereto the following new section:

34 NEW SECTION. A consent in writing to any medical or
35 surgical procedure or course of procedures in patient care

1 which meets the requirements of this section shall be
2 conclusively presumed to be valid and effective, in the
3 absence of clear proof that execution of the consent was
4 induced by fraudulent misrepresentation of material facts.
5 Unless fraudulent misrepresentation of material facts is
6 established, no evidence shall be admissible to impeach,
7 modify or limit the authorization for performance of the
8 procedure or procedures set forth in that written consent. A
9 consent in writing meets the requirements of this section if it:

10 1. Sets forth in general terms the nature and purpose of
11 the procedure or procedures, together with the known risks, if
12 any, of death, brain damage, quadriplegia, paraplegia, the loss
13 or loss of function of any organ or limb, or disfiguring scars
14 associated with such procedure or procedures, with the
15 probability of each such risk if reasonably determinable.

16 2. Acknowledges that the disclosure of that information has
17 been made and that all questions asked about the procedure or
18 procedures have been answered in a satisfactory manner.

19 3. Is signed by the patient for whom the procedure is to
20 be performed, or if the patient for any reason lacks legal
21 capacity to consent, is signed by a person who has legal
22 authority to consent on behalf of that patient in those
23 circumstances.

24 Sec. 17. Section five hundred nineteen point one (519.1),
25 Code 1975, is amended to read as follows:

26 519.1 AUTHORIZATION. Any number of physicians, druggists,
27 dentists, and graduate nurses, licensed to practice their
28 profession in this state, and hospitals licensed under chapter
29 one hundred thirty-five B (135B) of the Code, may, by complying
30 with the provisions of this chapter and without regard to other
31 statutory provisions, enter into contracts with each other for
32 the purpose of protecting themselves by insurance against loss
33 by reason of actions at law on account of their alleged error,
34 mistake, negligence, or carelessness in the treatment
35 and care of patients, including the performance of surgical

1 operations, or in the prescribing and dispensing of drugs
2 and medicines, or for loss by reason of damages in other
3 respects, and to reimburse any member in case of such loss.

4 Sec. 18. Section five hundred nineteen point two (519.2),
5 Code 1975, is amended to read as follows:

6 519.2 INCORPORATION--POWERS. All corporations,
7 organized for the purpose of transacting such insurance
8 business under the provisions of this chapter, shall incorporate
9 under the provisions of chapter 491, and be known as mutual
10 corporations; and are hereby empowered to collect such
11 assessments, or premium payments, provided for in their
12 articles of incorporation or bylaws, as are required to pay
13 losses and expenses incurred in the conduct of their business
14 and to cede reinsurance. Such mutual insurance corporations
15 may issue certificates of membership, or policies; and may
16 provide that all assessments, or premium payments, payable
17 thereunder, be made in cash, or on the installment, or
18 assessment plan.

19 Sec. 19. Section five hundred nineteen point five (519.5),
20 Code 1975, is amended to read as follows:

21 519.5 CONDITIONS. No such certificate shall be issued by
22 the commissioner of insurance until two hundred fifty applications
23 have been received, ~~representing, in the aggregate, one million~~
24 ~~dollars of insurance,~~ and until the commissioner of insurance
25 has satisfied himself that such mutual insurance corporation
26 has bona fide applications representing the number of applicants
27 ~~and the amount of insurance herein~~ required, and that there is
28 in the possession of such mutual insurance corporation cash
29 assets amounting to not less than ten ~~thousand dollars~~ times
30 the maximum single retained risk.

31 Sec. 20. Section five hundred nineteen point six (519.6),
32 Code 1975, is amended to read as follows:

33 519.6 REPORTS. Such mutual insurance corporations doing
34 business under the provisions of this chapter shall, annually,
35 ~~in the month of January~~ before the first day of March, report

1 to the commissioner of insurance, upon blanks furnished by him,
2 the same facts, so far as applicable, as are required to be
3 furnished by mutual insurance associations under the statutes
4 of Iowa, which report shall be tabulated by the commissioner
5 of insurance and published by him in the annual report on
6 insurance.

7 Sec. 21. Section five hundred nineteen point eight
8 (519.8), Code 1975, is amended to read as follows:

9 519.8 CANCELLATION OF POLICY. Any certificate of member-
10 ship, or policy, issued by such a mutual insurance corporation
11 may be canceled by the corporation by giving ~~five~~ thirty days'
12 written notice thereof to the insured; or such cancellation
13 may be upon demand of the insured; and such cancellation,
14 when so made, either by the corporation or by the insured,
15 shall be upon a pro rata basis, and the cancellation of such
16 certificate or policy shall release the member from all other
17 future obligations to such corporation.

18 Sec. 22. Section five hundred nineteen point nine (519.9),
19 Code 1975, is amended to read as follows:

20 519.9 FEES. Such a mutual insurance corporation shall pay
21 the same fees for admission into the state, for annual reports,
22 and for annual certificates of authority as are required to
23 be paid by domestic mutual companies organized and doing
24 business under chapter 515; such certificate shall expire
25 ~~March-1~~ May first of the year following the date of its issue.

26 Sec. 23. Section five hundred nineteen point twelve
27 (519.12), Code 1975, is amended to read as follows:

28 519.12 FOREIGN COMPANIES. Any mutual insurance association
29 organized under the laws of any other state, for the purpose
30 of transacting the kind of business described in this chapter,
31 ~~and which has been-in-business-not-less-than-one-year,-and-has~~
32 on hand ~~cash-assets-in-an-amount-of~~ surplus amounting to not less
33 than ten ~~thousand-dollars~~ times the maximum single retained risk,
34 and has not less than ~~three~~ two hundred ~~fifty~~ members, shall
35 may upon application, be admitted to do business in this state

1 if the commissioner finds such admission is in the public interest;
2 and shall thereafter make all reports and be subject to
3 taxation, examination, and supervision by the commissioner
4 of insurance to the same extent and in the same manner as
5 are domestic corporations organized under the provisions
6 of this chapter.

7 Sec. 24. Chapter one hundred forty-seven (147), Code 1975,
8 is amended by adding the following new section:

9 NEW SECTION. In any action for personal injury or
10 wrongful death against any health care practitioner licensed
11 under this chapter or a hospital licensed for operation in
12 this state, based upon the alleged negligence of the licensee
13 in the practice of that profession or occupation, or upon
14 the alleged negligence of the hospital in patient care,
15 the court shall determine the reasonableness of any contingent
16 fee arrangement between the plaintiff and the plaintiff's
17 attorney.

18 Sec. 25. Section six hundred fourteen point one (614.1),
19 Code 1975, is amended by adding the following new subsection:

20 NEW SUBSECTION. MALPRACTICE. Those founded on injuries
21 to the person or wrongful death against any physician and
22 surgeon, osteopath, osteopathic physician and surgeon,
23 dentist, podiatrist, optometrist, chiropractor, or nurse,
24 licensed under chapter one hundred forty-seven (147) of
25 the Code, or a hospital licensed under chapter one hundred
26 thirty-five B (135B) of the Code, arising out of patient care,
27 within two years after the date on which the claimant knew,
28 or through the use of reasonable diligence should have known,
29 or received notice in writing of the existence of, the injury
30 or death for which damages are sought in the action, which-
31 ever of the dates occurs first, but in no event shall any
32 action be brought more than six years after the date on which
33 occurred the act or omission or occurrence alleged in the
34 action to have been the cause of the injury or death unless
35 a foreign object unintentionally left in the body caused

1 the injury or death.

2 Sec. 26. Chapter six hundred nineteen (619), Code 1975,
3 is amended by adding the following new section:

4 NEW SECTION. In an action for personal injury or wrongful
5 death against a physician and surgeon, osteopath, osteopathic
6 physician and surgeon, dentist, podiatrist, optometrist,
7 pharmacist,

8 chiropractor, or nurse licensed to practice that profession
9 in this state, or against a hospital licensed for operation
10 in this state, based upon the alleged negligence of the
11 practitioner in the practice of the profession or occupation,
12 or upon the alleged negligence of the hospital in patient
13 care, the amount of money damages demanded shall not be stated
14 in the petition, or original notice, or in any counterclaim
15 or cross petition.

16 Sec. 27. This Act, being deemed of immediate importance,
17 shall take effect and be in force from and after its publica-
18 tion in Iowa City Press-Citizen, a newspaper published in
19 Iowa City, Iowa, and in Marshalltown Times-, a
20 newspaper published in Marshalltown, Iowa. Republican

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S-4072

1 Amend the Rabedeaux amendment S-4028 to House File
2 803 as amended, passed and reprinted by the House, on
3 page 11, by inserting after line 8 the following new
4 section:
5 "Sec. _____. Section six hundred fourteen point one (614.1),
6 Code 1975, is amended by adding the following new subsection:
7 NEW SUBSECTION. MALPRACTICE. Those founded on injuries
8 to the person or wrongful death against any physician and
9 surgeon, osteopath, osteopathic physician and surgeon,
10 dentist, podiatrist, optometrist, chiropractor, or nurse,
11 licensed under chapter one hundred forty-seven (147) of
12 the Code, or a hospital licensed under chapter one hundred
13 thirty-five B (135B) of the Code, arising out of patient care,
14 within two years after the date on which the claimant knew,
15 or through the use of reasonable diligence should have known,
16 or received notice in writing of the existence of, the injury
17 or death for which damages are sought in the action, which-
18 ever of the dates occurs first, but in no event shall any
19 action be brought more than six years after the date on which
20 occurred the act or omission or occurrence alleged in the
21 action to have been the cause of the injury or death unless
22 a foreign object unintentionally left in the body caused
23 the injury or death."

S-4072 FILED & LOST (1773) BY WARREN E. CURTIS
JUNE 5, 1975 DALE L. TIEDEN

S-4075

1 Amend House File 803, as amended, passed and
2 reprinted by the House as follows:
3 1. Page 11, line 1, by striking the word "be".
4 2. Page 11, by striking lines 2 through 8 and
5 inserting in lieu thereof the following:
6 "create a presumption that informed consent was
7 given. A".

S-4075 FILED AND ADOPTED (1796) BY GENE W. GLENN
JUNE 5, 1975

HOUSE FILE 803

S-4031

1 Amend House File 803, as amended, passed and re-
2 printed by the House, as follows:
3 1. Page 14, line 32, by striking the word "six"
4 and inserting in lieu thereof the word "four".

S-4031 FILED - *Last 6/5* (1784) BY DALE L. TIEDEN
JUNE 4, 1975

1 two hundred fifty members, ~~shall~~ may upon application,
2 be admitted to do business in this state if the
3 commissioner finds such admission is in the public
4 interest; and shall thereafter make all reports and
5 be subject to taxation, examination, and supervision
6 by the commissioner of insurance to the same extent
7 and in the same manner as are domestic corporations
8 organized under the provisions of this chapter."

