RE-RE-ENGROSSED
HB 1267

AS PASSED BY THE LEGISLATURE

A bill to be entitled

An act relating to medical liability insurance and civil law revisions concerning medical malpractice actions; providing a short title; creating s. 627.352, Florida Statutes, relating to the creation of a medical liability insurance study commission; creating s. 395.18, Florida Statutes, authorizing certain hospitals to establish internal risk management programs; amending subsection (1) of s. 627.355, Florida Statutes, to allow total self-insurance by a group or association of physicians or health care facilities organized for any purpose; creating s. 768.133, Florida Statutes, providing for the establishment of medical liability mediation panels in each judicial circuit; providing for the filing, hearing and disposition of claims, and providing a filing fee; providing for legal proceedings subsequent to the decision of the mediation panels; amending s. 95.11(4), Florida Statutes, 1974 Supplement, relating to the statute of limitations, to provide that actions for medical malpractice shall be commenced within two years from the time the incident occurred or the injury is discovered but not to exceed four years from the date the incident occurred; providing exceptions for fraud and misrepresentation; creating s. 768.042, Florida Statutes, to prohibit the stating of the amount of general damages in any complaint for recovery of damages for personal injury or wrongful death; amending s. 725.01, Florida Statutes, to provide that medical guarantees shall be governed by the Statute of Frauds; creating s. 768.132, Florida Statutes, entitled the "Florida Medical Consent Law"; covering consent in all cases not covered by s. 768.13, Florida Statutes, entitled the "Good Samaritan Act"; setting standards for information necessary for consent; providing a presumption where a valid consent was given; amending s. 458.1201(1)(m), Florida Statutes, and adding paragraphs (o) and (p) to said section; providing that the State Board of Medical Examiners determine standards of acceptable and prevailing medical practice; authorizing board action in medical malpractice cases and certain disciplinary cases; providing for a civil penalty; adding paragraphs (c) and (d) to s. 458.1201(2), Florida Statutes; providing for appointment of licensed physicians to act for the board; providing for immunity from liability for investigations conducted pursuant to this act; amending s. 458.1201(3)(a), Florida Statutes; authorizing board to require physicians to participate in continuing education programs; authorizing board to require physicians to practice under the direction of a physician in certain locations; adding s. 458.1201(5), Florida Statutes; requiring the board to report to the legislature; creating s. 395.065, Florida Statutes, providing for hospital disciplinary powers; adding subsection (8) to s. 627.351, Florida Statutes, to provide for a joint underwriting plan offering medical malpractice insurance coverage to be set up by

insurers writing casualty insurance as defined in s. 624.605(1)(b), (j), and (p), Florida Statutes, and self-insurers authorized under s. 627.355, Florida Statutes; creating s. 627.353, Florida Statutes, to provide for the limitation of liability when certain provisions are met for any licensed hospital, physician, physician's assistant, osteopath or podiatrist for the amount of any settlement approved by the joint underwriting association established under s. 627.351(8), Florida Statutes, or any judgment exceeding $100,000 for any claim arising out of the rendering of medical care or services; creating a patient's compensation fund to be administered by said joint underwriting association subject to supervision by a board of governors to provide coverage for the amount of any such settlement or judgment affected by said limitation of liability; providing for fees to support the fund including an assessment against participants for deficits; providing for costs in administering or defending the fund; providing claims procedures; providing an effective date.

WHEREAS, the cost of purchasing medical professional liability insurance for doctors and other health care providers has skyrocketed in the past few months; and

WHEREAS, it is not uncommon to find physicians in high-risk categories paying premiums in excess of $20,000 annually; and

WHEREAS, the consumer ultimately must bear the financial burdens created by the high cost of insurance; and

WHEREAS, without some legislative relief, doctors will be forced to curtail their practices, retire, or practice defensive medicine at increased cost to the citizens of Florida; and

WHEREAS, the problem has reached crisis proportion in Florida, NOW THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. The short title of this act shall be "The Medical Malpractice Reform Act of 1975".

Section 2. Section 627.352, Florida Statutes, is created to read:

627.352 Medical Liability Insurance Commission.--

(1) The Florida Medical Liability Insurance Commission is hereby created, consisting of the following members: the Insurance Commissioner, the Secretary of the Department of Health and Rehabilitative Services, and twelve members to be appointed. The Governor, the President of the Senate, and the Speaker of the House of Representatives shall each appoint four members to the commission. Each shall appoint a member of the legal profession, a provider of health services, a lay citizen and a representative from the insurance industry.

(2) The Insurance Commissioner shall be the chairman of the commission and shall provide records management for the commission. A majority of the commission members shall constitute a quorum for the transaction of any business or the exercise of any power or function of the commission. The affirmative vote by a majority of the quorum present at a duly called and noticed meeting shall be required to exercise any power or function of the commission. Each member shall be entitled to one vote on all matters which may come before the commission. The commission may delegate to one or more of its members such duties as it deems proper.

(3) The Insurance Commissioner and the Secretary of the Department of Health and Rehabilitative Services may designate a representative from his agency to exercise his power and perform his duties, including the right to vote on the commission.

(4) Members of the commission serving as representatives of the general public shall receive mileage and $20 per diem for attending meetings of the commission. Each member of the commission shall be allowed the necessary and actual expenses which he shall incur in the performance of his duties under this section.

(5) On or before January 1, 1976, the commission, in cooperation and consultation with appropriate state and federal agencies, the medical and legal professions, the insurance industry and representatives of the general public, shall prepare and submit to the Governor and the legislature its report and recommendations.

(a) The goal of the plan shall be to recommend a medical liability insurance system which can be operated at reasonable cost for the purpose of providing prompt, equitable compensation to those sustaining medical injury.

(b) Primary consideration shall be given, but not limited to, establishing an insurance system which can be underwritten by private insurers on a self-supporting basis using actuarially sound rates.

(c) If the commission finds that no insurance system meeting the goal of the plan can be underwritten by private insurers on a self-supporting basis using actuarially sound rates, it shall specify the needed changes in the statutes to create a viable market for medical liability insurance, or self-insurance.

(d) The comprehensive report shall include recommendations to the legislature for reducing the incidence of medical injuries, including establishing standards of care and procedures for peer review; reducing the cost of prosecuting and defending claims and administering the insurance mechanism, changes in existing law governing the eligibility of injured persons for compensation and the amount of compensation, including limitations on the time within which claims may be brought and the elements of loss for which compensation may be recovered and any other matters or procedures which the commission considers relevant to the medical liability insurance problem.

(e) The commission is authorized and encouraged to make interim reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives concerning specific legislative proposals, which need immediate consideration.

Section 3. Section 395.18, Florida Statutes, is created to read:

395.18 Internal risk management program.--Every hospital licensed pursuant to this chapter, having in excess of 300 beds, as a part of its administrative functions, shall establish an internal risk management program which shall include the following components:

(1) The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients; and

(2) The development of appropriate measures to minimize the risk of injuries and adverse incidents to patients through the cooperative efforts of all personnel; and

(3) The analysis of patient grievances which relate to patient care and the quality of medical services.

The risk management program shall be carried out either through a person on the administrative staff of a hospital, as part of his administrative duties; or by a committee of the

hospital board of trustees or directors; or by the medical staff in a manner deemed appropriate.

Section 4. Subsection (1) of s. 627.355, Florida Statutes, is amended to read:

627.355 Medical malpractice insurance; purchase.--

(1) A group or association of physicians or health care facilities, composed of any number of members, ~~organized for purposes other than the purchase of medical malpractice insurance~~, ~~which has been in continuing existence for a period of at least 2 years~~, is authorized partially to self-insure against claims of medical malpractice upon obtaining approval from the Department of Insurance and upon complying with the following conditions:

(a) Establishment of a medical malpractice risk management trust fund to provide coverage against professional medical malpractice liability.

(b) Employment of a professional ~~staff and~~ consultants for loss prevention and claims management coordination under a risk management program.

Section 5. Section 768.133, Florida Statutes, is created to read:

768.133 Medical liability mediation panel.--

(1) The chief judge of each judicial circuit shall prepare a list of persons to serve on medical liability mediation panels, whose purpose shall be to hear and to facilitate the disposition of all medical malpractice actions arising within the jurisdiction of the circuit. The number of persons on the list shall be determined by the chief judge but shall be in sufficient numbers to efficiently carry out the intent of this section. All hearings, as hereinafter provided for, shall be before a three-member panel hereinafter referred to as the panel, mediation panel or hearing panel composed as follows: a judicial referee who shall be the presiding member of the hearing panel,

shall be a circuit judge. Such appointments shall be made by a "blind" system. The other panel members shall be selected in accordance with the following procedure:

(a) A list of physicians licensed to practice under chapters 458 or 459 shall be prepared by the chief judge. In making the list, the chief judge may accept the recommendations of recognized professional medical societies. The list shall be divided into lists of physicians according to the particular specialty of each if possible.

(b) A list of qualified attorneys shall be prepared by the chief judge. In making the list the chief judge may accept the recommendations of recognized professional legal societies.

(c) Names of physicians and attorneys may be added to or taken off the panel list at any time by the chief judge at his discretion, provided, however, that all names added to the list shall be placed at the bottom of the list.

(d) A physician or attorney selected to be on the hearing panel for a particular case may disqualify himself or be challenged for cause.

(e) A filing fee not to exceed $25 shall be established by the chief judge in each circuit and shall be paid to the clerk of the circuit court. The filing fee shall be used to meet such incidental expenses as the panel may incur.

(2) Any person or his representative claiming damages by reason of injury, death or monetary loss on account of the alleged malpractice by any medical or osteopathic physician, hospital, or health maintenance organization and against whom he believes there is a reasonable basis for a claim shall submit such claim to the appropriate panel before that claim may be filed in any court of this state. Claims shall be made on

forms provided by the circuit court and shall be filed initially with the clerk of that court, with copies mailed to the person against whom the claim is made and to the administrative board licensing such professional. Service of process shall be effected as provided by law. Constructive service of process may be effected as provided by law. All parties named as defendants in the claim shall file an answer to such claim within 20 days of the date of service. No other pleadings shall be allowed. If no answer is filed within such time limit, the jurisdiction of the mediation panel over the subject matter shall terminate, and the parties may proceed in accordance with law. Within 30 days after service of process, the parties shall file with the clerk a document designating the type of medical specialist who should hear the claim. In the event the parties do not agree on the specialist, the judicial referee shall make the determination. In no event shall more than one medical practitioner serve on a mediation panel.

(3) If both parties agree upon a doctor and an attorney to serve on the hearing panel, they may so stipulate. In the event that no agreement is reached within 10 days after determination of the specialty of medical practice involved, the clerk shall mail to the parties and the panel members hereinafter described the names selected at random of five attorneys who are members of the hearing panel and the names selected at random of five physicians of the designated specialty who are members of the hearing panel, or if it is impractical to designate the physicians by specialty, the names selected at random of five physicians without regard to specialty. Thereafter, the panel members so selected shall have 10 days within which to disqualify themselves and the parties shall have the same time in which to challenge panel members for cause. A decision on challenges for cause shall be made by agreement or by the

judicial referee. If there are disqualifications or challenges for cause, the clerk shall appoint additional panel members as required. Thereafter, from the list of five attorneys and five physicians, the parties shall agree on one attorney and one physician to serve on the hearing panel. If the parties are unable to agree, each side shall then strike names alternately from the attorneys' list and from the physicians' list separately, with the claimant striking first, until each side has stricken two names from each list. The remaining attorney and physician shall serve on the hearing panel.

(4) The clerk shall, with the advice and cooperation of the parties and their counsel, fix a date, time and place for a hearing on the claim before the hearing panel, provided, however, that the hearing shall be held within 120 days of the date the claim is filed with the clerk, unless for good cause shown upon order of the judicial referee, such time is extended. Such extension shall not exceed six months from the date the claim is filed. If no hearing is held on the merits within 10 months of the date the claim is filed, the jurisdiction of the mediation panel on the subject matter shall terminate and the parties may proceed in accordance with law.

(5) The filing of the claim shall toll any applicable statute of limitations, and such statute of limitations shall remain tolled until the hearing panel issues its written decision, or the jurisdiction of the panel is otherwise terminated. In any event, a party shall have 60 days from the date the decision of the hearing panel is mailed to the parties or the date on which the jurisdiction of the panel is otherwise terminated in which to file a complaint in circuit court.

(6) All parties shall be allowed to utilize any discovery procedure provided for by the Florida Rules of Civil Procedure. Any motion for relief arising out of the use of such discovery procedures shall be decided by the judicial

referee. The judicial referee may in his discretion make reasonable limitations on the extent of discovery.

