

February 17, 1998

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# ENGROSSED HOUSE BILL No. 1286

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DIGEST OF HB 1286 (Updated February 12, 1998 12:53 pm - DI 97)

**Citations Affected:** IC 27-12; noncode.

**Synopsis:** Medical malpractice. Provides that a health care provider for whom an insurer submits proof of financial responsibility and payment of the surcharge to the department of insurance in an untimely manner may be in compliance with patient compensation fund requirements if certain conditions are met by the insurer. Requires a health care provider to carry a policy of malpractice liability insurance of at least \$250,000 per occurrence and \$750,000 in the annual aggregate in order  
(Continued next page)

**Effective:** Upon passage; July 1, 1998; January 1, 1999; July 1, 1999.

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**Fry, M. Smith, Torr, Fesko**

(SENATE SPONSORS — HARRISON, LEWIS, LANDSKE)

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January 13, 1998, read first time and referred to Committee on Insurance, Corporations and Small Business.

January 22, 1998, amended, reported — Do Pass.

January 29, 1998, read second time, amended, ordered engrossed.

January 30, 1998, engrossed.

February 3, 1998, read third time, passed. Yeas 98, nays 0.

SENATE ACTION

February 9, 1998, read first time and referred to Committee on Insurance and Interstate Cooperation.

February 16, 1998, amended, reported favorably — Do Pass.

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EH 1286—LS 7170/DI 88+



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to be covered under the medical malpractice act. (Current law requires policy limits of \$100,000 per occurrence and \$300,000 in the annual aggregate.) Requires a hospital to carry a policy of malpractice liability insurance of at least \$5,000,000 in the annual aggregate if the hospital has 100 or fewer beds, and a policy of at least \$7,500,000 in the annual aggregate if the hospital has more than 100 beds. (Current law provides limits of \$2,000,000 and \$3,000,000, respectively.) Requires that a health maintenance organization or limited service health maintenance organization carry an annual aggregate policy of malpractice liability insurance of at least \$1,750,000. Requires that a health facility with not more than 100 beds carry an annual aggregate policy of malpractice liability insurance of at least \$750,000, and that a health facility with more than 100 beds carry an annual aggregate policy of malpractice liability insurance of at least \$1,250,000. Increases from \$25 to \$100 the minimum annual surcharge each health care provider is required to pay. Provides methods of calculation of the annual surcharge for physicians and hospitals. Provides for changes in the calculation of the annual surcharge for health care providers. Requires the commissioner to pay an attorney to protect the patient compensation fund. Requires the commissioner to retain legal counsel to represent the department when a trial court determination is necessary to resolve a patient compensation fund claim. Provides that the commissioner has sole authority for making decisions regarding the settlement of claims against the patient compensation fund and determining the reasonableness of any fee submitted by an attorney who defends the patient compensation fund. Allows a malpractice claimant to initiate a confidential action in court at the same time the claimant's proposed complaint is being considered by a medical review panels. Specifies the circumstances under which the name of a negligent health care provider must be referred to the appropriate board of professional registration. Requires the commissioner to order a hearing on the motion of a party or on the commissioner's own initiative to dismiss a case before the department of insurance if no action has been taken in the case for at least two years. Increases from \$1,250 to \$2,000 the maximum a medical review panel chairman may be paid. Increases the maximum amount recoverable for an injury or death of a patient from \$750,000 to \$1,250,000 for an act of malpractice that occurs after December 31, 1998. Increases from \$100,000 to \$250,000 the maximum amount for which a qualified provider may be held liable for an act of malpractice. Repeals a provision allowing the commissioner to decrease the amount of the surcharge paid by providers if the patient compensation fund maintains a balance of at least \$125,000,000 at the end of two consecutive 6 month periods.

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February 17, 1998

Second Regular Session 110th General Assembly (1998)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 1997 General Assembly.