S-4028 FILED - *Lost 6/5 (1773)* BY W. R. RABEDEAUX
JUNE 3, 1975

1 ~~the number of applicants and the amount of insurance~~
2 ~~herein~~ required, and that there is in the possession
3 of such mutual insurance corporation cash assets
4 amounting to not less than ten ~~thousand dollars~~ times
5 the maximum single retained risk.

6 Sec. 17. Section five hundred nineteen point six
7 (519.6), Code 1975, is amended to read as follows:

8 519.6 REPORTS. Such mutual insurance corporations
9 doing business under the provisions of this chapter
10 shall, annually, ~~in the month of January~~ before the
11 first day of March, report to the commissioner of
12 insurance, upon blanks furnished by him, the same
13 facts, so far as applicable, as are required to be
14 furnished by mutual insurance associations under the
15 statutes of Iowa, which report shall be tabulated
16 by the commissioner of insurance and published by
17 him in the annual report on insurance.

18 Sec. 18. Section five hundred nineteen point eight
19 (519.8), Code 1975, is amended to read as follows:

20 519.8 CANCELLATION OF POLICY. Any certificate
21 of membership, or policy, issued by such a mutual
22 insurance corporation may be canceled by the
23 corporation by giving ~~five~~ thirty days' written notice
24 thereof to the insured; or such cancellation may be
25 upon demand of the insured; and such cancellation,
26 when so made, either by the corporation or by the
27 insured, shall be upon a pro rata basis, and the
28 cancellation of such certificate or policy shall
29 release the member from all other future obligations
30 to such corporation.

31 Sec. 19. Section five hundred nineteen point nine
32 (519.9), Code 1975, is amended to read as follows:

33 519.9 FEES. Such a mutual insurance corporation
34 shall pay the same fees for admission into the state,
35 for annual reports, and for annual certificates of
36 authority as are required to be paid by domestic
37 mutual companies organized and doing business under
38 chapter 515; such certificate shall expire ~~March 4~~
39 May first of the year following the date of its issue.

40 Sec. 20. Section five hundred nineteen point
41 twelve (519.12), Code 1975, is amended to read as
42 follows:

43 519.12 FOREIGN COMPANIES. Any mutual insurance
44 association organized under the laws of any other
45 state, for the purpose of transacting the kind of
46 business described in this chapter, and which has
47 ~~been in business not less than one year, and has on~~
48 ~~hand cash assets in an amount of surplus amounting~~
49 ~~to not less than ten thousand dollars~~ times the maximum
50 single retained risk, and has not less than ~~three~~

1 by any of them in any report or communication
2 concerning risks insured or to be insured by the
3 association, or during any proceedings within the
4 scope of sections two (2) through thirteen (13) of
5 this Act.

6 Sec. 14. Section five hundred nineteen point one
7 (519.1), Code 1975, is amended to read as follows:

8 519.1 AUTHORIZATION. Any number of physicians,
9 ~~druggists~~ and surgeons, osteopaths, osteopathic
10 physicians and surgeons, podiatrists, chiropractors,
11 pharmacists, dentists, and graduate nurses, licensed
12 to practice their profession in this state, and
13 hospitals licensed under chapter one hundred thirty-
14 five B (135B) of the Code, may, by complying with
15 the provisions of this chapter and without regard
16 to other statutory provisions, enter into contracts
17 with each other for the purpose of protecting
18 themselves by insurance against loss by reason of
19 actions at law on account of their alleged error,
20 mistake, negligence, or carelessness in the treatment
21 and care of patients, including the performance of
22 surgical operations, or in the prescribing and
23 dispensing of drugs and medicines, or for loss by
24 reason of damages in other respects, and to reimburse
25 any member in case of such loss.

26 Sec. 15. Section five hundred nineteen point two
27 (519.2), Code 1975, is amended to read as follows:

28 519.2 INCORPORATION--POWERS. All corporations,
29 organized for the purpose of transacting such insurance
30 business under the provisions of this chapter, shall
31 incorporate under the provisions of chapter 491, and
32 be known as mutual corporations; and are hereby
33 empowered to collect such assessments, or premium
34 payments, provided for in their articles of
35 incorporation or bylaws, as are required to pay losses
36 and expenses incurred in the conduct of their business
37 and to cede reinsurance. Such mutual insurance
38 corporations may issue certificates of membership,
39 or policies; and may provide that all assessments,
40 or premium payments, payable thereunder, be made in
41 cash, or on the installment, or assessment plan.

42 Sec. 16. Section five hundred nineteen point five
43 (519.5), Code 1975, is amended to read as follows:

44 519.5 CONDITIONS. No such certificate shall be
45 issued by the commissioner of insurance until two
46 hundred fifty applications have been received,
47 ~~representing, in the aggregate, one million dollars~~
48 ~~of insurance,~~ and until the commissioner of insurance
49 has satisfied himself that such mutual insurance
50 corporation has bona fide applications representing

1 association at which the eight elected governors
2 serving on the first board shall be elected. The
3 commissioner shall appoint the appointive governors
4 of the board on or before the date of such meeting.
5 The commissioner may, prior to the first meeting
6 of the members of the association, appoint an interim
7 governing board of the association consisting of eight
8 member insurers and three representatives of the
9 licensed health care providers. The eight member
10 insurers of that interim governing board shall serve
11 until their successors are elected by the members
12 of the association. In appointing members of the
13 association to the interim governing board, the
14 commissioner shall consider among other things whether
15 all member insurers are fairly represented.

16 Sec. 10. NEW SECTION. APPEALS AND JUDICIAL REVIEW.

17 1. Any applicant or any person insured pursuant
18 to section seven (7) of this Act, or a legal
19 representative, or any affected insurer, may appeal
20 to the commissioner within thirty days after any
21 ruling, action or decision by or on behalf of the
22 association, with respect to those items the plan
23 of operation defines as appealable matters.

24 2. All orders of the commissioner made pursuant
25 to sections two (2) through thirteen (13) of this
26 Act shall be subject to judicial review as provided
27 in the Iowa administrative procedure Act.

28 Sec. 11. NEW SECTION. ANNUAL STATEMENTS. The
29 association shall file in the office of the
30 commissioner on or before the first day of March each
31 year, a statement as prescribed by the commissioner.
32 The statement shall contain matters and information
33 required by the commissioner including, but not limited
34 to, information with respect to its transactions,
35 condition, operations and affairs during the preceding
36 year, and shall be in a form approved by the
37 commissioner. The commissioner may, at any time,
38 require the association to furnish additional
39 information with respect to matters considered to
40 be material to the scope, operation and experience
41 of the association.

42 Sec. 12. NEW SECTION. EXAMINATIONS. The
43 commissioner shall make an examination of the
44 association at least annually. The expenses of each
45 examination shall be paid by the association.

46 Sec. 13. NEW SECTION. PRIVILEGED COMMUNICATIONS.
47 There shall be no liability on the part of, and no
48 cause of action of any nature shall arise against
49 the association, the commissioner, or any other person
50 or organization, for any statements made in good faith

1 discharged. Any monies remaining in the fund after
2 all such retrospective premium charges have been paid
3 shall be returned to policyholders pursuant to
4 procedures authorized by the directors.

5 Sec. 7. NEW SECTION. PROCEDURES.

6 1. Upon a finding by the commissioner, after
7 notice and opportunity for hearing, that medical
8 malpractice insurance is not available at a reasonable
9 cost for a specific type of licensed health care
10 provider in the voluntary market and upon notification
11 of that finding to the association, any licensed
12 health care provider of the type specified in the
13 commissioner's finding shall be entitled to apply
14 to the association for medical malpractice insurance
15 coverage. The application may be made on behalf of
16 a licensed health care provider by an authorized
17 agent.

18 2. If the association determines that the applicant
19 meets the underwriting standards of the association
20 as prescribed in the plan of operation, then the
21 association, upon receipt of the premium or such
22 portion thereof as is prescribed in the plan of
23 operation, shall cause to be issued a policy of medical
24 malpractice insurance.

25 Sec. 8. NEW SECTION. PARTICIPATION. All members
26 of the association shall participate in its writings,
27 expenses, servicing allowance, management fees and
28 losses in the proportion that the net direct premiums
29 of each member, excluding that portion of premiums
30 attributable to the operation of the association,
31 written during the preceding calendar year bears to
32 the aggregate net direct premiums written in this
33 state by all members of the association. Each member's
34 proportion shall be determined annually on the basis
35 of the annual statements and other reports filed by
36 the insurer with the commissioner.

37 Sec. 9. NEW SECTION. GOVERNING BOARD.

38 1. The association shall be governed by a board
39 of eleven governors of whom three shall be appointed
40 annually by the commissioner to represent the licensed
41 health care providers. Eight governors shall be
42 elected annually, except as provided in subsection
43 two (2) of this section, by the members of the
44 association. Vacancies on the board shall be filled
45 for the remaining period of the term by majority vote
46 of the remaining governors subject to approval of
47 the commissioner.

48 2. Within fifteen days after the effective date
49 of this Act the commissioner shall designate a time
50 and place for a meeting of the members of the

1 The fund shall be administered by three directors,
2 one of whom shall be the commissioner. The remaining
3 two directors shall be appointed by the commissioner:
4 One shall be a representative of the association and
5 the other a representative of its policyholders.

6 2. The directors shall act by majority vote with
7 two directors constituting a quorum for the transaction
8 of any business or the exercise of any power of the
9 fund. The directors shall serve without salary, but
10 each director other than the commissioner shall be
11 reimbursed for actual and necessary expenses incurred
12 in the performance of official duties as a director.
13 The directors shall not be subject to any personal
14 liability with respect to the administration of the
15 fund for acts or decisions made in good faith pursuant
16 to the provisions of this Act.

17 3. Each policyholder shall pay to the association
18 a stabilization reserve fund charge determined by
19 the directors which shall not exceed the amount of
20 one annual premium due for insurance through the
21 association. Such charge shall be separately stated
22 in the policy. The association shall cancel the
23 policy of any policyholder who fails to pay the
24 stabilization reserve fund charge.

25 4. The association shall promptly pay to the fund
26 all stabilization reserve fund charges which it
27 collects from its policyholders and any retrospective
28 premium refunds payable under any group retrospective
29 rating plan approved by the commissioner under the
30 provisions of this Act.