(7) The claim shall be submitted to the hearing panel under such procedural rules as may be established by the Supreme Court, provided that strict adherence to the rules of procedure and evidence applicable in civil cases shall not be required. Witnesses may be called, all testimony shall be under oath, testimony may be taken either orally before the panel or by deposition, copies of records, x-rays and other documents may be produced and considered by the panel and the right to subpoena witnesses and evidence shall obtain as in all other proceedings in the circuit court. The right of cross-examination shall obtain as to all witnesses who testify in person. Both parties shall be entitled, individually and through counsel, to make opening and closing statements. No transcript or record of the proceedings shall be required, but any party may have the proceedings transcribed or recorded. The judge presiding at the hearing shall not preside at any trial arising out of the claim or hear any application in the case not connected with the hearing itself. No other hearing panel member shall participate in a trial arising out of the claim either as counsel or witness.

(8) Within 30 days after the completion of any hearing, the hearing panel shall file a written decision with the clerk of the court who shall thereupon mail copies to all parties concerned and their counsel. The panel shall decide the issue of liability and shall state its conclusion in substantially the following language: "We find the defendant was actionably negligent in his care and/or treatment of the patient and we, therefore, find for the plaintiff"; or "We find the defendant was not actionably negligent in his care and/or treatment of the patient and we, therefore, find for the defendant". The

decision shall be signed by all members of the hearing panel; however, any member of the panel may file a written concurring or dissenting opinion.

(9) After a finding of liability, if the adverse parties agree, the panel may continue mediation for the purpose of assisting the parties in reaching a settlement. In such event, the panel shall also make a recommendation as to a reasonable range of damages, if any, which should be awarded in the case. The recommendation as to damages shall include in simple, concise terms some breakdown as to which portion of the damages recommended are attributable to past and estimated future health or custodial care expenses attributable to the alleged malpractice or any of the other elements of damage enumerated in s. 768.21, Florida Statutes, for wrongful death or recognized by the Florida Standard Jury Instructions as elements of damages in injuries due to negligence. However, the panel shall not have the right to determine punitive damages. Any findings of damages shall not be admissible in evidence in a subsequent trial.

(10) In the event any party rejects the decision of the hearing panel, the claimant may institute litigation based upon the claim in the appropriate court. Furthermore, in any civil medical malpractice action, the trial on the merits shall be conducted without any reference to insurance, insurance coverage or joinder in the suit of the insurer as a co-defendant.

(11) The conclusion of the hearing panel on the issue of liability may be admitted into evidence in any subsequent trial. However, no specific findings of fact shall be admitted into evidence at trial. Parties may, in the opening statement or argument to the court or jury, comment on the panel's conclusion in the same manner as any other evidence introduced at trial. If there is a dissenting opinion, the numerical vote of the panel shall also be admissible. Panel members may not

be called to testify as to the merits of the case. The jury shall be instructed that the conclusion of the hearing panel shall not be binding but shall be accorded such weight as they choose to ascribe to it.

(12) No member of the hearing panel shall be liable in damages for libel, slander or defamation of character of any party to the mediation proceedings for any action taken or recommendation made by such member acting within his official capacity as a member of the hearing panel.

Section 6. The provisions of section 5 of this act shall not be applicable to any case in which formal suit has been instituted prior to the effective date of that section, which shall be July 1, 1975.

Section 7. Subsection (4) of section 95.11, Florida Statutes, 1974 Supplement, is amended to read:

95.11 Limitations other than for the recovery of real property.--Actions other than for recovery of real property shall be commenced as follows:

(4) WITHIN TWO YEARS.--

(a) An action for professional malpractice, other than medical malpractice, whether founded on contract or tort; provided that the period of limitations shall run from the time the cause of action is discovered or should have been discovered with the exercise of due diligence; provided, however, that the limitation of actions herein for professional malpractice shall be limited to persons in privity with the professional.

(b) An action for medical malpractice shall be commenced within two years from the time the incident occurred giving rise to the action, or within two years from the time the incident is discovered, or should have been discovered with the exercise of due diligence, provided, however, that in no event shall the action be commenced later than four years from the date of the

incident or occurrence out of which the cause of action accrued. An action for medical malpractice is defined as a claim in tort or in contract for damages because of the death, injury, or monetary loss to any person arising out of any medical, dental, or surgical diagnosis, treatment, or care by any provider of health care. The limitation of actions within this subsection shall be limited to the health care provider and persons in privity with the provider of health care. In those actions covered by this paragraph where it can be shown that fraud, concealment, or intentional misrepresentation of fact prevented the discovery of the injury within the four-year period, the period of limitations is extended forward two years from the time that the injury is discovered or should have been discovered with the exercise of due diligence, but in no event to exceed seven years from the date the incident giving rise to the injury occurred.

(c)(b) An action to recover wages or overtime or damages or penalties concerning payment of wages and overtime.

(d)(c) An action for wrongful death.

Section 8. Section 768.042, Florida Statutes, is created to read:

768.042 Damages.--In any action brought in the circuit court to recover damages for personal injury or wrongful death, the amount of general damages shall not be stated in the complaint, but the amount of special damages, if any, may be specifically pleaded and the requisite jurisdictional amount established for filing in any court of competent jurisdiction.

Section 9. The provisions of section 8 of this act shall not apply to any complaint filed prior to the effective date of this act.

Section 10. Section 725.01, Florida Statutes, is amended to read:

725.01 Promise to pay another's debt, etc.--No action shall be brought whereby to charge any executor or administrator upon any special promise to answer or pay any debt or damages out of his own estate, or whereby to charge the defendant upon any special promise to answer for the debt, default or miscarriage of another person or to charge any person upon any agreement made upon consideration of marriage, or upon any contract for the sale of lands, tenements or hereditaments, or of any uncertain interest in or concerning them, or for any lease thereof for a period longer than one year, or upon any agreement that is not to be performed within the space of one year from the making thereof, or whereby to charge any health care provider upon any guarantee, warranty or assurance as to the results of any medical, surgical or diagnostic procedure, performed by any physician licensed under chapter 458, Florida Statutes, osteopath licensed under chapter 459, Florida Statutes, chiropractor licensed under chapter 460, Florida Statutes, podiatrist licensed under chapter 461, Florida Statutes, or dentist licensed under chapter 466, Florida Statutes, unless the agreement or promise upon which such action shall be brought, or some note or memorandum thereof shall be in writing and signed by the party to be charged therewith or by some other person by him thereunto lawfully authorized.

Section 11. Section 768.132, Florida Statutes, is created to read:

768.132 Florida medical consent law.--

(1) This section shall be known and cited as the "Florida Medical Consent Law".

(2) In any medical treatment activity not covered by s. 768.13, Florida Statutes, entitled "the Good Samaritan Act", this act shall govern.

(3) No recovery shall be allowed in any court in this

state against any physician licensed under chapter 458, Florida Statutes, osteopath licensed under chapter 459, Florida Statutes, chiropractor licensed under chapter 460, Florida Statutes, podiatrist licensed under chapter 461, Florida Statutes, or dentist licensed under chapter 466, Florida Statutes, in an action brought for treating, examining, or operating on a patient without his informed consent where:

(a) The action of the physician, osteopath, chiropractor, podiatrist, or dentist in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community; and

(b) A reasonable individual from the information provided by the physician, osteopath, chiropractor, podiatrist, or dentist under the circumstances, would have a general understanding of the procedure and medically acceptable alternative procedures or treatments and substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among other physicians, osteopaths, chiropractors, podiatrists, or dentists in the same or similar community who perform similar treatments or procedures; or

(c) The patient would reasonably, under all the surrounding circumstances, have undergone such treatment or procedure had he been advised by the physician, osteopath, chiropractor, podiatrist, or dentist in accordance with the provisions of paragraphs (a) and (b) of this section.

(4)(a) A consent which is evidenced in writing and meets the requirements of subsection (3), shall, if validly signed by the patient or another authorized person, be conclusively presumed to be valid consent. This presumption may be rebutted if there was a fraudulent misrepresentation of a material fact in

obtaining the signature.

(b) A valid signature is one which is given by a person who under all the surrounding circumstances is mentally and physically competent to give consent.

Section 12. Subsection (5) of s. 458.1201, Florida Statutes, is renumbered as subsection (6), and a new subsection (5) is added to said section; paragraph (m) of subsection (1) of said section is amended and paragraphs (o) and (p) are added to said subsection; paragraphs (c) and (d) are added to subsection (2) of said section; paragraph (a) of subsection (3) of said section is amended to read:

458.1201 Denial, suspension, revocation of license; disciplinary powers.--

(1) The board shall have authority to deny an application for a license or to discipline a physician licensed under this chapter or any antecedent law who, after hearing has been adjudged unqualified or guilty of any of the following:

(m) Being guilty of immoral or unprofessional conduct, incompetence, negligence, or willful misconduct. Unprofessional conduct shall include any departure from, or the failure to conform to, the ~~minimal~~ standards of acceptable and prevailing medical practice in his area of expertise as determined by the board, in which proceeding actual injury to a patient need not be established; ~~or the committing by a physician of any act contrary to honesty, justice, or good morals,~~ when whether the same is committed in the course of his practice ~~or otherwise~~, and whether committed within or without this state;

(o) Being found liable for medical malpractice or any personal injury resulting from an act or omission committed or omitted by a person in his capacity as a physician licensed pursuant to this chapter.

(p) Being removed or suspended or having disciplinary

action taken by his peers within any professional medical association, society, professional standards review organization established pursuant to section 249F of Public Law 92-603, or similarly constituted professional body, whether or not such association, society, organization, or body is local, regional, state, national, or international in scope, or by being disciplined by a licensed hospital or medical staff of said hospital for immoral or unprofessional conduct or willful misconduct or negligence by a person in his capacity as a physician licensed pursuant to this chapter. Any body taking action as set forth in this paragraph shall report such action to the board within 30 days of its occurrence or be subject to a fine assessed by the board in an amount not exceeding $500.

(2)(c) In any proceeding under subsection (1) of this section the board may appoint one or more licensed physicians to act for the board in investigating the conduct or competence of a physician.

(d) There shall be no liability on the part of, and no cause of action of any nature shall arise against the board, its agents, its employees, or any organization or its members identified in paragraph (p) of subsection(1) of this section, for any statements made by them in any reports or communications concerning an investigation of the conduct or competence of a physician.

(3)(a) When the board finds any person unqualified or guilty of any of the grounds set forth in subsection (1), it may enter an order imposing one or more of the following:

1. Deny his application for a license;

2. Permanently withhold issuance of a license;

3. Administer a public or private reprimand;

4. Suspend or limit or restrict his license to practice medicine for a period of up to five years;

5. Revoke indefinitely his license to practice medicine;

6. Require him to submit to the care, counseling, or treatment of physicians designated by the board;

7. Require him to participate in a program of continuing education prescribed by the board;

8. Require him to practice under the direction of a physician in a public institution, public or private health care program, or private practice for a period of time specified by the board.

(5) The board shall report to the President of the Senate and the Speaker of the House of Representatives, on February 1 of each year beginning February 1, 1976, the status of the actions taken by the board in carrying out its responsibilities assigned to it under this section.

(6)(5) The provisions of this section are enacted in the public welfare and shall be liberally construed so as to advance the remedy.

Section 13. Section 395.065, Florida Statutes, is created to read:

395.065 Hospital disciplinary powers.--

(1) The medical staff of any hospital licensed pursuant to chapter 395, Florida Statutes, is authorized to suspend, deny, revoke, or curtail the staff privileges of any staff member for good cause, which shall include, but not be limited to:

(a) Incompetence;

(b) Negligence;

(c) Being found an habitual user of intoxicants or drugs to the extent that the physician is deemed dangerous to himself or others; or

(d) Being found liable by a court of competent jurisdiction for medical malpractice.

Provided, however, that the procedures for such actions shall comply with the standards outlined by the Joint Commission of Accreditation of Hospitals and the

Principles of Participation in the Federal Health Insurance Program for the Aged.

(2) There shall be no liability on the part of and no cause of action of any nature shall arise against any hospital, hospital medical staff or hospital disciplinary body, its agents or employees, for any action taken in good faith and without malice in carrying out the provisions of this act.

Section 14. Subsection (8) of s. 627.351, Florida Statutes, is created to read:

627.351 Insurance risk apportionment plan.--

(8)(a) The Department of Insurance shall, after consultation with insurers as set forth in paragraph (b), adopt a temporary joint underwriting plan as set forth in paragraph (d).