31 5. All monies received by the fund shall be held
32 in trust by a corporate trustee selected by the
33 directors. The corporate trustee may invest the
34 monies held in trust, subject to the approval of the
35 directors. All investment income shall be credited
36 to the fund, and all expenses of administration of
37 the fund shall be charged against the fund. The
38 monies held in trust shall be used solely for the
39 purpose of discharging when due any retrospective
40 premium charges payable by policyholders of the
41 association under the group retrospective rating plan
42 approved by the commissioner. Payment of retrospective
43 premium charges shall be made by the directors upon
44 certification to them by the association of the amount
45 due. If all monies accruing to the fund are finally
46 exhausted in payment of retrospective premium charges,
47 all liability and obligations of the association's
48 policyholders with respect to the payment of
49 retrospective premium charges shall thereupon terminate
50 and shall be conclusively presumed to have been

1 5. All policies issued by the association shall
2 be subject to a nonprofit group retrospective rating
3 plan to be approved by the commissioner under which
4 the final premium for all policyholders of the
5 association, as a group, will be equal to the
6 administrative expenses, loss and loss adjustment
7 expenses and taxes, plus a reasonable allowance for
8 contingencies and servicing. Policyholders shall
9 be given full credit for all investment income, net
10 of expenses and a reasonable management fee, on
11 policyholder supplied funds. The standard premium,
12 before retrospective adjustment, for each policy
13 issued by the association shall be established for
14 portions of the policy period coinciding with the
15 association's fiscal year on the basis of the
16 association's rates, rating plans, rating rules, and
17 rating classifications then in effect. The maximum
18 final premium for all policyholders of the associa-
19 tion, as a group, shall be limited as provided in
20 subsection five (5) of section six (6) of this Act.
21 Since the business of the association is subject to
22 the nonprofit group retrospective rating plan required
23 by this subsection, there shall be a presumption that
24 the rates filed and premiums imposed by the association
25 are not unreasonable or excessive.

26 6. The association shall certify to the
27 commissioner the estimated amount of any deficit
28 remaining after the stabilization reserve fund has
29 been exhausted in payment of the maximum final premium
30 for all policyholders of the association. Within
31 sixty days after that certification the commissioner
32 shall authorize the members of the association to
33 commence recoupment of their respective shares of
34 the deficit by deducting their share of the deficit
35 from past or future premium taxes due the state of
36 Iowa. The association shall amend the amount of its
37 certification of deficit to the commissioner as the
38 values of its incurred losses become finalized and
39 the members of the association shall amend their
40 recoupment procedure accordingly.

41 7. In the event that sufficient funds are not
42 available for the sound financial operation of the
43 association, all members shall contribute to the
44 financial requirements of the association in the
45 manner provided for in section eight (8) of this Act.
46 Any contribution shall be reimbursed to the members
47 by recoupment as provided in subsection six (6) of
48 this section.

49 Sec. 6. NEW SECTION. STABILIZATION RESERVE FUND.
50 1. There is created a stabilization reserve fund.

1 reinsurance, appointment of servicing carriers or
2 other servicing arrangements and procedures for
3 determining amounts of insurance to be provided by
4 the association.

5 3. All member insurers shall comply with the plan
6 of operation.

7 Sec. 5. NEW SECTION. POLICY FORMS AND RATES.

8 1. The rates, rating plans, rating classifications,
9 and policy forms and endorsements applicable to
10 insurance written by the association and the
11 statistical and experience data relating thereto shall
12 be subject to sections two (2) through thirteen (13)
13 of this Act and to the provisions of the general
14 insurance code which are not inconsistent with the
15 purposes and provisions of this Act.

16 2. All policies issued by the association shall
17 provide for a continuous period of coverage beginning
18 with their respective effective dates and terminating
19 automatically at 12:01 a.m. on July 1, 1977, unless
20 sooner terminated in accordance with sections two
21 (2) through thirteen (13) of this Act, or unless
22 terminated because of failure of the policyholder
23 to pay any premium or stabilization reserve fund
24 charge or portion of either when due. All policies
25 shall be issued subject to the group retrospective
26 rating plan and the stabilization reserve fund
27 authorized by this Act. No policy form shall be used
28 by the association unless it has been filed with and
29 approved by the commissioner.

30 3. The commissioner shall specify whether policy
31 forms and the rate structure shall be on a "claims-
32 made" or "occurrence" basis and coverage shall be
33 provided by the association only on the basis specified
34 by the commissioner. The commissioner shall specify
35 the "claims-made" basis only if the contract makes
36 provision for residual "occurrence" coverage upon
37 the retirement, death, disability or removal from
38 this state of the insured. Provision may be made
39 for a premium charge allocable to any such residual
40 "occurrence" coverage and such premium charges for
41 such residual coverage shall be segregated and
42 separately maintained for such purpose which may
43 include the reinsurance of all or a part of that
44 portion of the risk.

45 4. The rates, rating plans, rating rules, and
46 rating classifications applicable to the insurance
47 written by the association shall be on an actuarially
48 sound basis, giving due consideration to the group
49 retrospective rating plan and the stabilization reserve
50 fund, and shall be calculated to be self-supporting.

- 1 a. To issue, or to cause to be issued, policies
- 2 of insurance to applicants, including incidental
- 3 coverages and subject to limits as specified in the
- 4 plan of operation but not to exceed one million dollars
- 5 for each claimant under one policy and three million
- 6 dollars for all claimants under one policy in any
- 7 one year.
- 8 b. To underwrite such insurance and to adjust
- 9 and pay losses with respect thereto, or to appoint
- 10 service companies to perform those functions.
- 11 c. To assume reinsurance from its members.
- 12 d. To cede reinsurance.

13 Sec. 4. NEW SECTION. PLAN OF OPERATION.

14 1. The association shall submit a plan of operation

15 to the commissioner, together with any amendments

16 necessary or suitable to assure the fair, reasonable,

17 and equitable administration of the association

18 consistent with sections two (2) through thirteen

19 (13) of this Act. The plan of operation and any

20 amendments thereto shall become effective only after

21 promulgation of the plan or amendment by the

22 commissioner as a rule pursuant to section seventeen

23 A point four (17A.4) of the Code: Provided that the

24 initial plan may in the discretion of the commissioner

25 become effective immediately upon filing with the

26 secretary of state pursuant to subparagraph one (1)

27 of paragraph b of subsection two (2) of section

28 seventeen A point five (17A.5) of the Code.

29 If the association fails to submit a suitable plan

30 of operation within twenty-five days following the

31 effective date of this Act or if at any time thereafter

32 the association fails to submit suitable amendments

33 to the plan, the commissioner shall, after notice

34 and opportunity for hearing, adopt rules necessary

35 to effectuate sections two (2) through thirteen (13)

36 of this Act. Such rules shall continue in force until

37 modified by the commissioner or superseded by a plan

38 submitted by the association and approved by the

39 commissioner.

40 2. The plan of operation shall provide for

41 economic, fair and nondiscriminatory administration,

42 and for the prompt and efficient provision of medical

43 malpractice insurance. The plan shall contain other

44 provisions including, but not limited to, preliminary

45 assessment of all members for initial expenses

46 necessary to commence operations, establishment of

47 necessary facilities, management of the association,

48 assessment of members to defray losses and expenses,

49 commission arrangements, reasonable and objective

50 underwriting standards, acceptance and cession of

1 in the annual statements filed by the insurers with
2 the commissioner, including the liability component
3 of multiple peril package policies as computed by
4 the commissioner, less return premiums for the unused
5 or unabsorbed portions of premium deposits.

6 5. "Licensed health care provider" means and
7 includes a physician and surgeon, osteopath,
8 osteopathic physician and surgeon, dentist, podiatrist,
9 optometrist, pharmacist, chiropractor or nurse licensed
10 pursuant to chapter one hundred forty-seven (147)
11 of the Code, and a hospital licensed pursuant to
12 chapter one hundred thirty-five B (135B) of the Code.

13 Sec. 3. NEW SECTION. TEMPORARY JOINT UNDERWRITING
14 ASSOCIATION.

15 1. A temporary joint underwriting association
16 is created, consisting of all insurers authorized
17 to write and engaged in writing on a direct basis
18 within this state liability insurance, including
19 insurers covering such peril in multiple peril poli-
20 cies. Every such insurer shall be a member of the
21 association and shall remain a member as a condition
22 of its authority to continue to write liability
23 insurance in this state.

24 2. The purpose of the association shall be to
25 provide, for a period not exceeding two years, a
26 market for medical malpractice insurance on a self-
27 supporting basis without subsidy from its members.

28 3. The association shall not commence underwriting
29 operations for health care providers until the
30 commissioner, after notice and opportunity for hearing,
31 has determined that medical malpractice insurance
32 is not available at a reasonable cost for a specific
33 type of licensed health care provider in the voluntary
34 market. Upon such determination the association shall
35 be authorized to issue policies of medical malpractice
36 insurance for such specific type of health care
37 provider but need not be the exclusive agency through
38 which such insurance may be written on a primary basis
39 in this state.

40 If the commissioner determines at any time that
41 medical malpractice insurance can be made available
42 in the voluntary market at a reasonable price for
43 any specific type of licensed health care provider,
44 the association shall thereby cease underwriting
45 medical malpractice insurance for that type of licensed
46 health care provider.

47 4. The association shall, subject to the terms
48 and conditions of sections two (2) through thirteen
49 (13) of this Act, have and exercise the following
50 powers on behalf of its members:

1 Amend House File 803, as amended, passed and
2 reprinted by the House, by striking everything after
3 the enacting clause and inserting in lieu thereof
4 the following:

5 "Section 1. The general assembly finds that a
6 critical situation exists because of the high cost
7 and impending unavailability of medical malpractice
8 insurance. The purposes of sections two (2) through
9 thirteen (13) of this Act are to assure that the
10 public is adequately protected against losses arising
11 out of medical malpractice by providing licensed
12 health care providers with medical malpractice
13 insurance through the requirement that certain
14 liability insurance carriers write medical malpractice
15 insurance for a period of two years upon a finding
16 of an emergency by the commissioner of insurance that
17 either such insurance is not available through normal
18 channels or that it is not available on a reasonable
19 basis because of lack of competition for such
20 insurance, or otherwise; to establish an association
21 to equitably spread the risks for such insurance;
22 and to provide for recoupment of losses resulting
23 from the operation of the association through a
24 stabilization reserve fund contributed to by insureds,
25 or a favorable premium tax treatment.

26 It is the intent of this Act to provide only an
27 interim solution to the impending unavailability of
28 medical malpractice insurance. It is not anticipated
29 that this Act will resolve the underlying causes of
30 the unavailability and high cost which extend beyond
31 the insurance mechanism. It is anticipated that
32 future legislation will be required to deal on a more
33 permanent basis with the underlying causes of the
34 current situation.

35 Sec. 2. NEW SECTION. DEFINITIONS. As used in
36 this Act, unless the context otherwise requires:

37 1. "Association" means the joint underwriting
38 association established pursuant to sections two (2)
39 through thirteen (13) of this Act.

40 2. "Commissioner" means the commissioner of
41 insurance or a designee.

42 3. "Medical malpractice insurance" means insurance
43 coverage against the legal liability of the insured
44 and against loss, damage, or expense incident to a
45 claim arising out of the death or injury of any person
46 as the result of negligence or malpractice in rendering
47 professional service by any licensed physician,
48 hospital, or other licensed health care provider.

49 4. "Net direct premiums" means gross direct
50 premiums written on liability insurance as reported

1 Amend House File 803 as amended, passed and
2 reprinted by the House as follows:

3 1. Page 1, line 17, by striking the words "an
4 assessment of the policyholders" and inserting in lieu
5 thereof the words "a stabilization reserve fund
6 contributed to by insureds".

7 2. Page 2, by striking line 5, and inserting in
8 lieu thereof the words "licensed health care".

9 3. Page 2, by inserting after line 12 the following
10 new subsection:

11 "5. "Licensed health care provider" means and
12 includes a physician and surgeon, osteopath,
13 osteopathic physician and surgeon, dentist, podiatrist,
14 optometrist, pharmacist, chiropractor or nurse licensed
15 pursuant to chapter one hundred forty-seven (147)
16 of the Code, and a hospital licensed pursuant to
17 chapter one hundred thirty-five B (135B) of the Code."

18 4. Page 4, by striking lines 12 through 19.

19 5. Page 5, by striking lines 15 and 16 and
20 inserting in lieu thereof the following:

21 "All policies shall be issued subject to the group
22 retrospective rating plan and the stabilization reserve
23 fund authorized by this Act. No policy".

24 6. Page 5, line 35, by inserting after the word
25 "basis," the following:

26 "giving due consideration to the group retrospective
27 rating plan and the stabilization reserve fund,".

28 7. Page 6, by striking lines 4 through 10 and
29 inserting in lieu thereof the following:

30 "ject to a nonprofit group retrospective rating
31 plan to be approved by the commissioner under which
32 the final premium for all policyholders of the
33 association, as a group, will be equal to the
34 administrative expenses, loss and loss adjustment
35 expenses and taxes, plus a reasonable allowance for
36 contingencies and servicing. Policyholders shall
37 be given full credit for all investment income, net
38 of expenses and a reasonable management fee, on
39 policyholder supplied funds. The standard premium,
40 before retrospective adjustment, for each policy
41 issued by the association shall be established for
42 portions of the policy period coinciding with the
43 association's fiscal year on the basis of the
44 association's rates, rating plans, rating rules, and
45 rating classifications then in effect. The maximum
46 final premium for all policyholders of the associa-
47 tion, as a group, shall be limited as provided in
48 subsection five (5) of section six (6) of this Act.
49 Since the business of the association is subject to
50 the nonprofit group retrospective rating plan required

1 by this subsection, there shall be a presumption that
2 the rates filed and premiums imposed by the association
3 are not unreasonable or excessive."

4 8. Page 6, line 12, by striking the word
5 "assessment".

6 9. Page 6, by striking line 13 and inserting
7 in lieu thereof the following:

8 "the stabilization reserve fund has been exhausted
9 in payment of the maximum final premium for all
10 policyholders of the association."

11 10. Page 6, line 16, by striking the word "one".

12 11. Page 6, by striking lines 17 through 28 and
13 inserting in lieu thereof the following:

14 "deducting their share of the deficit from past
15 or future premium taxes due the state of Iowa. The
16 association shall amend the amount of".

17 12. Page 7, by inserting after line 4 the following
18 new section:

19 "Sec. 6. NEW SECTION. STABILIZATION RESERVE FUND.

20 1. There is created a stabilization reserve fund.
21 The fund shall be administered by three directors,
22 one of whom shall be the commissioner. The remaining
23 two directors shall be appointed by the commissioner:
24 One shall be a representative of the association and
25 the other a representative of its policyholders.

26 2. The directors shall act by majority vote with
27 two directors constituting a quorum for the transaction
28 of any business or the exercise of any power of the
29 fund. The directors shall serve without salary, but
30 each director other than the commissioner shall be
31 reimbursed for actual and necessary expenses incurred
32 in the performance of official duties as a director.
33 The directors shall not be subject to any personal
34 liability with respect to the administration of the
35 fund for acts or decisions made in good faith pursuant
36 to the provisions of this Act.

37 3. Each policyholder shall pay to the association
38 a stabilization reserve fund charge determined by
39 the directors which shall not exceed the amount of
40 one annual premium due for insurance through the
41 association. Such charge shall be separately stated
42 in the policy. The association shall cancel the
43 policy of any policyholder who fails to pay the
44 stabilization reserve fund charge.

45 4. The association shall promptly pay to the fund
46 all stabilization reserve fund charges which it
47 collects from its policyholders and any retrospective
48 premium refunds payable under any group retrospective
49 rating plan approved by the commissioner under the
50 provisions of this Act.

1 5. All monies received by the fund shall be held
2 in trust by a corporate trustee selected by the
3 directors. The corporate trustee may invest the
4 monies held in trust, subject to the approval of the
5 directors. All investment income shall be credited
6 to the fund, and all expenses of administration of
7 the fund shall be charged against the fund. The
8 monies held in trust shall be used solely for the
9 purpose of discharging when due any retrospective
10 premium charges payable by policyholders of the
11 association under the group retrospective rating plan
12 approved by the commissioner. Payment of retrospective
13 premium charges shall be made by the directors upon
14 certification to them by the association of the amount
15 due. If all monies accruing to the fund are finally
16 exhausted in payment of retrospective premium charges,
17 all liability and obligations of the association's
18 policyholders with respect to the payment of
19 retrospective premium charges shall thereupon terminate
20 and shall be conclusively presumed to have been
21 discharged. Any monies remaining in the fund after
22 all such retrospective premium charges have been paid
23 shall be returned to policyholders pursuant to
24 procedures authorized by the directors."

25 13. By renumbering sections of the bill and
26 correcting internal references in conformity with
27 sections 1, 5, 6, 7, 8, 9 and 12 of this amendment.

28 14. Page 11, line 1, by striking the word "be".

29 15. Page 11, by striking lines 2 through 8 and
30 inserting in lieu thereof the following:

31 "create a presumption that informed consent was
32 given. A".

33 16. Page 11, by striking line 26, and inserting
34 in lieu thereof the following:

35 519.1 AUTHORIZATION. Any number of physicians,
36 druggists and surgeons, osteopaths, osteopathic
37 physicians and surgeons, podiatrists, chiropractors,
38 pharmacists,".

39 17. Page 14, by striking lines 10 and 11 and
40 inserting in lieu thereof the following:

41 "wrongful death against any physician and surgeon,
42 osteopath, osteopathic physician and surgeon, dentist,
43 podiatrist, optometrist, pharmacist, chiropractor
44 or nurse licensed under this chapter or against any
45 hospital licensed under chapter one thirty-
46 five B (135B) of the Code,".

47 18. Page 14, line 12, by striking the words "this
48 state,".

49 19. Page 14, line 23, by inserting after
50 "optometrist," the word "pharmacist,".

Page 4

1 20. Page 15, by striking lines 16 through 20.

S-4069

1 Amend the Rabedeaux amendment, S-4028, to House
2 File 803 as follows:

3 1. Page 9, by inserting after line 5 the follow-
4 ing new sections:

5 "Sec. ____ . Section one hundred forty-seven point
6 one (147.1), Code 1975, is amended by adding the
7 following new subsections:

8 NEW SUBSECTION. "Peer review" means evaluation
9 of professional services rendered by a person licensed
10 to practice a profession.

11 NEW SUBSECTION. "Peer review committee" means
12 one or more persons acting in a peer review capacity
13 who also serve as an officer, director, trustee,
14 agent, or member of any of the following:

15 a. A state or local professional society of a
16 profession for which there is peer review.

17 b. Any organization approved to conduct peer
18 review by a society as designated in paragraph a of
19 this subsection.

20 c. The medical staff of any licensed hospital.

21 d. An examining board.

22 Sec. ____ . Chapter one hundred forty-seven (147),
23 Code 1975, is amended by adding the following new
24 section:

25 NEW SECTION. A person shall not be civilly liable
26 as a result of acts, omissions, or decisions made
27 in connection with the person's service on a peer
28 review committee. However, such immunity from civil
29 liability shall not apply if an act, omission, or
30 decision is made with malice."

S-4069 FILED & ADOPTED (1711) BY MINNETTE DODERER
JUNE 5, 1975

S-4073

1 Amend House File 803, as amended and passed by the
2 House and reprinted, Page 9, by inserting after line 22 the
3 following new section:

4 "Sec. ____ . Section one hundred thirty-five B point
5 twenty-six (135B.26), Code 1975, is amended to read as
6 follows:

7 135B.26 COMPENSATION. The contract between the
8 hospital and doctor in charge of the laboratory or x-ray
9 facilities may contain any provision for compensation of each
10 upon which they mutually agree; ~~provided; however; that no~~
11 ~~contract shall be entered into which in any way creates the~~
12 ~~relationship of employer and employee between the hospital~~
13 ~~and the doctor; and a.~~ A percentage arrangement or a
14 relationship of employer and employee between the hospital
15 and the doctor is not and shall not be construed to be unpro-
16 fessional conduct on the part of the doctor or in violation
17 of the statutes of this state upon the part of the hospital."
18
19

S-4073 FILED (RULED BY MINNETTE F. DODERER
JUNE 5, 1975 NOT GERMANE) 1786

S-4067

1 Amend House File 803, as amended, passed and re-
2 printed by the House as follows:

3 1. By striking sections one (1) through twelve
4 (12) and inserting in lieu thereof the following:

5 "Section 1. NEW SECTION. TITLE. This Act shall
6 be known as the Health Care Patient Malpractice Claims
7 Act.

8 Sec. 2. NEW SECTION. DEFINITIONS. As used in
9 this Act unless the context otherwise requires:

10 1. "Commissioner" means the commissioner of in-
11 surance or a designee.

12 2. "Fund" means the Iowa Health Care Patient
13 Compensation Fund created by section three (3) of
14 this Act.

15 3. "Malpractice insurance" means insurance against
16 the legal liability of an insured for loss, damage
17 or expense incident to a claim arising out of the
18 death or injury of a person as the result of
19 malpractice in the rendering of health care or
20 treatment by that insured.

21 4. "Health care practitioner" means and includes
22 a physician and surgeon, osteopath, osteopathic
23 physician and surgeon, dentist, podiatrist,
24 optometrist, chiropracter, pharmacist or nurse licensed
25 to practice his or her profession in this state.