(b) Entities licensed to issue casualty insurance as defined in s. 624.605(1)(b), (j), and (p), Florida Statutes, and self-insurers authorized to issue medical malpractice insurance under s. 627.355, Florida Statutes, shall participate in the plan and shall be members of the Temporary Joint Underwriting Association.

(c) The joint underwriting association shall operate subject to the supervision and approval of a board of governors consisting of representatives of five of the insurers participating in the joint underwriting association, an attorney to be named by the Florida Bar, a physician to be named by the Florida Medical Association, a hospital representative to be named by the Florida Hospital Association, and the Insurance Commissioner or his designated representative employed by the Department of Insurance. The Insurance Commissioner or his representative shall be the chairman of the board.

(d) The temporary joint underwriting plan shall function for a period not exceeding three years from the date of its adoption by the Department of Insurance and if still in existence

at the end of such three-year period, it shall automatically terminate. The plan shall provide professional liability or malpractice coverage in a standard policy form for all hospitals licensed under chapter 395, Florida Statutes, physicians licensed under chapter 458, Florida Statutes, osteopaths licensed under chapter 459, Florida Statutes, podiatrists licensed under chapter 461, Florida Statutes, dentists licensed under chapter 466, Florida Statutes, nurses licensed under chapter 464, Florida Statutes, and nursing homes licensed under chapter 400, Florida Statutes, or professional associations of such persons. The plan shall include, but not be limited to, the following:

1. Rules for the classification of risks and rates which reflect past and prospective loss and expense experience in different areas of practice and in different geographical areas.

2. A rating plan which reasonably recognizes the prior claims experience of insureds.

3. Provisions as to rates for insureds who are retired, semi-retired, the estate of a deceased insured, or part-time professionals.

4. Protection in an amount to be determined by the Insurance Commissioner and for those hospitals licensed under chapter 395, Florida Statutes, whose policies have been cancelled since April 1, 1975, that have not been able to otherwise secure coverage in the standard market shall provide continuous coverage at the limits available in the plan from the above date.

5. Rules to implement the orderly dissolution of the plan at its termination.

6. The Insurance Commissioner may, in his discretion, require that insurers participating in the joint underwriting association offer excess coverage.

(e) Premium contingency assessment.--

1. In the event an underwriting deficit exists at the end of any year the plan is in effect, each policyholder shall

pay to the association a premium contingency assessment not to exceed one-third of the annual premium payment paid by such policyholder to the association. The association shall cancel the policy of any policyholder who fails to pay the premium contingency assessment.

2. Any deficit sustained under the plan shall first be recovered through the premium contingency assessment. Concurrently, the rates for insureds shall be adjusted for the next year so as to be actuarially sound.

3. If there be any remaining deficit under the plan after maximum collection of the premium contingency assessment, such deficit shall be recovered from the companies participating in the plan in the proportion that the net direct premiums of each such member written during the preceding calendar year bears to the aggregate net direct premiums written in this state by all members of the association. Premiums as used herein shall mean premiums for the lines of insurance defined in s. 624.605(1)(b), (j), and (p), Florida Statutes, including premiums for such coverage issued under package policies.

(f) The plan shall provide for one or more insurers able and willing to provide policy service through licensed resident agents and claims service on behalf of all other insurers participating in the plan.

(g) The Department of Insurance, prior to termination of the plan, shall determine whether a need reasonably exists for continuing coverage for those who have been insured by the plan, as to claims solely for incidents which occurred during the existence of the plan. If such need is found, the Department of Insurance shall establish a plan for the purchase of such coverage for a reasonable time, prior to termination of the plan.

(h) All books, records, documents or audits relating

to the joint underwriting association or its operation shall be open to public inspection.

Section 15. Section 627.353, Florida Statutes, is created to read:

627.353 Limitation of liability and patient's compensation fund.--

(1) LIMITATION OF LIABILITY.--

(a) All hospitals licensed under chapter 395, Florida Statutes, shall, unless exempted under paragraph (c) of this section, and all physicians and physician's assistants licensed under chapter 458, Florida Statutes, osteopaths licensed under chapter 459, Florida Statutes, and podiatrists licensed under chapter 461, Florida Statutes, may, pay the yearly assessment into the patient's compensation fund pursuant to subsection (2) of this section prior to practicing during any [illegible]

(b) Said licensed hospital, physician, physician's assistant, osteopath, or podiatrist shall not be liable for an amount in excess of $100,000 for claims arising out of the rendering of medical care or services in this state if at the time the incident occurred giving rise to the cause of the claim the hospital, physician, physician's assistant, osteopath or podiatrist:

1. had posted bond in the amount of $100,000, proved financial responsibility in the amount of $100,000 to the satisfaction of the Insurance Commissioner through the establishment of an appropriate escrow account, obtained medical malpractice insurance in the amount of $100,000 or more from private insurers or the joint underwriting association established under section 14 of this act, or obtained self-insurance

as provided in s. 627.355, Florida Statutes, providing coverage in an amount of $100,000 or more, and

2. Had paid for the year in which the incident occurred for which the claim was filed the fee required pursuant to subsection (2) of this section.

(c) Any hospital that can meet one of the following provisions demonstrating financial responsibility to meet claims arising out of the rendering of medical care or services in this state shall not be required to participate in the fund:

1. Post bond in an amount equivalent to $10,000 for each hospital bed in said hospital not to exceed $2,500,000; or

2. Prove financial responsibility in an amount equivalent to $10,000 for each hospital bed in said hospital not to exceed $2,500,000 to the satisfaction of the Insurance Commissioner through the establishment of an appropriate escrow account; or

3. Obtain professional liability coverage in an amount equivalent to $10,000 or more for each bed in said hospital from a private insurer, from the joint underwriting association established under section 14 of this act, or through a plan of self-insurance as provided in s. 627.355, Florida Statutes; provided, however, no hospital shall be required to obtain such coverage in an amount exceeding $2,500,000.

(d) Any licensed hospital, physician, physician's assistant, osteopath, or podiatrist who does not meet the provisions of paragraph (b) of this subsection shall be subject to liability under law without regard to the provisions of this section.

(2) PATIENT'S COMPENSATION FUND.--

(a) The fund.--There is created a "Florida Patient's Compensation Fund" hereinafter referred to as the "Fund", for the purpose of paying that portion of any medical malpractice claim which is in excess of $100,000 as set forth in paragraph

(b) of subsection (1) of this section. The Fund shall be liable only for payment of claims against hospitals, physicians, physician's assistants, osteopaths and podiatrists in compliance with the provisions of paragraph (b) of subsection (1) of this section, and reasonable and necessary expenses incurred in payment of claims and fund administrative expenses.

(b) Fund administration and operation.--Management of the fund shall be vested with the joint underwriting association authorized by section 14 of this act, hereinafter referred to as the JUA. The JUA shall operate subject to the supervision and approval of a board of governors consisting of representatives of five of the insurers participating in the JUA, an attorney to be named by the Florida Bar, a physician to be named by the Florida Medical Association, a hospital representative to be named by the Florida Hospital Association, and the Insurance Commissioner or his designated representative employed by the Department of Insurance. The Insurance Commissioner or his representative shall be the chairman of the board. In the event of termination or dissolution of said JUA with respect to providing professional liability or malpractice insurance, the JUA shall continue to operate for the purpose of fund management as provided in this subsection.

(c) Fees and assessments.--Annually, each licensed hospital, physician, physician's assistant, osteopath or podiatrist as set forth in subsection (1) electing to comply with paragraph (b) of subsection (1) of this section shall pay the fees established under this act for deposit into the fund, which shall be remitted for deposit in a manner prescribed by the Insurance Commissioner. The coverage provided by the fund shall begin July 1, 1975 and run thereafter on a fiscal year basis. For the first year of operation each participating licensed hospital, physician, physician's assistant, osteopath,

or podiatrist covered under the fund shall pay a fee for deposit into the fund in the amount of $1,000 for any individual and $300 per bed for any hospital. The fee charged after the first year of operation shall consist of a base fee of $500 for any individual and $300 per bed for any hospital. In addition, after the first year of operation additional fees shall be assessed based on the following considerations:

1. Past and prospective loss and expense experience in different types of practice and in different geographical areas within the state.

2. The prior claims experience of persons or hospitals covered under the fund.

3. Risk factors for persons who are retired, semi-retired or part-time professionals.

Said base fees may be adjusted downward for any fiscal year in which a lesser amount would be adequate and in which the additional fee would not be necessary to maintain the solvency of the fund. Said additional fee shall be based on not more than two geographical areas with three categories of practice and with a fourth category which contemplates individual risk rating for hospitals. The fund shall be maintained at not more than $25,000,000. Fees shall be set by the Insurance Commissioner after consultation with the JUA. Nothing contained herein shall be construed as imposing liability for payment of any part of a fund deficit on the JUA or its member insurers. If the JUA determines that the amount of money in the fund is not sufficient to satisfy the claims made against the fund in a given fiscal year, the JUA shall certify the amount of the projected insufficiency to the Insurance Commissioner and shall request the Insurance Commissioner to levy a deficit assessment against all participants in the fund for that fiscal year. The Insurance Commissioner shall levy such deficit assessment

against such participants in amounts that fairly reflect the classifications prescribed above and which are sufficient to obtain the money necessary to meet all claims for said fiscal year.

(d) Fund accounting and audit.--

1. Monies shall be withdrawn from the fund only upon vouchers approved by the JUA as authorized by the Board of Governors.

2. All books, records, and audits of the fund shall be open for reasonable inspection to the general public.

3. Persons authorized to receive deposits, withdraw, issue vouchers or otherwise disburse any fund monies shall post a blanket fidelity bond in an amount reasonably sufficient to protect fund assets. The cost of such bond shall be paid from the fund.

4. Annually, the JUA shall furnish an audited financial report to all fund participants and to the Department of Insurance and to the Joint Legislative Auditing Committee. The report shall be prepared in accordance with accepted accounting procedures and shall include income and such other information as may be required by the Department of Insurance or the Joint Legislative Auditing Committee.

5. Monies held in the fund shall be invested in short-term interest bearing investments by the JUA as administrator, provided that in no case shall said moneys be invested in the stock of any insurer participating in the JUA or in the parent company or company owning a controlling interest of said insurer. All income derived from such investments shall be credited to the fund.

6. Any person or hospital participating in the fund may withdraw from such participation at the end of any fiscal year; however, such person or hospital shall remain subject to any

deficit assessment pertaining to any year in which such person or hospital participated in the fund.

(e) Claims procedures.--

1. Any person may file an action for damages arising out of the rendering of medical care or services against a person covered under the fund provided that the person filing the claim shall not recover against the fund any portion of a judgment for damages arising out of the rendering of medical care or services against a person covered under the fund unless the fund was named as a defendant in the suit. If after reviewing the facts upon which the claim is based it appears that the claim will exceed $100,000, the fund shall appear and actively defend itself when named as a defendant in the suit. In so defending, the fund shall retain counsel and pay out of the fund attorney's fees and expenses including court costs incurred in defending the fund. The attorney or law firm retained to defend the fund shall not be retained or employed by the JUA to perform legal services for the JUA other than those directly connected with the fund. The fund is authorized to negotiate with any claimants having a judgment exceeding $500,000 to reach an agreement as to the manner in which that portion of the judgment exceeding $500,000 is to be paid. Any judgment affecting the fund may be appealed under the Florida Appellate Rules of Procedure as with any defendant.

2. It shall be the responsibility of the insurer or self-insurer providing insurance or self-insurance for a hospital, physician, physician's assistant, osteopath or podiatrist who is also covered by the fund to provide an adequate defense on any claim filed that potentially affects the fund with respect to such insurance contract or self-insurance contract. The insurer shall act in a fiduciary relationship with respect to any claim affecting the fund. No settlement exceeding

$100,000, or any other amount which could require payment by the fund, shall be agreed to unless approved by the JUA.

3. A person who has recovered a final judgment or a settlement approved by the JUA against a hospital, physician, physician's assistant, osteopath or podiatrist, who is covered by the fund may file a claim with the JUA to recover that portion of such judgment or settlement which is in excess of $100,000 as set forth in paragraph (b) of subsection (1) of this section. In the event the fund incurs liability exceeding $1,000,000 to any person under a single occurrence the fund shall pay not more than $1,000,000 per year until the claim has been paid in full.

4. Claims filed against the fund shall be paid in the order received within 90 days after filing unless appealed by the fund. If the fund does not have enough money to pay all of the claims, claims received after the funds are exhausted shall be immediately payable the following year in the order in which they were received.

5. If a person or hospital participating in the fund has coverage in excess of $100,000, he shall be liable for losses up to the amount of his coverage, and he shall receive an appropriate reduction of his assessment for the fund. Such reduction shall be granted only after that person has proved to the satisfaction of the JUA that he has such coverage.

Section 16. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared severable.

Section 17. This act shall take effect upon becoming law.

COLLEGE OF MEDICINE AND DENTISTRY OF NEW JERSEY

MARTLAND HOSPITAL
NEW JERSEY MEDICAL SCHOOL
65 Bergen St. Newark, N. J. 07107

AUGUST 19, 1975

ARTHUR ELLENBERGER
ESSEX COUNTY MEDICAL SOCIETY
144 SOUTH HARRISON STREET
EAST ORANGE, NEW JERSEY

DEAR ARTHUR:

ENCLOSED YOU WILL FIND COPIES OF LETTERS AND REFERENCE ON MAL PRACTICE. DR. BELLINO OF MONTCLAIR HAS BEEN WORKING ON THESE PROBLEMS OVER A YEAR AND WOULD WORK WITH US IN ANY CAPACITY WE DESIRE.

A NUMBER OF OLDER LETTERS AND PAMPHLETS HAVE BEEN AVAILABLE, BUT ARE NOW OUT OF DATE.

PLEASE SEND A COPY TO EACH MEMBER OF THE COMMITTEE.

SINCERELY,

Steve

STEPHEN R. LOVERME, M.D.
DIRECTOR OF PLASTIC AND
RECONSTRUCTIVE SURGERY

SL:GB
ENC.

February 1975

Martin L. Greenberg, State Senator
100 Evergreen Place
E. Orange, New Jersey 07018

Dear Mr. Greenberg,

Undoubtedly you are aware of recent staggering rises in malpractice premiums in this state and neighboring states reaching $30,000 to $50,000 annual premium (cash in advance).

It is obvious that this cost must be passed on to the patient and especially the poor and the elderly who are least able to pay.

The CONTINGENCY FEE practice as presently existing in this state allows the legal profession to reap windfall profits at the expense of the consumer, especially the poor and the elderly. The usual plantiff's share of malpractice judgements amounts to only 14 to 19 percent of the total, the balance to legal fees and expenses.

In your own state, Compensation awards and payments as approved by the state itself, are very limited. Such compensation practice in theory is dismetrically opposed to the contingency fee system which allows huge awards for the same or lesser degree of disability.

In nearby Canada, the annual premium is $50, approximately 1,000 times less. Doesn't this give you a hint as to the absurdity of the current situation?

This situation will certainly result in prohibitive medical costs to the public. In addition, part time medical personnel and those close to retirement will simply give up the practice of medicine. New graduates will not enter private practice in this state because they simply cannot afford this premium to open their offices.

This intolerable system rests in your hands, since few people are in a position to help remedy this deplorable situation.

Sincerely,

Malpractice Claims

To the Editor:

I don't know whether the statistics Stephen H. Mackauf cites in his Jan. 15 letter on medical malpractice insurance are correct. But if what he says is true, it is indeed difficult to understand why casualty insurance companies refuse to write medical malpractice policies.

There are now 33,000 practicing physicians in this state. Assuming the average annual premium to be at the ridiculous low figure of $1,500 per physician, an insurance carrier would realize about $50 million in annual premiums. Mackauf, a lawyer, states that payments of only $18 million were made in 1973. If this is accurate, it would be a bonanza for any insurance company. I am not aware of any recent trend where business concerns walk away from such sure huge profits.

The plain truth is that malpractice claims are promoted and developed by a small group of so-called "trial lawyers" who generally stop at nothing in the quest for a recovery. Practically, the cases are solicited through "forwarding attorneys," who receive a part of the recovery for being merely brokers in the transaction. To put it bluntly, malpractice suits as now processed are, to use the vernacular, a racket. It should be stopped.

If all that is involved is a minimum number of claims, there should be no objection to taking malpractice out of the courts and putting it where it belongs, namely, in arbitration. At the same time, lawyers who appear for claimants should have their contingency fees sharply cut.

ABRAHAM ENGELMAN

New York, Jan. 22, 1975

February, 1975

Board of Trustees
Medical-Surgical Plan of New Jersey
33 Washington Street
Newark, New Jersey 07102

Gentlemen:

This is a request for review of the Plan's Schedule of Payments to physicians. Though there have been minor adjustments, the last complete schedule sent to physicians is dated January 1, 1975.

The economic events of the past years have been characterized by tremendous inflationary pressures and the medical sector has, in no way, been exempted. In the area of medical liability and malpractice insurance premiums, however, the physicians have, in fact, been singled out for some extraordinary increases. If recent experiences in our state as well as other states are to be considered, the increases in forthcoming premiums are to be of larger and larger magnitudes. Fee schedules, of necessity, must reflect these inflated premiums. The Malpractice problem with its attendant astronomical costs must be contained if there is to be any relief to spiraling health costs.

If there is to be no check in premium hikes, there is no alternative left but to request some measure of relief through larger Plan payments.

In view of the recent increasing costs, is is imperative that the Plan officials act promptly to increase the allowable fees for the entire range of Medical and Surgical Services.

Very truly yours,

M.D.

$50 Annual Fee Protects Most Canadian MDs on Malpractice

Internal Medicine News Service

TORONTO — About 80% of Canadian physicians enjoy a comparatively inexpensive way to fight legal battles without paying the high costs of insurance comparable to those paid by physicians in the United States.

The Canadian Medical Protective Association offers legal advice and has always paid any award against a doctor since 1932, said Dr. F. Norman Brown, secretary-treasurer of the Association.

Current yearly membership costs $50.00 for each of the 27,000 members.

The Association, patterned after an organization in England, was founded in 1901. Since that time, it has offered legal advice to members who are faced with legal actions arising out of their medical practice.

The organization retains a general counsel to investigate and advise on any threatened actions for malpractice. Doctors are advised to contact the Association at the earliest inkling of possible litigation, said Dr. Brown, the chief administrative officer at Association headquarters in Ottawa.

Such an organization would probably be difficult to establish in the United States because circumstances there are much different from those in Canada, he said during an interview with this newspaper at an Association meeting held in conjunction with the annual meeting of the Canadian Medical Association.

For one thing, decisions by a jury —capable of being swayed by the emotional presentation of a professional malpractice attorney—are uncommon in Canada. Juries ordinarily do not have to give written reasons for their decision.

Most Canadian litigation on possible malpractice is heard by a judge—versed in the law and less likely to be swayed from its guidance—who delivers a written opinion with reasons for his decision. Written decisions offer a better chance for appeal than jury decisions, Dr. Brown said.

Commenting on the discrepancy between the cost of malpractice insurance in the United States and the minimal fee paid to the Association, Dr. Brown stressed that the Association's service was not "insurance" but that the Association was formed to provide legal advice to doctor-members. It may pay off judgments but is not legally obligated to do so. However, since 1932, the Association has always paid judgments for its members.

"It is a mutual nonprofit organization. We have no policy or contract, just the rights of membership. There is no legal obligation by the Association," he added.

Another difference between Canada and the United States is that the counsel contingency fee, a practice in the United States, is not allowed in Canada. In effect, the hiring of counsel on a contingency basis without the need for money favors

(Continued on page 38)

(Continued from page 1)

initiation of malpractice suit because the patient has nothing to lose and everything to gain.

Canadian law forces the patient to use his own money to hire legal counsel, which deters harassment suits on little evidence, with hopes that an out-of-court settlement will be reached to save time and trouble, Dr. Brown said.

Legal aid programs are available to aggrieved patients who have no financial resources. Therefore, no potential litigant is denied recourse through the courts because of indigence.

If a court judgment goes against the physician in Canada, it is likely to be much smaller than a judgment in the United States, he added.

"Inflated" malpractice judgments have become a common threat to American insurance companies handling malpractice claims. In contrast to awards in the millions of dollars for one claim in America, "an award of $150,000 in Canada is very, very high."

"Discussions with American doctors emphasize the difference between the two countries. They can't believe our experience here.

Even Complaints Reported

"We feel that the educational role of the Association is important. We find out about hazards in practice and we warn our members. We feel that we contribute to the public welfare," Dr. Brown emphasized.

Members are urged to report to the Association the slightest threat about initiation of claims against them or even significant complaints from patients. They should include a copy or summary of all pertinent records for review of the medical merits of any claim by a council of elected Association physicians and referral to the general counsel for legal consideration.

The threatened physician is advised by the Association during every step of the proceedings and, if a final judgment is entered against him after he has followed the advice, the Association has always paid the claim.

"If the doctor has done no wrong, he will be defended as far as is needed despite the cost.

"There will be no settlement because of nuisance value," he said.

This resistance to the economically expedient settlement of unjust claims has kept malpractice claims and judgments lower in countries with similar organizations than in those nations where nuisance claims become profitable.

In situations where the physician is judged to be at fault, the claim is paid and no punitive action is taken against the physician except in situations where there is continued "blatant disregard" of Association advice, and membership can be terminated, Dr. Brown expained.

February 10, 1975

Mr. William Hyland, Attorney General
State Of New Jersey
State House Annex
Trenton, New Jersey 08625

Dear Mr. Hyland:

Undoubtedly you are aware of recent staggering rises in malpractice premiums in this state and neighboring states reaching $30,000 to $50,000 annual premium (cash in advance).

It is obvious that this cost must be passed on to the patient and especially the poor and the elderly who are least able to pay.

The CONTINGENCY FEE practice as presently exists in this state allows the legal profession to reap windfall profits at the expense of the consumer, especially the poor and the elderly. The usual plantiff's share of malpractice judgements amounts to only 14 to 19 percent of the total, the balance to legal fees and expenses.

In your own state, Compensation awards and payments as approved by the state itself, are very limited. Such compensation practice in theory is diametrically opposed to the contingency fee system which allows huge awards for the same or lesser degree of disability.

In nearby Canada, the annual premium is $50, approximately 1,000 times less. Doesn't this give you a hint as to the absurdity of the current situation?

This situation will certainly result in prohibitve medical costs to the public. In addition, part time medical personnel and those close to retirement will simply give up the practice of medicine. New graduates will not enter private practice in this state because they simply cannot afford this premium to open their offices.

This intolerable system rests in your hands, since few people are in a position to help remedy this deplorable situation.

Sincerely,

February, 1975

James Sheeran
Commissioner of Insurance
201 East State Street
Trenton, New Jersey 08625

Dear Mr. Sheeran:

As a citizen voter in this state of New Jersey, I am most concerned about the rising costs of medical care. One outstanding factor which is most disturbing is the escalating cost of Malpractice insurance premiums.

Many patients already hurt by the present period of inflation and recession and are now being asked to absorb the skyrocketing costs of Malpractice insurance. If the premiums continue to escalate, good medical care will become prohibitive, especially to the poor and the elderly.

I, therefore, request that you investigate the relationship between premiums paid to insurance companies and the total amount of awards, in order that you, the protector of the citizen, may be able to offer some resolution to this problem.

It is time that you take the necessary measures to insure stabilization and offer a rational approach to the problem of Malpractice insurance.

Sincerely,

February 1975

Mr. Jack Ayres
Medical Administration Division
Medicare
P.O. Box 471
Millville, New Jersey 08332

Dear Mr. Ayres,

This is a request for review of Medicare's Schedule of Payments to Physicians.

The economic events of the past years have been characterized by tremendous inflationary pressures and the medical sector has in no way been exempted. However, in the area of medical liability and malpractice insurance premiums the physicians have in fact been singled out for some extraordinary increases. And if recent experiences in our state as well as other states are to be considered, the increases in forthcoming premiums are to be of larger and larger magnitudes. Fee schedules, of necessity, must reflect these inflated premiums. The Malpractice problem with its attendant astronomical costs must be contained if there is to be any relief to spiraling health costs for the elderly and poor.

If there is to be no check in premium hikes, there is no alternative left but to request some measure of relief through larger Medicare payments.

In view of the recent increasing costs, it is imperative that Medicare officials act promptly to increase the allowable fees for the entire range of Medical and Surgical Services.

Very truly yours,

M.D.

Malpractice strike looms

New Jersey doctors are considering a strike July 1 if no action is taken to alleviate increases of up to 400 per cent on "umbrella" malpractice insurance premiums.

Interstate Insurance Group of Chicago has indicated it would supply the insurance at greatly increased rates when Commercial Union Insurance Co., London, ceases its coverage July 1.