26 5. "Hospital" means and includes each facility
27 licensed as a hospital under chapter one hundred
28 thirty-five B (135B) of the Code.

29 6. "Health care provider" means and includes
30 a hospital and a health care practitioner.

31 7. "Board of governors" means the board of
32 governors of the fund created by this Act.

33 Sec. 3. NEW SECTION. FUND CREATED. There is
34 created the Iowa Patient Compensation Fund to pro-
35 vide for the payment of claims and judgments of
36 malpractice arising from the delivery of health care
37 or treatment by health care providers who are insured
38 by the fund. The fund shall be the exclusive agency
39 by which malpractice insurance may be written for
40 health care providers in this state, and every health
41 care provider licensed in this state shall obtain
42 and maintain malpractice insurance from the fund as
43 a condition of retaining licensure. The fund shall
44 not be subject to attachment or levy of execution,
45 and disbursements shall not be made from the fund
46 except as provided in this Act.

47 Sec. 4. NEW SECTION. FUND ADMINISTRATION AND
48 OPERATION. It shall be the duty and responsibility
49 of the commissioner to manage the fund, subject to
50 the supervision and approval of the board. The

1 commissioner shall promulgate rules pursuant to chapter
2 seventeen A (17A) of the Code for the administration
3 and operation of the fund. The fund shall provide
4 for the continuous writing of malpractice insurance
5 for health care providers licensed in this state,
6 and for the servicing of malpractice insurance policies
7 issued by the fund.

8 Sec. 5. NEW SECTION. BOARD CREATED.

9 1. There is created a seven member board of
10 governors to supervise and advise the commissioner
11 with respect to the management of the fund, and to
12 perform other duties as provided in this Act.

13 2. The members of the board shall include the
14 treasurer of state and six members appointed by the
15 governor as provided in this subsection.

16 a. One member shall be appointed who has experience
17 in the management of liability insurance underwriting
18 in this state.

19 b. One member shall be appointed who has experience
20 as a trial attorney in this state.

21 c. One member shall be appointed who has experience
22 in the investment of securities.

23 d. One member shall be appointed who has experience
24 as a health care practitioner in this state.

25 e. One member shall be appointed who has experience
26 as a hospital administrator in this state.

27 f. One member shall be appointed who is not asso-
28 ciated or affiliated with the insurance industry,
29 the health care industry, the bar association, or
30 the securities industry and who shall represent the
31 interests of the general public.

32 The members appointed pursuant to paragraphs a through
33 f of this subsection initially shall be appointed
34 to terms of one through six years, respectively.
35 Thereafter, appointments shall be made for uniform
36 terms of four years each.

37 3. The board shall meet regularly once each month
38 and at other times upon the written request of the
39 commissioner. Five members shall constitute a quorum
40 for the transacting of business and a majority of
41 four votes shall be sufficient to take any action.

42 4. The members of the board, except the treasurer
43 of state, shall receive a per diem of forty dollars
44 for each day in the performance of official duties,
45 and shall be reimbursed for actual and reasonable
46 expense necessarily incurred. All per diem and
47 expenses shall be charged to and paid from the fund.

48 Sec. 6. NEW SECTION. DUTIES OF COMMISSIONER.

49 Subject to the conditions and limitations of this
50 Act the commissioner shall have the following duties:

1 1. To establish a plan of malpractice insurance
2 for health care providers. To engage in the writing
3 of malpractice insurance on behalf of the fund, and
4 to cancel any insurance contract for cause.

5 2. To invest the monies of the fund, to adjust
6 and pay losses, expenses and costs of the operation
7 of the fund, and to account for receipts and disburse-
8 ments of the fund.

9 3. To investigate, negotiate and settle malprac-
10 tice claims.

11 4. To sue and be sued on behalf of the fund.

12 5. To establish the rates, rating plans, rating
13 rules and rating classifications to be used by the
14 fund.

15 6. To employ persons pursuant to chapter nineteen
16 A (19A) of the Code as necessary to carry out the
17 duties of the commissioner or the board of governors
18 as provided in this Act. The salaries and expenses
19 of employment of those persons shall be charged to
20 the fund and paid into the general fund of the state.

21 7. To exercise any other reasonable and neces-
22 sary powers and duties with respect to the manage-
23 ment and operation of the fund which are not incons-
24 sistent with the provisions of this Act.

25 Sec. 7. NEW SECTION. TERMS OF POLICIES. The
26 commissioner shall establish the form of insurance
27 policies written by the fund. Policies shall con-
28 tain terms which the commissioner determines to be
29 necessary, but every policy shall be subject to the
30 following provisions:

31 1. Policies shall not be written on the claims
32 made basis unless the insurance contract provides
33 for residual occurrence coverage upon the retire-
34 ment, death, disability or other cessation by the
35 licensee from providing health care in this state.

36 2. Every insured shall agree to cooperate with
37 and assist the fund and any of its officers, employees
38 and attorneys in the investigations, negotiations,
39 settlements and actions on any claims of liability
40 made against the insured, and covered by the insurance
41 contract.

42 3. Every insured shall acknowledge the right of
43 the fund to cancel upon reasonable notice any policy
44 upon the material failure of the insured to comply
45 with any term of the insurance contract.

46 4. Every policy of insurance shall be written
47 for a term not exceeding one year, and shall be issued
48 only upon the payment of the required premium in full.
49 Every insurance policy shall be subject to cancellation
50 for cause.

- 1 Sec. 8. NEW SECTION. ANNUAL PREMIUMS.
- 2 1. Each licensed health care provider shall pay
- 3 the premiums established under this section for deposit
- 4 into the fund. Failure to pay any premium when due
- 5 shall constitute grounds for revocation of the health
- 6 care provider's license to practice that profession.
- 7 The insurance coverage provided by the fund shall
- 8 begin January 1, 1976, but then existing licensees
- 9 shall pay the initial premium not later than October
- 10 1, 1975.
- 11 2. Each health care provider shall pay into the
- 12 fund a membership premium determined according to
- 13 the following schedule:
- 14 a. Persons licensed to practice chiropractic
- 15 -- two hundred forty dollars.
- 16 b. Dentists performing oral surgery under gen-
- 17 eral anesthesia rendering the patient unconscious
- 18 -- two hundred twenty-five dollars.
- 19 c. Dentists not included in paragraph b of this
- 20 subsection -- one hundred twenty dollars.
- 21 d. Hospitals shall pay a premium determined by
- 22 multiplying the number of acute care hospital beds
- 23 by four hundred dollars.
- 24 e. Medical doctors and doctors of osteopathy not
- 25 performing or participating in surgery or obstetrical
- 26 procedures -- one thousand five hundred dollars.
- 27 f. Medical doctors and doctors of osteopathy
- 28 practicing surgery, including those specializing in
- 29 proctology, ophthalmology and cardiology, but excluding
- 30 surgeons specified in paragraphs g, h or i of this
- 31 subsection -- three thousand two hundred dollars.
- 32 g. Medical doctors and doctors of osteopathy
- 33 specializing in thoracic surgery, vascular surgery,
- 34 neurosurgery or orthopedics -- eight thousand six
- 35 hundred dollars.
- 36 h. Medical doctors and doctors of osteopathy
- 37 specializing as cardiac surgeons, specializing in
- 38 general surgery, anesthesiologists, and oto-
- 39 laryngologists whether or not plastic surgery is
- 40 performed -- five thousand four hundred dollars.
- 41 i. Medical doctors and doctors of osteopathy
- 42 specializing as plastic surgeons or in obstetrics-
- 43 gynecology -- six thousand four hundred fifty dollars.
- 44 j. Optometrists -- one hundred fifty dollars.
- 45 k. Podiatrists -- one thousand five hundred
- 46 dollars.
- 47 l. Pharmacists -- fifty dollars.
- 48 m. Nurses specializing in administering anesthetics
- 49 -- one hundred forty dollars.
- 50 n. Nurses other than those specified in paragraph

1 m of this subsection -- twenty-five dollars.

2 The respective amounts specified in this subsection
3 shall be payable in each of the first five years the
4 insured is a policyholder: However, if the net balance
5 of the fund reaches one hundred million dollars prior
6 to the expiration of five years after October 1, 1975,
7 the installments shall be abated according to the
8 number of full years less than five yet to expire
9 at the time the fund reaches that balance.

10 3. Each health care provider which becomes licensed
11 in this state for the first time subsequent to October
12 1, 1975, shall pay into the fund the membership premium
13 determined according to the schedule specified in
14 subsection two (2) of this section, and additionally
15 shall pay any premium for annual coverage which is
16 in effect at the time of issuance of the first policy
17 of insurance.

18 4. Upon the renewal of any policy after initial
19 issuance, each insured shall pay an annual premium,
20 if any, in the amount established by the commissioner
21 by rule. The premiums established by the commissioner
22 shall be determined by the following standards:

23 a. The rates, rating plans, rating rules and
24 rating classifications applicable to the insurance
25 coverage provided by the fund shall be established
26 on an actuarially sound basis, and shall be calculated
27 to maintain a nonprofit and self-supporting fund
28 without subsidy from the state or any other source.

29 b. The rating plan may recognize prior claims
30 experience of individual insureds.

31 c. The rating plan may recognize health care
32 practitioners who are retired or semiretired, or who
33 are part-time practitioners.

34 d. The rating plan may recognize past and
35 prospective loss and claim experience in different
36 types of practice and in different geographical or
37 demographic areas of the state.

38 e. The rating plan may recognize differences
39 in risk between the various types of practice engaged
40 in by health care practitioners and between hospitals
41 based upon the kinds of health care and treatment
42 provided. The rating plan adopted by the commissioner
43 shall not be subject to any limitation or restriction
44 as a result of the schedule contained in subsection
45 two (2) of this section.

46 Sec. 9. NEW SECTION. FUND ACCOUNTING.

47 1. Premiums and other amounts received by the
48 fund shall be remitted for deposit as determined by
49 the commissioner. Monies held in the fund and not
50 needed for current operating expense or contingencies

1 shall be invested in any interest-bearing investments
2 in which the treasurer of state would be permitted
3 to invest pursuant to section four hundred fifty-two
4 point ten (452.10) of the Code.

5 2. Monies may be withdrawn from the fund only
6 upon approval by the commissioner. Any person
7 authorized to receive deposits, to withdraw funds,
8 to issue vouchers, or otherwise to disburse monies
9 shall give bond in an amount reasonably sufficient
10 to protect the public interest. The cost of a bond
11 shall be charged to and paid out of the fund.

12 3. Not later than the fifteenth day of March
13 annually, the commissioner shall submit to the governor
14 and to the general assembly an audited financial
15 statement and report respecting the operation of the
16 fund. The statement shall be prepared in accordance
17 with generally accepted accounting principles and
18 procedures.