Anesthesiologists and other high-risk practitioners must purchase "umbrella" coverage to augment basic liability insurance. Some specialties would also have to increase their basic coverage in order to qualify for Interstate's "umbrella" protection.

The Medical Society of New Jersey voted last week to strike in six months if no legislative action is taken to alleviate malpractive problems, but that was before the "umbrella" rate hike became known.

A strike by anesthesiologists would effectively halt all but emergency surgery in the state's hospitals.

Malpractice Rates Drive Up Doctor Fees

By LAWRENCE K. ALTMAN

Soaring malpractice insurance rates for doctors and hospitals have sharply driven up costs of medical diagnosis and treatment for patients and, in the view of many health officials, are threatening the quality of health care given Americans.

The sudden imposition of such drastic rate increases and the withdrawal of some insurance carriers from the medical liability field in recent weeks have dramatically focused public attention on what medical observers regard as perhaps the most important problem affecting the doctor-patient relationship in the last decade, if not longer.

And the problem has begun to extend to other health professionals. Patients going to some osteopathic physicians, dentists and podiatrists are also paying more, largely because, these professionals say, they themselves are being charged increasingly higher rates for their liability premiums. But the rises are less than for medical doctors.

Also, the unpredictable nature of rising malpractice costs has made it much more difficult to estimate future medical care costs, thereby reducing prospects for passage of national health insurance legislation, according to some experts.

Action Taken by States

The jump in malpractice insurance rates is widely attributed to the increase in the number of malpractice suits in recent years accompanied by a steep rise in the size of damage awards.

So important has the malpractice problem become that thus far this year the legislatures of at least 27 states, acting on an emergency basis, have passed malpractice bills.

The substance of such legislation has varied widely among the states. In most instances, the legislation has been described as stopgap, designed to insure the availability of malpractice coverage for doctors and hospitals, or involving the establishment of commissions to study the malpractice problem.

But a few states, such as Michigan, New York, Indiana and Nevada, have overhauled the legal tort system. Though such laws have not gone far enough to satisfy many doctors, some of the legislation, as in Indiana, has led lawyers to propose court tests of its constitutionality.

Despite the drastic nature of some legislative action, medical and legal experts and

Continued on Page 24, Column 1

2

N.Y. TIMES Aug '75

Study Finds Malpractice System No Service to Public

By LAWRENCE K. ALTMAN

The medical malpractice system is costly and out of control, does not serve the public interest and benefits just a small percentage of lawyers, a Michigan doctors' group has charged on the basis of its study of 1,910 malpractice suits filed in the metropolitan Detroit area between 1970 and 1974.

The pioneering study, released last week, is a survey of court dockets for all malpractice suits filed in one geographic area. It was financed by the Physicians' Crisis Committee, a group of 1,578 Michigan doctors who, confronted with soaring malpractice premium rates, sought data about key factors leading to the malpractice crisis that has struck across the country in recent weeks.

Though some doctors elsewhere were threatened with $40,000 yearly malpractice premiums, apparently only the Michigan group organized a research team to obtain basic facts about why malpractice litigation was rising so sharply.

Detroit patients, the study found, paid an estimated $70-million in legal fees for malpractice cases to a small number of law firms. Though the average settlement was $78,-148, the plaintiffs received less money than the lawyers, the doctors' report said.

Another finding — that doctors do not win the vast majority of cases—ran counter to a contention advanced by many attorneys. Trial lawyers particularly have argued that because doctors win most cases, lawyers need a high contingency fee to make malpractice litigation profitable.

Money was awarded Detroit plaintiffs in more than four out of five medical malpractice cases surveyed. Accordingly, the doctors charged that lawyers stood a minimal risk of loss and that the attorneys' 50 per cent contingency fee on each case was unjustified.

The overwhelming majority of malpractice cases never go to trial, and attorneys settle many cases for reasons that seldom relate to the merit of the charges, the report said, adding that "the vaunted American jury clearly makes the decision in less than one out of every 10 cases."

Still another finding was that doctors of osteopathy were defendants in malpractice cases in a disproportionate number of cases compared with doctors of medicine.

Though the Physicians Crisis Committee report was highly critical of lawyers and the judicial system, the Michigan doctors stressed that the malpractice problem would not be solved unless doctors began to convince the public that they were regulating and upgrading the standards of medical care and removing the bad and incompetent doctor from practice.

"Doctors are not blameless" in the malpractice crisis, Dr. Arthur B. Eisenbrey, the committee's chairman, said in a news release.

Nevertheless, the group's report said that "the public simply doesn't understand it is the highly trained, more technically proficient surgical specialists who are being sued and not the physician who should truly not be practicing medicine."

Another finding in the study of Wayne, Oakland and Macomb Circuit Courts in greater Detroit was evidence of a clear relationship between the advent of no-fault automobile insurance and the growth of the malpractice crisis in Michigan.

Three times as many malpractice suits were filed in 1974 as in 1970. A relatively gradual increase occurred through 1973, at which time there was a sharp rise when no-fault auto insurance became effective.

John F. Dodge, attorney for the committee, said in a telephone interview that law firms that once had concentrated on automobile litigation cases had entered the malpractice field recently and were largely responsible for the precipitous rise in malpractice claims.

Serious questions about the insurance industry's rates for various medical and surgical specialists were raised in the doctors' minds because they said, "our information suggests that at least some ratings are based on total ignorance, completely haphazard guessing—or worse."

Results of the survey "disclosed an immense discrepancy between" the very high rates charged anesthesiologists and the relatively low number of suits filed against these specialists. One suit per 10.7 anesthesiologists and one suit per 9.6 pediatricians were filed.

Yet the insurance carriers charged the anesthesiologists the highest and the pediatricians the lowest rates among all types of specialists. Neurosurgeons had the highest ratio, one suit per 0.8 brain surgeons.

Anesthesiologists have been among the leaders of the doctors' work slowdowns in California and elsewhere over proposed doubling and tripling of their malpractice rates.

Accordingly, the Michigan group urged that greater regulatory control be placed over insurance carriers.

The Michigan group was highly critical of the Department of Health, Education and Welfare's commission on malpractice study in 1971 that cost taxpayers $1.5-million.

"In less than half the time and for 2 per cent of what it cost the HEW commission for their report, we have collected, confirmed and emphasized information that can no longer be ignored or denied about the present court-jury system and those who operate within it," Dr. Eisenbrey said. He added:

"We feel that because of the information we've uncovered Congressional leaders and society should ask why similar information buried within the H.E.W. report was not brought out and investigated, further, thereby possibly averting the "malpractice crisis" that has threatened the entire nation with the loss of quality medical care."

Because the group considers the Detroit experience "a barometer" of the factors producing a malpractice crisis elsewhere, the Physicians Crisis Committee, at 1930 Buhl Building, Detroit, is making its report available at $4 a copy.

Hospitals Seeking to Form Insurance Company

Special to The New York Times

AUSTIN, Tex., Aug. 2—Texas hospitals, smarting from increases in medical malpractice insurance rates, have decided to form their own insurance company.

A hearing is expected later this month on the charter application for a reciprocal insurance exchange filed by the Texas Hospital Association with the State Board of Insurance.

"We had no desire to get into the insurance business," C. Dean Davis of Austin, counsel for the hospital association, said. But the hospitals did not want to go on paying "unreasonable rates," he added.

No High Profits

The company should be operating by Oct. 1, Mr. Davis said, and could be operating sooner if necessary. It might be necessary, he said, because 75 Texas hospitals may be without insurance by that time, due to cancellations from commercial carriers, primarily the Argonaut Insurance Company of Menlo Park, Calif., the major carrier for Texas hospitals. Those cancellations may come Sept. 1.

O. Ray Hurst, president of the hospital association, said the reciprocal insurance exchange could offer lower rates "because we do not have to look for 15 to 20 per cent profit for our stockholders."

"We will be geared solely for hospital problems," Mr. Hurst said. "Malpractice insurance is just a sideline with most companies now," he added.

Texas hospitals and physicians may be able to get malpractice coverage next week, according to Joe Christie, chairman of the State Board of Insurance, because of actions of the board and the Joint Underwriting Association created by the Texas Legislature this year.

The board approved filings by 11 company groups, the first time in 20 years that it has approved malpractice rates, under authority restored to it by the Legislature.

Mr. Christie said the action would assure doctors of rates for a one-year period and that future increases would have to be approved by the state.

Malpractice rates may force some physicians to take down shingle

By JOSEPH RURA
Herald-News Staff Writer

Dr. Dominick Kujda, an orthopedic surgeon in Pompton Plains, says that if malpractice insurance rates continue to rise rapidly, he could be forced out of his practice in the next few years.

Dr. Kujda now pays $8,400 for a year's coverage and he says he may have to pay twice that much next year.

In 15 years of orthopedic surgery, the 54-year-old doctor has never been sued, a fact that does little to relieve his insurance burden.

He cannot raise his fees to meet the higher premiums because charges are to a large extent established by Blue Cross and Blue Shield reimbursement schedules.

"WHAT IS happening is that my income is being frozen and costs are getting out of control," he says.

While most persons would consider the gross salary of a New Jersey orthopedic surgeon to be considerable — about $80,000 — Kujda estimates that some 60 per cent of his income disappears in expenses.

Kujda, who works more than 60 hours a week, fears that without an increase in fees or controls of malpractice insurance costs, many doctors will either drop out of business or limit their practice in some way.

DR. MELVIN Robbins is a pediatrician who works from his home in Fair Lawn and does not have as bad a malpractice insurance problem as Dr. Kujda.

Since pediatrics is considered a low-risk specialty by insurance companies, Dr. Robbins pays only about $800 a year in premiums — one-tenth what Dr. Kujda pays.

Yet the threat of a reputation damaging suit hangs over the heads of doctors like him and, to some extent influences their work.

DR. ROBBINS says he performs no surgery — other than "sewing a few stitches" — and has not even assisted in an operation for the last 10 years.

He also admits practicing so-called "defensive medicine" by ordering Xrays probably more often than necessary to be sure that what looks like a sprain is not a fracture. That means costlier medicine.

"I'm not that happy about the indiscriminate use of X rays," says Robbins, noting potential radiation danger. "I also try not to prescribe too much medication."

JAMES MURASSA, director of the New Jersey Medical Society, says there may be some doctors who have already pulled in their shingles because of the malpractice problem.

"There is hearsay that a few neurosurgeons have gone out of business, but I haven't been able to track down anyone," Murassa says, noting that neurosurgeons are currently the group paying the highest insurance rates — about $14,000 a year.

He said Chubb & Sons, a major insuror of doctors, has filed an application with the state Department of Insurance for a 25 per cent increase in rates across the board for high-risk specialties.

"IT'S STILL more pleasant in New Jersey than it is in New York or Pennsylvania," observes Marussa. He points out that neurosurgeons in New York must pay as much as $45,000 a year for malpractice coverage.

Marussa blames much of the problem on a lack of a strong statute of limitation for malpractice claims, saying that it is not unusual that a claim be filed 20 years after the alleged wrongdoing.

He cites the example of American Mutual Insurance Co., which stopped writing malpractice policies in New Jersey in 1967, yet has received 28 claims since January of this year alone on incidents that occurred a minimum of eight years ago.

ACCORDING TO Marussa's reckoning, claims against New Jersey doctors have risen annually from about 300 to 700 in six years. "One in 16 doctors will have a claim against him this year," he says.

Marussa says most claims are withdrawn voluntarily by the plaintiff and, of those that are not, the majority are settled in the courts in the doctors' favor.

Hospital malpractice insurance rates have been rising even more dramatically than individual doctors' coverage, in some cases as high as 400 per cent.

YET SOME SAY that hospital malpractice coverage has long been a bargain and today still represents usually no more than 2 to 3 per cent of the hospital's overall budget, compared to insurance bites of up to 20 per cent or more from a doctor's salary.

Doctors in the state have called for a limit on the amount of money juries may award plaintiffs as one means of keeping insurance rates from skyrocketing. Indiana recently took such a step and now limits awards to $100,000, except for certain special cases where the limit is $500,000.

Dr. Kujda, speaking as one doctor whose livelihood is threatened by the situation, feels that a clear definition of malpractice is also needed.

"The courts feel that any result that is not perfect is malpractice," he says.

RE-RE-ENGROSSED
HB 1267

FILED

AS PASSED BY THE LEGISLATURE

A bill to be entitled

An act relating to medical liability insurance and civil law revisions concerning medical malpractice actions; providing a short title; creating s. 627.352, Florida Statutes, relating to the creation of a medical liability insurance study commission; creating s. 395.18, Florida Statutes, authorizing certain hospitals to establish internal risk management programs; amending subsection (1) of s. 627.355, Florida Statutes, to allow total self-insurance by a group or association of physicians or health care facilities organized for any purpose; creating s. 768.133, Florida Statutes, providing for the establishment of medical liability mediation panels in each judicial circuit; providing for the filing, hearing and disposition of claims, and providing a filing fee; providing for legal proceedings subsequent to the decision of the mediation panels; amending s. 95.11(4), Florida Statutes, 1974 Supplement, relating to the statute of limitations, to provide that actions for medical malpractice shall be commenced within two years from the time the incident occurred or the injury is discovered but not to exceed four years from the date the incident occurred; providing exceptions for fraud and misrepresentation; creating s. 768.042, Florida Statutes, to prohibit the stating of the amount of general damages in any complaint for recovery of damages for personal injury or wrongful death; amending s. 725.01, Florida Statutes, to provide that medical guarantees shall be governed by the Statute of Frauds; creating s. 768.132, Florida Statutes, entitled the "Florida Medical Consent Law"; covering consent in all cases not covered by s. 768.13, Florida Statutes, entitled the "Good Samaritan Act"; setting standards for information necessary for consent; providing a presumption where a valid consent was given; amending s. 458.1201(1)(m), Florida Statutes, and adding paragraphs (o) and (p) to said section; providing that the State Board of Medical Examiners determine standards of acceptable and prevailing medical practice; authorizing board action in medical malpractice cases and certain disciplinary cases; providing for a civil penalty; adding paragraphs (c) and (d) to s. 458.1201(2), Florida Statutes; providing for appointment of licensed physicians to act for the board; providing for immunity from liability for investigations conducted pursuant to this act; amending s. 458.1201(3)(a), Florida Statutes; authorizing board to require physicians to participate in continuing education programs; authorizing board to require physicians to practice under the direction of a physician in certain locations; adding s. 458.1201(5), Florida Statutes; requiring the board to report to the legislature; creating s. 395.065, Florida Statutes, providing for hospital disciplinary powers; adding subsection (8) to s. 627.351, Florida Statutes, to provide for a joint underwriting plan offering medical malpractice insurance coverage to be set up by

insurers writing casualty insurance as defined in s. 624.605(1)(b), (j), and (p), Florida Statutes, and self-insurers authorized under s. 627.355, Florida Statutes; creating s. 627.353, Florida Statutes, to provide for the limitation of liability when certain provisions are met for any licensed hospital, physician, physician's assistant, osteopath or podiatrist for the amount of any settlement approved by the joint underwriting association established under s. 627.351(8), Florida Statutes, or any judgment exceeding $100,000 for any claim arising out of the rendering of medical care or services; creating a patient's compensation fund to be administered by said joint underwriting association subject to supervision by a board of governors to provide coverage for the amount of any such settlement or judgment affected by said limitation of liability; providing for fees to support the fund including an assessment against participants for deficits; providing for costs in administering or defending the fund; providing claims procedures; providing an effective date.

WHEREAS, the cost of purchasing medical professional liability insurance for doctors and other health care providers has skyrocketed in the past few months; and

WHEREAS, it is not uncommon to find physicians in high-risk categories paying premiums in excess of $20,000 annually; and

WHEREAS, the consumer ultimately must bear the financial burdens created by the high cost of insurance; and

WHEREAS, without some legislative relief, doctors will be forced to curtail their practices, retire, or practice defensive medicine at increased cost to the citizens of Florida; and

WHEREAS, the problem has reached crisis proportion in Florida, NOW THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. The short title of this act shall be "The Medical Malpractice Reform Act of 1975".

Section 2. Section 627.352, Florida Statutes, is created to read:

627.352 Medical Liability Insurance Commission.--

(1) The Florida Medical Liability Insurance Commission is hereby created, consisting of the following members: the Insurance Commissioner, the Secretary of the Department of Health and Rehabilitative Services, and twelve members to be appointed. The Governor, the President of the Senate, and the Speaker of the House of Representatives shall each appoint four members to the commission. Each shall appoint a member of the legal profession, a provider of health services, a lay citizen and a representative from the insurance industry.

(2) The Insurance Commissioner shall be the chairman of the commission and shall provide records management for the commission. A majority of the commission members shall constitute a quorum for the transaction of any business or the exercise of any power or function of the commission. The affirmative vote by a majority of the quorum present at a duly called and noticed meeting shall be required to exercise any power or function of the commission. Each member shall be entitled to one vote on all matters which may come before the commission. The commission may delegate to one or more of its members such duties as it deems proper.

(3) The Insurance Commissioner and the Secretary of the Department of Health and Rehabilitative Services may designate a representative from his agency to exercise his power and perform his duties, including the right to vote on the commission.

(4) Members of the commission serving as representatives of the general public shall receive mileage and $20 per diem for attending meetings of the commission. Each member of the commission shall be allowed the necessary and actual expenses which he shall incur in the performance of his duties under this section.

(5) On or before January 1, 1976, the commission, in cooperation and consultation with appropriate state and federal agencies, the medical and legal professions, the insurance industry and representatives of the general public, shall prepare and submit to the Governor and the legislature its report and recommendations.

(a) The goal of the plan shall be to recommend a medical liability insurance system which can be operated at reasonable cost for the purpose of providing prompt, equitable compensation to those sustaining medical injury.

(b) Primary consideration shall be given, but not limited to, establishing an insurance system which can be underwritten by private insurers on a self-supporting basis using actuarially sound rates.

(c) If the commission finds that no insurance system meeting the goal of the plan can be underwritten by private insurers on a self-supporting basis using actuarially sound rates, it shall specify the needed changes in the statutes to create a viable market for medical liability insurance, or self-insurance.

(d) The comprehensive report shall include recommendations to the legislature for reducing the incidence of medical injuries, including establishing standards of care and procedures for peer review; reducing the cost of prosecuting and defending claims and administering the insurance mechanism, changes in existing law governing the eligibility of injured persons for compensation and the amount of compensation, including limitations on the time within which claims may be brought and the elements of loss for which compensation may be recovered and any other matters or procedures which the commission considers relevant to the medical liability insurance problem.

(e) The commission is authorized and encouraged to make interim reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives concerning specific legislative proposals, which need immediate consideration.

Section 3. Section 395.18, Florida Statutes, is created to read:

395.18 Internal risk management program.--Every hospital licensed pursuant to this chapter, having in excess of 300 beds, as a part of its administrative functions, shall establish an internal risk management program which shall include the following components:

(1) The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients; and

(2) The development of appropriate measures to minimize the risk of injuries and adverse incidents to patients through the cooperative efforts of all personnel; and

(3) The analysis of patient grievances which relate to patient care and the quality of medical services.

The risk management program shall be carried out either through a person on the administrative staff of a hospital, as part of his administrative duties; or by a committee of the

hospital board of trustees or directors; or by the medical staff in a manner deemed appropriate.

Section 4. Subsection (1) of s. 627.355, Florida Statutes, is amended to read:

627.355 Medical malpractice insurance; purchase.--

(1) A group or association of physicians or health care facilities, composed of any number of members, ~~organized for purposes other than the purchase of medical malpractice insurance~~ ~~which has been in continuing existence for a period of at least 2 years~~, is authorized partially to self-insure against claims of medical malpractice upon obtaining approval from the Department of Insurance and upon complying with the following conditions:

(a) Establishment of a medical malpractice risk management trust fund to provide coverage against professional medical malpractice liability.

(b) Employment of a professional staff and consultants for loss prevention and claims management coordination under a risk management program.

Section 5. Section 768.133, Florida Statutes, is created to read:

768.133 Medical liability mediation panel.--

(1) The chief judge of each judicial circuit shall prepare a list of persons to serve on medical liability mediation panels, whose purpose shall be to hear and to facilitate the disposition of all medical malpractice actions arising within the jurisdiction of the circuit. The number of persons on the list shall be determined by the chief judge but shall be in sufficient numbers to efficiently carry out the intent of this section. All hearings, as hereinafter provided for, shall be before a three-member panel hereinafter referred to as the panel, mediation panel or hearing panel composed as follows: a judicial referee who shall be the presiding member of the hearing panel,

shall be a circuit judge. Such appointments shall be made by a "blind" system. The other panel members shall be selected in accordance with the following procedure:

(a) A list of physicians licensed to practice under chapters 458 or 459 shall be prepared by the chief judge. In making the list, the chief judge may accept the recommendations of recognized professional medical societies. The list shall be divided into lists of physicians according to the particular specialty of each if possible.

(b) A list of qualified attorneys shall be prepared by the chief judge. In making the list the chief judge may accept the recommendations of recognized professional legal societies.

(c) Names of physicians and attorneys may be added to or taken off the panel list at any time by the chief judge at his discretion, provided, however, that all names added to the list shall be placed at the bottom of the list.

(d) A physician or attorney selected to be on the hearing panel for a particular case may disqualify himself or be challenged for cause.

(e) A filing fee not to exceed $25 shall be established by the chief judge in each circuit and shall be paid to the clerk of the circuit court. The filing fee shall be used to meet such incidental expenses as the panel may incur.

(2) Any person or his representative claiming damages by reason of injury, death or monetary loss on account of the alleged malpractice by any medical or osteopathic physician, hospital, or health maintenance organization and against whom he believes there is a reasonable basis for a claim shall submit such claim to the appropriate panel before that claim may be filed in any court of this state. Claims shall be made on

forms provided by the circuit court and shall be filed initially with the clerk of that court, with copies mailed to the person against whom the claim is made and to the administrative board licensing such professional. Service of process shall be effected as provided by law. Constructive service of process may be effected as provided by law. All parties named as defendants in the claim shall file an answer to such claim within 20 days of the date of service. No other pleadings shall be allowed. If no answer is filed within such time limit, the jurisdiction of the mediation panel over the subject matter shall terminate, and the parties may proceed in accordance with law. Within 30 days after service of process, the parties shall file with the clerk a document designating the type of medical specialist who should hear the claim. In the event the parties do not agree on the specialist, the judicial referee shall make the determination. In no event shall more than one medical practitioner serve on a mediation panel.

(3) If both parties agree upon a doctor and an attorney to serve on the hearing panel, they may so stipulate. In the event that no agreement is reached within 10 days after determination of the specialty of medical practice involved, the clerk shall mail to the parties and the panel members hereinafter described the names selected at random of five attorneys who are members of the hearing panel and the names selected at random of five physicians of the designated specialty who are members of the hearing panel, or if it is impractical to designate the physicians by specialty, the names selected at random of five physicians without regard to specialty. Thereafter, the panel members so selected shall have 10 days within which to disqualify themselves and the parties shall have the same time in which to challenge panel members for cause. A decision on challenges for cause shall be made by agreement or by the

judicial referee. If there are disqualifications or challenges for cause, the clerk shall appoint additional panel members as required. Thereafter, from the list of five attorneys and five physicians, the parties shall agree on one attorney and one physician to serve on the hearing panel. If the parties are unable to agree, each side shall then strike names alternately from the attorneys' list and from the physicians' list separately, with the claimant striking first, until each side has stricken two names from each list. The remaining attorney and physician shall serve on the hearing panel.

(4) The clerk shall, with the advice and cooperation of the parties and their counsel, fix a date, time and place for a hearing on the claim before the hearing panel, provided, however, that the hearing shall be held within 120 days of the date the claim is filed with the clerk, unless for good cause shown upon order of the judicial referee, such time is extended. Such extension shall not exceed six months from the date the claim is filed. If no hearing is held on the merits within 10 months of the date the claim is filed, the jurisdiction of the mediation panel on the subject matter shall terminate and the parties may proceed in accordance with law.

(5) The filing of the claim shall toll any applicable statute of limitations, and such statute of limitations shall remain tolled until the hearing panel issues its written decision, or the jurisdiction of the panel is otherwise terminated. In any event, a party shall have 60 days from the date the decision of the hearing panel is mailed to the parties or the date on which the jurisdiction of the panel is otherwise terminated in which to file a complaint in circuit court.

(6) All parties shall be allowed to utilize any discovery procedure provided for by the Florida Rules of Civil Procedure. Any motion for relief arising out of the use of such discovery procedures shall be decided by the judicial

referee. The judicial referee may in his discretion make reasonable limitations on the extent of discovery.