19 4. All books, records and audits of the fund shall
20 be public records.

21 Sec. 10. NEW SECTION. FUND TO DEFEND ACTIONS.

22 1. The fund shall defend each insured against
23 civil claims brought as a result of the insured's
24 rendering of health care or treatment. The fund shall
25 not defend or represent any licensee in proceedings
26 relating to the licensure of that health care provider.

27 2. The attorney general or a designee shall
28 represent the fund in any actions in which the fund
29 or any officer or employee thereof is a party, and
30 shall represent insureds in civil claims or actions
31 in which the fund might be liable as an insurer.
32 Private legal counsel may be employed by the fund
33 in any claim or action involving more than one insured
34 and in which the attorney general or the designee
35 would be involved in a conflict of interest by the
36 representation of all insureds.

37 3. All costs and expenses incurred in the
38 investigation and defense of any claim shall be paid
39 from the fund. Any amounts representing actual
40 expenses and salaries of the attorney general and
41 other employees of the department of justice in
42 providing services to or on behalf of the fund shall
43 be paid by the fund and into the general fund of this
44 state.

45 Sec. 11. NEW SECTION. SETTLEMENT OF CLAIMS.

46 1. The commissioner is empowered, with the advice
47 and consent of the board, to consider, ascertain,
48 adjust, compromise, determine, settle, and pay any
49 claim or judgment against an insured. However, no
50 prejudgment settlement may be agreed to wherein the

1 amount to be paid to or on behalf of all claimants
2 exceeds one hundred thousand dollars.

3 2. A settlement may not be agreed to unless the
4 claimant or a personal representative as consideration
5 agrees to release the insured against whom the claim
6 was made from all further liability arising from the
7 occurrence upon which the claim is based.

8 3. A settlement involving an amount payable to
9 all claimants in excess of five thousand dollars shall
10 not be valid except after an action has been filed,
11 and the court has approved a judgment in settlement.

12 Sec. 12. NEW SECTION. ACTIONS. Nothing in this
13 Act shall be deemed to prevent the filing of any
14 action against a health care provider by a person
15 asserting a malpractice claim against that health
16 care provider. Upon the filing of any claim for
17 damages the claimant shall deliver written notice
18 to the commissioner. Upon the commencement of any
19 action arising from the care or treatment of a person
20 by a health care provider the claimant shall deliver
21 original notice to the fund by delivering a copy of
22 the notice and petition to the attorney general.
23 Neither the state, nor the fund, nor any member of
24 the board nor any employee of the state shall be
25 joined as a party to any civil action against an
26 insured: However, prior to entry of any judgment
27 or judgment in settlement against an insured the fund
28 shall be admitted as a party defendant and any judgment
29 entered shall be enforceable against the fund.

30 Sec. 13. NEW SECTION. PAYMENT OF JUDGMENT.
31 Upon entry of a judgment or judgment in settlement
32 the fund shall pay to the claimants the full amount
33 of the judgment or one hundred thousand dollars,
34 whichever is the lesser, within thirty days of entry,
35 unless a judgment upon a trial to the court or to
36 a jury is appealed. Any balance of a judgment in
37 excess of one hundred thousand dollars shall be payable
38 in installments of one hundred thousand dollars each,
39 or such lesser amount as satisfies the judgment, at
40 successive twelve month intervals after the initial
41 payment. Interest shall be payable upon the judgment
42 in the same manner and to the same extent as interest
43 in other civil actions for money judgment.

44 Sec. 14. NEW SECTION. APPEALS. A judgment of
45 the district court in any civil action against an
46 insured upon liability covered by the insurance policy,
47 other than one entered upon an agreed settlement,
48 shall be subject to appeal by any party and by the
49 fund in the same manner and to the same extent as
50 in other civil actions for money judgment. Any

1 judgment entered shall be stayed upon appeal without
2 the filing of any bond, regardless of the party taking
3 the appeal.

4 Sec. 15. NEW SECTION. JUDGMENT AS BAR. A judgment
5 entered against the fund shall be a complete bar to
6 any further action by the claimant or any person on
7 his or her behalf, by reason of the same subject
8 matter, against any health care provider defending
9 in that action, and no execution or other process
10 shall be ordered against any defendant as a result
11 of that judgment.

12 Sec. 16. NEW SECTION. EXEMPTION FROM LIABILITY.
13 The fund, the commissioner, members of the board,
14 and officers and employees of the fund shall not be
15 civilly liable for any act, omission, communication,
16 statement or decision made in good faith by any of
17 them concerning any insured or any person applying
18 to be insured by the fund, or concerning any duties
19 or proceedings within the scope of this Act. However,
20 such immunity shall not apply if an act, omission,
21 communication, statement or decision is made with
22 malice.

S-4067 FILED & LOST (1781) BY E. KEVIN KELLY
JUNE 5, 1975 JAMES M. REDMOND

HOUSE FILE 803

S-4044

1 Amend House File 803, page 14, line 35, by
2 striking the word "unintentionally".

S-4044 FILED. *Withdrawn 6/5* BY PHILIP B. HILL
JUNE 4, 1975 (1784)

S-4064

1 Amend House File 803, as amended, passed and
2 reprinted by the House as follows:
3 1. Page 14, line 32 by striking the word "six"
4 and inserting in lieu thereof the word "ten".

S-4064 FILED & LOST (1785) BY PHILIP B. HILL
JUNE 5, 1975

S-4037

1 Amend House File 803, as amended, passed and re-
2 printed by the House, as follows:
3 1. Page 10, by inserting after line 31 the follow-
4 ing new section:

5 "Sec. ____ Chapter one hundred forty-seven (147),
6 Code 1975, is amended by adding the following new
7 section:

8 NEW SECTION.

9 1. Liability for personal injury or wrongful death
10 shall not be imposed against any physician and surgeon,
11 osteopath, osteopathic physician and surgeon,
12 chiropractor, pharmacist, nurse, dentist or podiatrist
13 licensed to practice that profession in this state,
14 based upon the alleged negligence of the licensee
15 in the practice of that profession unless expert
16 testimony is presented which establishes all of the
17 following:

18 a. The accepted standard of care by the profession
19 and the specialty thereof, if any, that the defendant
20 practices in the community in which the defendant
21 practices.

22 b. That the defendant acted or failed to act with
23 less than ordinary and reasonable care in accordance
24 with that accepted standard of care in the specific
25 circumstances of the case.

26 c. That as a proximate result of that act or
27 failure to act, the plaintiff suffered injuries or
28 death which otherwise would not have occurred.

29 2. Expert testimony shall not be required pursuant
30 to subsection one (1) of this section, and a rebuttable
31 inference that the personal injury or death was caused
32 by negligence shall arise, where evidence is presented
33 that the personal injury or death occurred in any
34 of the following circumstances:

35 a. A foreign substance other than medication or
36 a prosthetic device was unintentionally left within
37 the body of a patient following surgery.

38 b. An explosion or fire originating in a substance
39 used in treatment occurred in the course of treatment.

40 c. A surgical procedure was performed on the wrong
41 organ, limb or part of a patient's body or on the
42 wrong patient."

S-4037 FILED - Lost 6/5 (1783) BY DALE L. TIEDEN
JUNE 4, 1975

S-4065

1 Amend House File 803, as amended, passed and
2 reprinted by the House as follows:
3 1. Page 2, by striking line 5, and inserting in
4 lieu thereof the words "licensed health care".
5 2. Page 2, by inserting after line 12 the following
6 new subsection:
7 "5. "Licensed health care provider" means and
8 includes a physician and surgeon, osteopath,
9 osteopathic physician and surgeon, dentist, podiatrist,
10 optometrist, pharmacist, chiropractor or nurse licensed
11 pursuant to chapter one hundred forty-seven (147)
12 of the Code, and a hospital licensed pursuant to
13 chapter one hundred thirty-five B (135B) of the Code."
14 3. Page 11, by striking line 26, and inserting
15 in lieu thereof the following:
16 "519.1 AUTHORIZATION. Any number of physicians,
17 ~~druggists~~ and surgeons, osteopaths, osteopathic
18 physicians and surgeons, podiatrists, chiropractors,
19 pharmacists,".
20 4. Page 14, by striking lines 10 and 11 and
21 inserting in lieu thereof the following:
22 "wrongful death against any physician and surgeon,
23 osteopath, osteopathic physician and surgeon, dentist,
24 podiatrist, optometrist, pharmacist, chiropractor
25 or nurse licensed under this chapter or against any
26 hospital licensed under chapter one hundred thirty-
27 five B (135B) of the Code,".
28 5. Page 14, line 12, by striking the words "this
29 state,".
30 6. Page 14, line 23, by inserting after
31 "optometrist," the word "pharmacist,".

S-4065 FILED & ADOPTED (1782) BY LOWELL L. JUNKINS
JUNE 5, 1975

S-4076

1 Amend House File 803 as amended, passed and reprinted
2 by the House, page 15, by inserting after line 1 the
3 following new paragraph:
4 "This section shall not apply to any claim based upon
5 an act or omission occurring prior to the effective date
6 of this Act."

S-4076 FILED & LOST (1785) BY JAMES M. REDMOND
JUNE 5, 1975

AN ACT

RELATING TO THE COMPENSATION OF PERSONS SUFFERING LOSS AS A
RESULT OF MEDICAL MALPRACTICE.

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

Section 1. The general assembly finds that a critical situation exists because of the high cost and impending unavailability of medical malpractice insurance. The purposes of sections two (2) through thirteen (13) of this Act are to assure that the public is adequately protected against losses arising out of medical malpractice by providing licensed health care providers with medical malpractice insurance through the requirement that certain liability insurance carriers write medical malpractice insurance for a period of two years upon a finding of an emergency by the commissioner of insurance that either such insurance is not available through normal channels or that it is not available on a reasonable basis because of lack of competition for such insurance, or otherwise; to establish an association to equitably spread the risks for such insurance; and to provide for recoupment of losses resulting from the operation of the association through a stabilization reserve fund contributed to by insureds, a surcharge on future liability insurance policies, or a favorable premium tax treatment.

It is the intent of this Act to provide only an interim solution to the impending unavailability of medical malpractice insurance. It is not anticipated that this Act will resolve the underlying causes of the unavailability and high cost which extend beyond the insurance mechanism. It is anticipated that future legislation will be required to deal on a more permanent basis with the underlying causes of the current situation.

Sec. 2. NEW SECTION. DEFINITIONS. As used in this Act, unless the context otherwise requires:

1. "Association" means the joint underwriting association established pursuant to sections two (2) through thirteen (13) of this Act.

2. "Commissioner" means the commissioner of insurance or a designee.