(7) The claim shall be submitted to the hearing panel under such procedural rules as may be established by the Supreme Court, provided that strict adherence to the rules of procedure and evidence applicable in civil cases shall not be required. Witnesses may be called, all testimony shall be under oath, testimony may be taken either orally before the panel or by deposition, copies of records, x-rays and other documents may be produced and considered by the panel and the right to subpoena witnesses and evidence shall obtain as in all other proceedings in the circuit court. The right of cross-examination shall obtain as to all witnesses who testify in person. Both parties shall be entitled, individually and through counsel, to make opening and closing statements. No transcript or record of the proceedings shall be required, but any party may have the proceedings transcribed or recorded. The judge presiding at the hearing shall not preside at any trial arising out of the claim or hear any application in the case not connected with the hearing itself. No other hearing panel member shall participate in a trial arising out of the claim either as counsel or witness.

(8) Within 30 days after the completion of any hearing, the hearing panel shall file a written decision with the clerk of the court who shall thereupon mail copies to all parties concerned and their counsel. The panel shall decide the issue of liability and shall state its conclusion in substantially the following language: "We find the defendant was actionably negligent in his care and/or treatment of the patient and we, therefore, find for the plaintiff"; or "We find the defendant was not actionably negligent in his care and/or treatment of the patient and we, therefore, find for the defendant". The

decision shall be signed by all members of the hearing panel; however, any member of the panel may file a written concurring or dissenting opinion.

(9) After a finding of liability, if the adverse parties agree, the panel may continue mediation for the purpose of assisting the parties in reaching a settlement. In such event, the panel shall also make a recommendation as to a reasonable range of damages, if any, which should be awarded in the case. The recommendation as to damages shall include in simple, concise terms some breakdown as to which portion of the damages recommended are attributable to past and estimated future health or custodial care expenses attributable to the alleged malpractice or any of the other elements of damage enumerated in s. 768.21, Florida Statutes, for wrongful death or recognized by the Florida Standard Jury Instructions as elements of damages in injuries due to negligence. However, the panel shall not have the right to determine punitive damages. Any findings of damages shall not be admissible in evidence in a subsequent trial.

(10) In the event any party rejects the decision of the hearing panel, the claimant may institute litigation based upon the claim in the appropriate court. Furthermore, in any civil medical malpractice action, the trial on the merits shall be conducted without any reference to insurance, insurance coverage or joinder in the suit of the insurer as a co-defendant.

(11) The conclusion of the hearing panel on the issue of liability may be admitted into evidence in any subsequent trial. However, no specific findings of fact shall be admitted into evidence at trial. Parties may, in the opening statement or argument to the court or jury, comment on the panel's conclusion in the same manner as any other evidence introduced at trial. If there is a dissenting opinion, the numerical vote of the panel shall also be admissible. Panel members may not

be called to testify as to the merits of the case. The jury shall be instructed that the conclusion of the hearing panel shall not be binding but shall be accorded such weight as they choose to ascribe to it.

(12) No member of the hearing panel shall be liable in damages for libel, slander or defamation of character of any party to the mediation proceedings for any action taken or recommendation made by such member acting within his official capacity as a member of the hearing panel.

Section 6. The provisions of section 5 of this act shall not be applicable to any case in which formal suit has been instituted prior to the effective date of that section, which shall be July 1, 1975.

Section 7. Subsection (4) of section 95.11, Florida Statutes, 1974 Supplement, is amended to read:

95.11 Limitations other than for the recovery of real property.--Actions other than for recovery of real property shall be commenced as follows:

(4) WITHIN TWO YEARS.--

(a) An action for professional malpractice, other than medical malpractice, whether founded on contract or tort; provided that the period of limitations shall run from the time the cause of action is discovered or should have been discovered with the exercise of due diligence; provided, however, that the limitation of actions herein for professional malpractice shall be limited to persons in privity with the professional.

(b) An action for medical malpractice shall be commenced within two years from the time the incident occurred giving rise to the action, or within two years from the time the incident is discovered, or should have been discovered with the exercise of due diligence, provided, however, that in no event shall the action be commenced later than four years from the date of the

incident or occurrence out of which the cause of action accrued. An action for medical malpractice is defined as a claim in tort or in contract for damages because of the death, injury, or monetary loss to any person arising out of any medical, dental, or surgical diagnosis, treatment, or care by any provider of health care. The limitation of actions within this subsection shall be limited to the health care provider and persons in privity with the provider of health care. In those actions covered by this paragraph where it can be shown that fraud, concealment, or intentional misrepresentation of fact prevented the discovery of the injury within the four-year period, the period of limitations is extended forward two years from the time that the injury is discovered or should have been discovered with the exercise of due diligence, but in no event to exceed seven years from the date the incident giving rise to the injury occurred.

(c)~~(b)~~ An action to recover wages or overtime or damages or penalties concerning payment of wages and overtime.

(d)~~(c)~~ An action for wrongful death.

Section 8. Section 768.042, Florida Statutes, is created to read:

768.042 Damages.--In any action brought in the circuit court to recover damages for personal injury or wrongful death, the amount of general damages shall not be stated in the complaint, but the amount of special damages, if any, may be specifically pleaded and the requisite jurisdictional amount established for filing in any court of competent jurisdiction.

Section 9. The provisions of section 8 of this act shall not apply to any complaint filed prior to the effective date of this act.

Section 10. Section 725.01, Florida Statutes, is amended to read:

725.01 Promise to pay another's debt, etc.--No action shall be brought whereby to charge any executor or administrator upon any special promise to answer or pay any debt or damages out of his own estate, or whereby to charge the defendant upon any special promise to answer for the debt, default or miscarriage of another person or to charge any person upon any agreement made upon consideration of marriage, or upon any contract for the sale of lands, tenements or hereditaments, or of any uncertain interest in or concerning them, or for any lease thereof for a period longer than one year, or upon any agreement that is not to be performed within the space of one year from the making thereof, or whereby to charge any health care provider upon any guarantee, warranty or assurance as to the results of any medical, surgical or diagnostic procedure, performed by any physician licensed under chapter 458, Florida Statutes, osteopath licensed under chapter 459, Florida Statutes, chiropractor licensed under chapter 460, Florida Statutes, podiatrist licensed under chapter 461, Florida Statutes, or dentist licensed under chapter 466, Florida Statutes, unless the agreement or promise upon which such action shall be brought, or some note or memorandum thereof shall be in writing and signed by the party to be charged therewith or by some other person by him thereunto lawfully authorized.

Section 11. Section 768.132, Florida Statutes, is created to read:

768.132 Florida medical consent law.--

(1) This section shall be known and cited as the "Florida Medical Consent Law".

(2) In any medical treatment activity not covered by s. 768.13, Florida Statutes, entitled "the Good Samaritan Act", this act shall govern.

(3) No recovery shall be allowed in any court in this

state against any physician licensed under chapter 458, Florida Statutes, osteopath licensed under chapter 459, Florida Statutes, chiropractor licensed under chapter 460, Florida Statutes, podiatrist licensed under chapter 461, Florida Statutes, or dentist licensed under chapter 466, Florida Statutes, in an action brought for treating, examining, or operating on a patient without his informed consent where:

(a) The action of the physician, osteopath, chiropractor, podiatrist, or dentist in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community; and

(b) A reasonable individual from the information provided by the physician, osteopath, chiropractor, podiatrist, or dentist under the circumstances, would have a general understanding of the procedure and medically acceptable alternative procedures or treatments and substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among other physicians, osteopaths, chiropractors, podiatrists, or dentists in the same or similar community who perform similar treatments or procedures; or

(c) The patient would reasonably, under all the surrounding circumstances, have undergone such treatment or procedure had he been advised by the physician, osteopath, chiropractor, podiatrist, or dentist in accordance with the provisions of paragraphs (a) and (b) of this section.

(4)(a) A consent which is evidenced in writing and meets the requirements of subsection (3), shall, if validly signed by the patient or another authorized person, be conclusively presumed to be valid consent. This presumption may be rebutted if there was a fraudulent misrepresentation of a material fact in

obtaining the signature.

(b) A valid signature is one which is given by a person who under all the surrounding circumstances is mentally and physically competent to give consent.

Section 12. Subsection (5) of s. 458.1201, Florida Statutes, is renumbered as subsection (6), and a new subsection (5) is added to said section; paragraph (m) of subsection (1) of said section is amended and paragraphs (o) and (p) are added to said subsection; paragraphs (c) and (d) are added to subsection (2) of said section; paragraph (a) of subsection (3) of said section is amended to read:

458.1201 Denial, suspension, revocation of license; disciplinary powers.--

(1) The board shall have authority to deny an application for a license or to discipline a physician licensed under this chapter or any antecedent law who, after hearing has been adjudged unqualified or guilty of any of the following:

(m) Being guilty of immoral or unprofessional conduct, incompetence, negligence, or willful misconduct. Unprofessional conduct shall include any departure from, or the failure to conform to, the ~~minimal~~ standards of acceptable and prevailing medical practice in his area of expertise as determined by the board, in which proceeding actual injury to a patient need not be established; ~~or the committing by a physician of any act contrary to honesty, justice, or good morals,~~ when whether the same is committed in the course of his practice ~~or otherwise~~, and whether committed within or without this state;

(o) Being found liable for medical malpractice or any personal injury resulting from an act or omission committed or omitted by a person in his capacity as a physician licensed pursuant to this chapter.

(p) Being removed or suspended or having disciplinary

action taken by his peers within any professional medical association, society, professional standards review organization established pursuant to section 249F of Public Law 92-603, or similarly constituted professional body, whether or not such association, society, organization, or body is local, regional, state, national, or international in scope, or by being disciplined by a licensed hospital or medical staff of said hospital for immoral or unprofessional conduct or willful misconduct or negligence by a person in his capacity as a physician licensed pursuant to this chapter. Any body taking action as set forth in this paragraph shall report such action to the board within 30 days of its occurrence or be subject to a fine assessed by the board in an amount not exceeding $500.

(2)(c) In any proceeding under subsection (1) of this section the board may appoint one or more licensed physicians to act for the board in investigating the conduct or competence of a physician.

(d) There shall be no liability on the part of, and no cause of action of any nature shall arise against the board, its agents, its employees, or any organization or its members identified in paragraph (p) of subsection(1) of this section, for any statements made by them in any reports or communications concerning an investigation of the conduct or competence of a physician.

(3)(a) When the board finds any person unqualified or guilty of any of the grounds set forth in subsection (1), it may enter an order imposing one or more of the following:

1. Deny his application for a license;

2. Permanently withhold issuance of a license;

3. Administer a public or private reprimand;

4. Suspend or limit or restrict his license to practice medicine for a period of up to five years;

5. Revoke indefinitely his license to practice medicine;

6. Require him to submit to the care, counseling, or treatment of physicians designated by the board;

7. Require him to participate in a program of continuing education prescribed by the board;

8. Require him to practice under the direction of a physician in a public institution, public or private health care program, or private practice for a period of time specified by the board.

(5) The board shall report to the President of the Senate and the Speaker of the House of Representatives, on February 1 of each year beginning February 1, 1976, the status of the actions taken by the board in carrying out its responsibilities assigned to it under this section.

(6)(5) The provisions of this section are enacted in the public welfare and shall be liberally construed so as to advance the remedy.

Section 13. Section 395.065, Florida Statutes, is created to read:

395.065 Hospital disciplinary powers.--

(1) The medical staff of any hospital licensed pursuant to chapter 395, Florida Statutes, is authorized to suspend, deny, revoke, or curtail the staff privileges of any staff member for good cause, which shall include, but not be limited to:

(a) Incompetence;

(b) Negligence;

(c) Being found an habitual user of intoxicants or drugs to the extent that the physician is deemed dangerous to himself or others; or

(d) Being found liable by a court of competent jurisdiction for medical malpractice.

Provided, however, that the procedures for such actions shall comply with the standards outlined by the Joint Commission of Accreditation of Hospitals and the

Principles of Participation in the Federal Health Insurance Program for the Aged.

(2) There shall be no liability on the part of and no cause of action of any nature shall arise against any hospital, hospital medical staff or hospital disciplinary body, its agents or employees, for any action taken in good faith and without malice in carrying out the provisions of this act.

Section 14. Subsection (8) of s. 627.351, Florida Statutes, is created to read:

627.351 Insurance risk apportionment plan.--

(8)(a) The Department of Insurance shall, after consultation with insurers as set forth in paragraph (b), adopt a temporary joint underwriting plan as set forth in paragraph (d).

(b) Entities licensed to issue casualty insurance as defined in s. 624.605(1)(b), (j), and (p), Florida Statutes, and self-insurers authorized to issue medical malpractice insurance under s. 627.355, Florida Statutes, shall participate in the plan and shall be members of the Temporary Joint Underwriting Association.

(c) The joint underwriting association shall operate subject to the supervision and approval of a board of governors consisting of representatives of five of the insurers participating in the joint underwriting association, an attorney to be named by the Florida Bar, a physician to be named by the Florida Medical Association, a hospital representative to be named by the Florida Hospital Association, and the Insurance Commissioner or his designated representative employed by the Department of Insurance. The Insurance Commissioner or his representative shall be the chairman of the board.

(d) The temporary joint underwriting plan shall function for a period not exceeding three years from the date of its adoption by the Department of Insurance and if still in existence

at the end of such three-year period, it shall automatically terminate. The plan shall provide professional liability or malpractice coverage in a standard policy form for all hospitals licensed under chapter 395, Florida Statutes, physicians licensed under chapter 458, Florida Statutes, osteopaths licensed under chapter 459, Florida Statutes, podiatrists licensed under chapter 461, Florida Statutes, dentists licensed under chapter 466, Florida Statutes, nurses licensed under chapter 464, Florida Statutes, and nursing homes licensed under chapter 400, Florida Statutes, or professional associations of such persons. The plan shall include, but not be limited to, the following:

1. Rules for the classification of risks and rates which reflect past and prospective loss and expense experience in different areas of practice and in different geographical areas.

2. A rating plan which reasonably recognizes the prior claims experience of insureds.

3. Provisions as to rates for insureds who are retired, semi-retired, the estate of a deceased insured, or part-time professionals.

4. Protection in an amount to be determined by the Insurance Commissioner and for those hospitals licensed under chapter 395, Florida Statutes, whose policies have been cancelled since April 1, 1975, that have not been able to otherwise secure coverage in the standard market shall provide continuous coverage at the limits available in the plan from the above date.

5. Rules to implement the orderly dissolution of the plan at its termination.

6. The Insurance Commissioner may, in his discretion, require that insurers participating in the joint underwriting association offer excess coverage.

(e) Premium contingency assessment.--

1. In the event an underwriting deficit exists at the end of any year the plan is in effect, each policyholder shall

pay to the association a premium contingency assessment not to exceed one-third of the annual premium payment paid by such policyholder to the association. The association shall cancel the policy of any policyholder who fails to pay the premium contingency assessment.

2. Any deficit sustained under the plan shall first be recovered through the premium contingency assessment. Concurrently, the rates for insureds shall be adjusted for the next year so as to be actuarially sound.

3. If there be any remaining deficit under the plan after maximum collection of the premium contingency assessment, such deficit shall be recovered from the companies participating in the plan in the proportion that the net direct premiums of each such member written during the preceding calendar year bears to the aggregate net direct premiums written in this state by all members of the association. Premiums as used herein shall mean premiums for the lines of insurance defined in s. 624.605(1)(b), (j), and (p), Florida Statutes, including premiums for such coverage issued under package policies.

(f) The plan shall provide for one or more insurers able and willing to provide policy service through licensed resident agents and claims service on behalf of all other insurers participating in the plan.

(g) The Department of Insurance, prior to termination of the plan, shall determine whether a need reasonably exists for continuing coverage for those who have been insured by the plan, as to claims solely for incidents which occurred during the existence of the plan. If such need is found, the Department of Insurance shall establish a plan for the purchase of such coverage for a reasonable time, prior to termination of the plan.

(h) All books, records, documents or audits relating

to the joint underwriting association or its operation shall be open to public inspection.

Section 15. Section 627.353, Florida Statutes, is created to read:

627.353 Limitation of liability and patient's compensation fund.--

(1) LIMITATION OF LIABILITY.--

(a) All hospitals licensed under chapter 395, Florida Statutes, shall, unless exempted under paragraph (c) of this section, and all physicians and physician's assistants licensed under chapter 458, Florida Statutes, osteopaths licensed under chapter 459, Florida Statutes, and podiatrists licensed under chapter 461, Florida Statutes, may, pay the yearly assessment into the patient's compensation fund pursuant to subsection (2) of this section prior to practicing during any

(b) Said licensed hospital, physician, physician's assistant, osteopath, or podiatrist shall not be liable for an amount in excess of $100,000 for claims arising out of the rendering of medical care or services in this state if at the time the incident occurred giving rise to the cause of the claim the hospital, physician, physician's assistant, osteopath or podiatrist:

1. had posted bond in the amount of $100,000, proved financial responsibility in the amount of $100,000 to the satisfaction of the Insurance Commissioner through the establishment of an appropriate escrow account, obtained medical malpractice insurance in the amount of $100,000 or more from private insurers or the joint underwriting association established under section 14 of this act, or obtained self-insurance

as provided in s. 627.355, Florida Statutes, providing coverage in an amount of $100,000 or more, and

2. Had paid for the year in which the incident occurred for which the claim was filed the fee required pursuant to subsection (2) of this section.

(c) Any hospital that can meet one of the following provisions demonstrating financial responsibility to meet claims arising out of the rendering of medical care or services in this state shall not be required to participate in the fund:

1. Post bond in an amount equivalent to $10,000 for each hospital bed in said hospital not to exceed $2,500,000; or

2. Prove financial responsibility in an amount equivalent to $10,000 for each hospital bed in said hospital not to exceed $2,500,000 to the satisfaction of the Insurance Commissioner through the establishment of an appropriate escrow account; or

3. Obtain professional liability coverage in an amount equivalent to $10,000 or more for each bed in said hospital from a private insurer, from the joint underwriting association established under section 14 of this act, or through a plan of self-insurance as provided in s. 627.355, Florida Statutes; provided, however, no hospital shall be required to obtain such coverage in an amount exceeding $2,500,000.

(d) Any licensed hospital, physician, physician's assistant, osteopath, or podiatrist who does not meet the provisions of paragraph (b) of this subsection shall be subject to liability under law without regard to the provisions of this section.

(2) PATIENT'S COMPENSATION FUND.--

(a) The fund.--There is created a "Florida Patient's Compensation Fund" hereinafter referred to as the "Fund", for the purpose of paying that portion of any medical malpractice claim which is in excess of $100,000 as set forth in paragraph

(b) of subsection (1) of this section. The fund shall be liable only for payment of claims against hospitals, physicians, physician's assistants, osteopaths and podiatrists in compliance with the provisions of paragraph (b) of subsection (1) of this section, and reasonable and necessary expenses incurred in payment of claims and fund administrative expenses.

(b) Fund administration and operation.--Management of the fund shall be vested with the joint underwriting association authorized by section 14 of this act, hereinafter referred to as the JUA. The JUA shall operate subject to the supervision and approval of a board of governors consisting of representatives of five of the insurers participating in the JUA, an attorney to be named by the Florida Bar, a physician to be named by the Florida Medical Association, a hospital representative to be named by the Florida Hospital Association, and the Insurance Commissioner or his designated representative employed by the Department of Insurance. The Insurance Commissioner or his representative shall be the chairman of the board. In the event of termination or dissolution of said JUA with respect to providing professional liability or malpractice insurance, the JUA shall continue to operate for the purpose of fund management as provided in this subsection.

(c) Fees and assessments.--Annually, each licensed hospital, physician, physician's assistant, osteopath or podiatrist as set forth in subsection (1) electing to comply with paragraph (b) of subsection (1) of this section shall pay the fees established under this act for deposit into the fund, which shall be remitted for deposit in a manner prescribed by the Insurance Commissioner. The coverage provided by the fund shall begin July 1, 1975 and run thereafter on a fiscal year basis. For the first year of operation each participating licensed hospital, physician, physician's assistant, osteopath,

or podiatrist covered under the fund shall pay a fee for deposit into the fund in the amount of $1,000 for any individual and $300 per bed for any hospital. The fee charged after the first year of operation shall consist of a base fee of $500 for any individual and $300 per bed for any hospital. In addition, after the first year of operation additional fees shall be assessed based on the following considerations:

1. Past and prospective loss and expense experience in different types of practice and in different geographical areas within the state.

2. The prior claims experience of persons or hospitals covered under the fund.

3. Risk factors for persons who are retired, semi-retired or part-time professionals.

Said base fees may be adjusted downward for any fiscal year in which a lesser amount would be adequate and in which the additional fee would not be necessary to maintain the solvency of the fund. Said additional fee shall be based on not more than two geographical areas with three categories of practice and with a fourth category which contemplates individual risk rating for hospitals. The fund shall be maintained at not more than $25,000,000. Fees shall be set by the Insurance Commissioner after consultation with the JUA. Nothing contained herein shall be construed as imposing liability for payment of any part of a fund deficit on the JUA or its member insurers. If the JUA determines that the amount of money in the fund is not sufficient to satisfy the claims made against the fund in a given fiscal year, the JUA shall certify the amount of the projected insufficiency to the Insurance Commissioner and shall request the Insurance Commissioner to levy a deficit assessment against all participants in the fund for that fiscal year. The Insurance Commissioner shall levy such deficit assessment

against such participants in amounts that fairly reflect the classifications prescribed above and which are sufficient to obtain the money necessary to meet all claims for said fiscal year.

(d) Fund accounting and audit.--

1. Monies shall be withdrawn from the fund only upon vouchers approved by the JUA as authorized by the Board of Governors.

2. All books, records, and audits of the fund shall be open for reasonable inspection to the general public.

3. Persons authorized to receive deposits, withdraw, issue vouchers or otherwise disburse any fund monies shall post a blanket fidelity bond in an amount reasonably sufficient to protect fund assets. The cost of such bond shall be paid from the fund.

4. Annually, the JUA shall furnish an audited financial report to all fund participants and to the Department of Insurance and to the Joint Legislative Auditing Committee. The report shall be prepared in accordance with accepted accounting procedures and shall include income and such other information as may be required by the Department of Insurance or the Joint Legislative Auditing Committee.

5. Monies held in the fund shall be invested in short-term interest bearing investments by the JUA as administrator, provided that in no case shall said moneys be invested in the stock of any insurer participating in the JUA or in the parent company or company owning a controlling interest of said insurer. All income derived from such investments shall be credited to the fund.

6. Any person or hospital participating in the fund may withdraw from such participation at the end of any fiscal year; however, such person or hospital shall remain subject to any

deficit assessment pertaining to any year in which such person or hospital participated in the fund.

(e) Claims procedures.--

1. Any person may file an action for damages arising out of the rendering of medical care or services against a person covered under the fund provided that the person filing the claim shall not recover against the fund any portion of a judgment for damages arising out of the rendering of medical care or services against a person covered under the fund unless the fund was named as a defendant in the suit. If after reviewing the facts upon which the claim is based it appears that the claim will exceed $100,000, the fund shall appear and actively defend itself when named as a defendant in the suit. In so defending, the fund shall retain counsel and pay out of the fund attorney's fees and expenses including court costs incurred in defending the fund. The attorney or law firm retained to defend the fund shall not be retained or employed by the JUA to perform legal services for the JUA other than those directly connected with the fund. The fund is authorized to negotiate with any claimants having a judgment exceeding $500,000 to reach an agreement as to the manner in which that portion of the judgment exceeding $500,000 is to be paid. Any judgment affecting the fund may be appealed under the Florida Appellate Rules of Procedure as with any defendant.

2. It shall be the responsibility of the insurer or self-insurer providing insurance or self-insurance for a hospital, physician, physician's assistant, osteopath or podiatrist who is also covered by the fund to provide an adequate defense on any claim filed that potentially affects the fund with respect to such insurance contract or self-insurance contract. The insurer shall act in a fiduciary relationship with respect to any claim affecting the fund. No settlement exceeding

$100,000, or any other amount which could require payment by the fund, shall be agreed to unless approved by the JUA.

3. A person who has recovered a final judgment or a settlement approved by the JUA against a hospital, physician, physician's assistant, osteopath or podiatrist, who is covered by the fund may file a claim with the JUA to recover that portion of such judgment or settlement which is in excess of $100,000 as set forth in paragraph (b) of subsection (1) of this section. In the event the fund incurs liability exceeding $1,000,000 to any person under a single occurrence the fund shall pay not more than $1,000,000 per year until the claim has been paid in full.

4. Claims filed against the fund shall be paid in the order received within 90 days after filing unless appealed by the fund. If the fund does not have enough money to pay all of the claims, claims received after the funds are exhausted shall be immediately payable the following year in the order in which they were received.

5. If a person or hospital participating in the fund has coverage in excess of $100,000, he shall be liable for losses up to the amount of his coverage, and he shall receive an appropriate reduction of his assessment for the fund. Such reduction shall be granted only after that person has proved to the satisfaction of the JUA that he has such coverage.

Section 16. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared severable.

Section 17. This act shall take effect upon becoming law.