3. "Medical malpractice insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering professional service by any licensed health care provider.

4. "Net direct premiums" means gross direct premiums written on liability insurance as reported in the annual statements filed by the insurers with the commissioner, including the liability component of multiple peril package policies as computed by the commissioner, less return premiums for the unused or unabsorbed portions of premium deposits.

5. "Licensed health care provider" means and includes physician and surgeon, osteopath, osteopathic physician and surgeon, dentist, podiatrist, optometrist, pharmacist, chiropractor or nurse licensed pursuant to chapter one hundred forty-seven (147) of the Code, and a hospital licensed pursuant to chapter one hundred thirty-five B (135B) of the Code.

Sec. 3. NEW SECTION. TEMPORARY JOINT UNDERWRITING ASSOCIATION.

1. A temporary joint underwriting association is created, consisting of all insurers authorized to write and engaged in writing on a direct basis within this state liability insurance, including insurers covering such peril in multiple peril policies. Every such insurer shall be a member of the association and shall remain a member as a condition of its authority to continue to write liability insurance in this state.

2. The purpose of the association shall be to provide, for a period not exceeding two years, a market for medical malpractice insurance on a self-supporting basis without subsidy from its members.

3. The association shall not commence underwriting operations for health care providers until the commissioner, after notice and opportunity for hearing, has determined that medical malpractice insurance is not available at a reasonable cost for a specific type of licensed health care provider in the voluntary market. Upon such determination the association shall be authorized to issue policies of medical malpractice insurance for such specific type of health care provider but need not be the exclusive agency through which such insurance may be written on a primary basis in this state.

If the commissioner determines at any time that medical malpractice insurance can be made available in the voluntary market at a reasonable price for any specific type of licensed health care provider, the association shall thereby cease underwriting medical malpractice insurance for that type of licensed health care provider.

4. The association shall, subject to the terms and conditions of sections two (2) through thirteen (13) of this Act, have and exercise the following powers on behalf of its members:

a. To issue, or to cause to be issued, policies of insurance to applicants, including incidental coverages and subject to limits as specified in the plan of operation but not to exceed one million dollars for each claimant under one policy and three million dollars for all claimants under one policy in any one year.

b. To underwrite such insurance and to adjust and pay losses with respect thereto, or to appoint service companies to perform those functions.

c. To assume reinsurance from its members.

d. To cede reinsurance.

Sec. 4. NEW SECTION. PLAN OF OPERATION.

1. The association shall submit a plan of operation to the commissioner, together with any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association consistent with sections

two (2) through thirteen (13) of this Act. The plan of operation and any amendments thereto shall become effective only after promulgation of the plan or amendment by the commissioner as a rule pursuant to section seventeen A point four (17A.4) of the Code: Provided that the initial plan may in the discretion of the commissioner become effective immediately upon filing with the secretary of state pursuant to subparagraph one (1) of paragraph b of subsection two (2) of section seventeen A point five (17A.5) of the Code.

If the association fails to submit a suitable plan of operation within twenty-five days following the effective date of this Act or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall adopt rules necessary to effectuate sections two (2) through thirteen (13) of this Act. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

2. The plan of operation shall provide for economic, fair and nondiscriminatory administration, and for the prompt and efficient provision of medical malpractice insurance. The plan shall contain other provisions including, but not limited to, preliminary assessment of all members for initial expenses necessary to commence operations, establishment of necessary facilities, management of the association, assessment of members to defray losses and expenses, commission arrangements, reasonable and objective underwriting standards, acceptance and cession of reinsurance, appointment of servicing carriers or other servicing arrangements and procedures for determining amounts of insurance to be provided by the association.

3. All member insurers shall comply with the plan of operation.

Sec. 5. NEW SECTION. POLICY FORMS AND RATES.

1. The rates, rating plans, rating classifications, and policy forms and endorsements applicable to insurance written by the association and the statistical and experience data relating thereto shall be subject to sections two (2)

through thirteen (13) of this Act and to the provisions of the general insurance code which are not inconsistent with the purposes and provisions of this Act.

2. All policies issued by the association shall provide for a continuous period of coverage beginning with their respective effective dates and terminating automatically at 12:01 a.m. on July 1, 1977, unless sooner terminated in accordance with sections two (2) through thirteen (13) of this Act, or unless terminated because of failure of the policyholder to pay any premium or stabilization reserve fund charge or portion of either when due. All policies shall be issued subject to the group retrospective rating plan and the stabilization reserve fund authorized by this Act. No policy form shall be used by the association unless it has been filed with and approved by the commissioner.

3. The commissioner shall specify whether policy forms and the rate structure shall be on a "claims-made" or "occurrence" basis and coverage shall be provided by the association only on the basis specified by the commissioner. The commissioner shall specify the "claims-made" basis only if the contract makes provision for residual "occurrence" coverage upon the retirement, death, disability or removal from this state of the insured. Provision may be made for a premium charge allocable to any such residual "occurrence" coverage and such premium charges for such residual coverage shall be segregated and separately maintained for such purpose which may include the reinsurance of all or a part of that portion of the risk.

4. The rates, rating plans, rating rules, and rating classifications applicable to the insurance written by the association shall be on an actuarially sound basis, giving due consideration to the group retrospective rating plan and the stabilization reserve fund, and shall be calculated to be self-supporting.

5. All policies issued by the association shall be subject to a nonprofit group retrospective rating plan to be approved by the commissioner under which the final premium

for all policyholders of the association, as a group, shall be equal to the administrative expenses, loss and loss adjustment expenses and taxes, plus a reasonable allowance for contingencies and servicing. Policyholders shall be given full credit for all investment income, net of expenses and a reasonable management fee, on policyholder supplied funds. The standard premium, before retrospective adjustment, for each policy issued by the association shall be established for portions of the policy period coinciding with the association's fiscal year on the basis of the association's rates, rating plans, rating rules, and rating classifications then in effect. The maximum final premium for all policyholders of the association, as a group, shall be limited as provided in subsection five (5) of section six (6) of this Act. Since the business of the association is subject to the nonprofit group retrospective rating plan required by this subsection, there shall be a presumption that the rates filed and premiums imposed by the association are not unreasonable or excessive.

6. The association shall certify to the commissioner the estimated amount of any deficit remaining after the stabilization reserve fund has been exhausted in payment of the maximum final premium for all policyholders of the association. Within sixty days after that certification the commissioner shall authorize the members of the association to commence recoupment of their respective shares of the deficit by deducting their share of the deficit from past or future premium taxes due the state of Iowa. The association shall amend the amount of its certification of deficit to the commissioner as the values of its incurred losses become finalized and the members of the association shall amend their recoupment procedure accordingly.

7. In the event that sufficient funds are not available for the sound financial operation of the association, all members shall contribute to the financial requirements of the association in the manner provided for in section eight (8) of this Act. Any contribution shall be reimbursed to the members by recoupment as provided in subsection six (6)

of this section.

Sec. 6. NEW SECTION. STABILIZATION RESERVE FUND.

1. There is created a stabilization reserve fund. The fund shall be administered by three directors, one of whom shall be the commissioner. The remaining two directors shall be appointed by the commissioner: One shall be a representative of the association and the other a representative of its policyholders.

2. The directors shall act by majority vote with two directors constituting a quorum for the transaction of any business or the exercise of any power of the fund. The directors shall serve without salary, but each director other than the commissioner shall be reimbursed for actual and necessary expenses incurred in the performance of official duties as a director. The directors shall not be subject to any personal liability with respect to the administration of the fund for acts or decisions made in good faith pursuant to the provisions of this Act.

3. Each policyholder shall pay to the association a stabilization reserve fund charge determined by the directors which shall not exceed the amount of one annual premium due for insurance through the association. Such charge shall be separately stated in the policy. The association shall cancel the policy of any policyholder who fails to pay the stabilization reserve fund charge.

4. The association shall promptly pay to the fund all stabilization reserve fund charges which it collects from its policyholders and any retrospective premium refunds payable under any group retrospective rating plan approved by the commissioner under the provisions of this Act.

5. All monies received by the fund shall be held in trust by a corporate trustee selected by the directors. The corporate trustee may invest the monies held in trust, subject to the approval of the directors. All investment income shall be credited to the fund, and all expenses of administration of the fund shall be charged against the fund. The monies held in trust shall be used solely for the purpose of

discharging when due any retrospective premium charges payable by policyholders of the association under the group retrospective rating plan approved by the commissioner. Payment of retrospective premium charges shall be made by the directors upon certification to them by the association of the amount due. If all monies accruing to the fund are finally exhausted in payment of retrospective premium charges, all liability and obligations of the association's policyholders with respect to the payment of retrospective premium charges shall thereupon terminate and shall be conclusively presumed to have been discharged. Any monies remaining in the fund after all such retrospective premium charges have been paid shall be returned to policyholders pursuant to procedures authorized by the directors.

Sec. 7. NEW SECTION. PROCEDURES.

1. Upon a finding by the commissioner, after notice and opportunity for hearing, that medical malpractice insurance is not available at a reasonable cost for a specific type of licensed health care provider in the voluntary market and upon notification of that finding to the association, any licensed health care provider of the type specified in the commissioner's finding shall be entitled to apply to the association for medical malpractice insurance coverage. The application may be made on behalf of a licensed health care provider by an authorized agent.

2. If the association determines that the applicant meets the underwriting standards of the association as prescribed in the plan of operation, then the association, upon receipt of the premium or such portion thereof as is prescribed in the plan of operation, shall cause to be issued a policy of medical malpractice insurance.

Sec. 8. NEW SECTION. PARTICIPATION. All members of the association shall participate in its writings, expenses, servicing allowance, management fees and losses in the proportion that the net direct premiums of each member, excluding that portion of premiums attributable to the operation of the association, written during the preceding calendar

year bears to the aggregate net direct premiums written in this state by all members of the association. Each member's proportion shall be determined annually on the basis of the annual statements and other reports filed by the insurer with the commissioner.

Sec. 9. NEW SECTION. GOVERNING BOARD.

1. The association shall be governed by a board of eleven directors of whom three shall be appointed annually by the commissioner to represent the licensed health care providers. Eight members shall be elected annually, except as provided in subsection two (2) of this section, by the members of the association. Vacancies on the board shall be filled for the remaining period of the term by majority vote of the remaining directors subject to approval of the commissioner.

2. Within fifteen days after the effective date of this Act the commissioner shall designate a time and place for a meeting of the members of the association at which the eight elected members serving on the first board shall be elected. The commissioner shall appoint the appointive members of the board on or before the date of such meeting.

The commissioner may, prior to the first meeting of the members of the association, appoint an interim governing board of the association consisting of eight member insurers and three representatives of the licensed health care providers. The eight member insurers of that interim governing board shall serve until their successors are elected by the members of the association. In appointing members of the association to the interim governing board, the commissioner shall consider among other things whether all member insurers are fairly represented.

Sec. 10. NEW SECTION. APPEALS AND JUDICIAL REVIEW.

1. Any applicant or any person insured pursuant to section seven (7) of this Act, or a legal representative, or any affected insurer, may appeal to the commissioner within thirty days after any ruling, action or decision by or on behalf of the association, with respect to those items the plan of operation defines as appealable matters.

2. All orders of the commissioner made pursuant to sections two (2) through thirteen (13) of this Act shall be subject to judicial review as provided in the Iowa administrative procedure Act.

Sec. 11. NEW SECTION. ANNUAL STATEMENTS. The association shall file in the office of the commissioner on or before the first day of March each year, a statement as prescribed by the commissioner. The statement shall contain matters and information required by the commissioner including, but not limited to, information with respect to its transactions, condition, operations and affairs during the preceding year, and shall be in a form approved by the commissioner. The commissioner may, at any time, require the association to furnish additional information with respect to matters considered to be material to the scope, operation and experience of the association.

Sec. 12. NEW SECTION. EXAMINATIONS. The commissioner shall make an examination of the association at least annually. The expenses of each examination shall be paid by the association.

Sec. 13. NEW SECTION. PRIVILEGED COMMUNICATIONS. There shall be no liability on the part of, and no cause of action of any nature shall arise against the association, the commissioner, or any other person or organization, for any statements made in good faith by any of them in any report or communication concerning risks insured or to be insured by the association, or during any proceedings within the scope of sections two (2) through thirteen (13) of this Act.

Sec. 14. Section one hundred forty-seven point one (147.1), Code 1975, is amended by adding the following new subsections:

NEW SUBSECTION. "Peer review" means evaluation of professional services rendered by a person licensed to practice a profession.

NEW SUBSECTION. "Peer review committee" means one or more persons acting in a peer review capacity who also serve as an officer, director, trustee, agent, or member of any of the following:

a. A state or local professional society of a profession for which there is peer review.

b. Any organization approved to conduct peer review by a society as designated in paragraph a of this subsection.

c. The medical staff of any licensed hospital.

d. An examining board.

Sec. 15. Chapter one hundred forty-seven (147), Code 1975, is amended by adding the following new section:

NEW SECTION. A person shall not be civilly liable as a result of acts, omissions, or decisions made in connection with the person's service on a peer review committee. However, such immunity from civil liability shall not apply if an act, omission, or decision is made with malice.

Sec. 16. Chapter one hundred forty-seven (147), Code 1975, is amended by adding the following new section:

NEW SECTION. In an action for damages for personal injury against a physician and surgeon, osteopath, osteopathic physician and surgeon, dentist, podiatrist, optometrist, pharmacist, chiropractor, or nurse licensed to practice that profession in this state, or against a hospital licensed for operation in this state, based on the alleged negligence of the practitioner in the practice of the profession or occupation, or upon the alleged negligence of the hospital in patient care, in which liability is admitted or established, the damages awarded shall not include actual economic losses incurred or to be incurred in the future by the claimant by reason of the personal injury, including but not limited to, the cost of reasonable and necessary medical care, rehabilitation services, and custodial care, and the loss of services and loss of earned income, to the extent that those losses are replaced or are indemnified by insurance, or by governmental, employment, or service benefit programs or from any other source except the assets of the claimant or of the members of the claimant's immediate family.

Sec. 17. Chapter one hundred forty-seven (147), Code 1975, is amended by adding thereto the following new section:

NEW SECTION. A consent in writing to any medical or

surgical procedure or course of procedures in patient care which meets the requirements of this section shall create a presumption that informed consent was given. A consent in writing meets the requirements of this section if it:

1. Sets forth in general terms the nature and purpose of the procedure or procedures, together with the known risks, if any, of death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such procedure or procedures, with the probability of each such risk if reasonably determinable.

2. Acknowledges that the disclosure of that information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner.

3. Is signed by the patient for whom the procedure is to be performed, or if the patient for any reason lacks legal capacity to consent, is signed by a person who has legal authority to consent on behalf of that patient in those circumstances.

Sec. 18. Section five hundred nineteen point one (519.1), Code 1975, is amended to read as follows:

519.1 AUTHORIZATION. Any number of physicians, ~~druggists~~ and surgeons, osteopaths, osteopathic physicians and surgeons, podiatrist, chiropractors, pharmacists, dentists, and graduate nurses, licensed to practice their profession in this state, and hospitals licensed under chapter one hundred thirty-five B (135B) of the Code, may, by complying with the provisions of this chapter and without regard to other statutory provisions, enter into contracts with each other for the purpose of protecting themselves by insurance against loss by reason of actions at law on account of their alleged error, mistake, negligence, or carelessness in the treatment and care of patients, including the performance of surgical operations, or in the prescribing and dispensing of drugs and medicines, or for loss by reason of damages in other respects, and to reimburse any member in case of such loss.

Sec. 19. Section five hundred nineteen point two (519.2),

Code 1975, is amended to read as follows:

519.2 INCORPORATION--POWERS. All corporations, organized for the purpose of transacting such insurance business under the provisions of this chapter, shall incorporate under the provisions of chapter 491, and be known as mutual corporations; and are hereby empowered to collect such assessments, or premium payments, provided for in their articles of incorporation or bylaws, as are required to pay losses and expenses incurred in the conduct of their business and to cede reinsurance. Such mutual insurance corporations may issue certificates of membership, or policies; and may provide that all assessments, or premium payments, payable thereunder, be made in cash, or on the installment, or assessment plan.

Sec. 20. Section five hundred nineteen point five (519.5), Code 1975, is amended to read as follows:

519.5 CONDITIONS. No such certificate shall be issued by the commissioner of insurance until two hundred fifty applications have been received, ~~representing, in the aggregate, one million dollars of insurance,~~ and until the commissioner of insurance has satisfied himself that such mutual insurance corporation has bona fide applications representing the number of applicants ~~and the amount of insurance herein~~ required, and that there is in the possession of such mutual insurance corporation cash assets amounting to not less than ten ~~thousand dollars~~ times the maximum single retained risk.

Sec. 21. Section five hundred nineteen point six (519.6), Code 1975, is amended to read as follows:

519.6 REPORTS. Such mutual insurance corporations doing business under the provisions of this chapter shall, annually, ~~in the month of January~~ before the first day of March, report to the commissioner of insurance, upon blanks furnished by him, the same facts, so far as applicable, as are required to be furnished by mutual insurance associations under the statutes of Iowa, which report shall be tabulated by the commissioner of insurance and published by him in the annual

report on insurance.

Sec. 22. Section five hundred nineteen point eight (519.8), Code 1975, is amended to read as follows:

519.8 CANCELLATION OF POLICY. Any certificate of membership, or policy, issued by such a mutual insurance corporation may be canceled by the corporation by giving five thirty days' written notice thereof to the insured; or such cancellation may be upon demand of the insured; and such cancellation, when so made, either by the corporation or by the insured, shall be upon a pro rata basis, and the cancellation of such certificate or policy shall release the member from all other future obligations to such corporation.

Sec. 23. Section five hundred nineteen point nine (519.9), Code 1975, is amended to read as follows:

519.9 FEES. Such a mutual insurance corporation shall pay the same fees for admission into the state, for annual reports, and for annual certificates of authority as are required to be paid by domestic mutual companies organized and doing business under chapter 515; such certificate shall expire ~~March 4~~ May first of the year following the date of its issue.

Sec. 24. Section five hundred nineteen point twelve (519.12), Code 1975, is amended to read as follows:

519.12 FOREIGN COMPANIES. Any mutual insurance association organized under the laws of any other state, for the purpose of transacting the kind of business described in this chapter, and which has ~~been in business not less than one year, and has~~ on hand ~~cash assets in an amount of surplus amounting to~~ not less than ten ~~thousand dollars~~ times the maximum single retained risk, and has not less than three two hundred fifty members, ~~shall may~~ upon application, be admitted to do business in this state if the commissioner finds such admission is in the public interest; and shall thereafter make all reports and be subject to taxation, examination, and supervision by the commissioner of insurance to the same extent and in the same manner as are domestic corporations organized under the provisions of this chapter.

Sec. 25. Chapter one hundred forty-seven (147), Code 1975, as amended by adding the following new section:

NEW SECTION. In any action for personal injury or wrongful death against any physician and surgeon, osteopath, osteopathic physician and surgeon, dentist, podiatrist, optometrist, pharmacist, chiropractor or nurse licensed under this chapter or against any hospital licensed under chapter one hundred thirty-five B (135B) of the Code, based upon the alleged negligence of the licensee in the practice of that profession or occupation, or upon the alleged negligence of the hospital in patient care, the court shall determine the reasonableness of any contingent fee arrangement between the plaintiff and the plaintiff's attorney.

Sec. 26. Section six hundred fourteen point one (614.1), Code 1975, is amended by adding the following new subsection:

NEW SUBSECTION. MALPRACTICE. Those founded on injuries to the person or wrongful death against any physician and surgeon, osteopath, osteopathic physician and surgeon, dentist, podiatrist, optometrist, pharmacist, chiropractor, or nurse, licensed under chapter one hundred forty-seven (147) of the Code, or a hospital licensed under chapter one hundred thirty-five B (135B) of the Code, arising out of patient care, within two years after the date on which the claimant knew, or through the use of reasonable diligence should have known, or received notice in writing of the existence of, the injury or death for which damages are sought in the action, whichever of the dates occurs first, but in no event shall any action be brought more than six years after the date on which occurred the act or omission or occurrence alleged in the action to have been the cause of the injury or death unless a foreign object unintentionally left in the body caused the injury or death.

Sec. 27. Chapter six hundred nineteen (619), Code 1975, is amended by adding the following new section:

NEW SECTION. In an action for personal injury or wrongful death against a physician and surgeon, osteopath, osteopathic physician and surgeon, dentist, podiatrist, optometrist, pharmacist, chiropractor, or nurse licensed to practice that

profession in this state, or against a hospital licensed for operation in this state, based upon the alleged negligence of the practitioner in the practice of the profession or occupation, or upon the alleged negligence of the hospital in patient care, the amount of money damages demanded shall not be stated in the petition, or original notice, or in any counterclaim or cross petition.

DALE M. COCHRAN
Speaker of the House

ARTHUR A. NEU
President of the Senate

I hereby certify that this bill originated in the House and is known as House File 803, Sixty-sixth General Assembly.

DAVID L. WRAY
Chief Clerk of the House

Approved _____, 1975

ROBERT D. RAY
Governor