## ENGROSSED HOUSE BILL No. 1286

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

*Be it enacted by the General Assembly of the State of Indiana:*

1 SECTION 1. IC 27-12-2-24.5 IS ADDED TO THE INDIANA  
2 CODE AS A NEW SECTION TO READ AS FOLLOWS  
3 [EFFECTIVE JULY 1, 1998]: **Sec. 24.5. "Qualified provider" means**  
4 **a health care provider that is qualified under this article by**  
5 **complying with the procedures set forth in IC 27-12-3.**

6 SECTION 2. IC 27-12-3-5 IS AMENDED TO READ AS  
7 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 5. (a) **Except as**  
8 **provided in subsection (b)**, the receipt of proof of financial  
9 responsibility and the surcharge constitutes compliance with section 2  
10 of this chapter:

11 (1) as of the date on which they are received; or  
12 (2) as of the effective date of the policy;  
13 if this proof is filed with and the surcharge paid to the department of  
14 insurance not later than ninety (90) days after the effective date of the  
15 insurance policy. ~~If proof of financial responsibility and the payment~~  
16 ~~of the surcharge is not made within ninety (90) days after the policy~~

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1 effective date, compliance occurs on the date when proof is filed and  
2 the surcharge is paid.

3 (b) If an insurer files proof of financial responsibility and makes  
4 payment of the surcharge to the department of insurance at least  
5 ninety-one (91) days but not more than one hundred eighty (180)  
6 days after the policy effective date, the health care provider is in  
7 compliance with section 2 of this chapter, if the insurer  
8 demonstrates to the satisfaction of the commissioner that the  
9 insurer:

10 (1) received the premium and surcharge in a timely manner;  
11 and

12 (2) failed to transmit the surcharge in a timely manner.

13 (c) If the commissioner accepts a filing as timely under  
14 subsection (b), the filing must be accompanied by a penalty amount  
15 as follows:

16 (1) Ten percent (10%) of the surcharge, if the proof of  
17 financial responsibility and surcharge are received by the  
18 commissioner at least ninety-one (91) days and not more than  
19 one hundred twenty (120) days after the original effective date  
20 of the policy.

21 (2) Twenty percent (20%) of the surcharge, if the proof of  
22 financial responsibility and surcharge are received by the  
23 commissioner at least one hundred twenty-one (121) days and  
24 not more than one hundred fifty (150) days after the original  
25 effective date of the policy.

26 (3) Fifty percent (50%) of the surcharge, if the proof of  
27 financial responsibility and surcharge are received by the  
28 commissioner at least one hundred fifty-one (151) days and  
29 not more than one hundred eighty (180) days after the  
30 original effective date of the policy.

31 SECTION 3. IC 27-12-4-1, AS AMENDED BY P.L.26-1994,  
32 SECTION 24, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
33 JULY 1, 1999]: Sec. 1. Financial responsibility of a health care  
34 provider and the provider's officers, agents, and employees while acting  
35 in the course and scope of their employment with the health care  
36 provider may be established under subdivision (1), (2), or (3):

37 (1) By the health care provider's insurance carrier filing with the  
38 commissioner proof that the health care provider is insured by a  
39 policy of malpractice liability insurance in the amount of at least  
40 ~~one two~~ **two hundred fifty** thousand dollars (~~\$100,000~~) (**\$250,000**)  
41 per occurrence and ~~three seven~~ **three hundred fifty** thousand dollars  
42 (~~\$300,000~~) (**\$750,000**) in the annual aggregate, except for the



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- 1 following:
- 2 (A) If the health care provider is a hospital, as defined in this
- 3 article, the minimum annual aggregate insurance amount is as
- 4 follows:
- 5 (i) For hospitals of not more than one hundred (100) beds,
- 6 ~~two five~~ million dollars (~~\$2,000,000~~): **(\$5,000,000)**.
- 7 (ii) For hospitals of more than one hundred (100) beds, ~~three~~
- 8 **seven million five hundred thousand** dollars (~~\$3,000,000~~):
- 9 **(\$7,500,000)**.
- 10 (B) If the health care provider is a health maintenance
- 11 organization (as defined in IC 27-13-1-19) or a limited service
- 12 health maintenance organization (as defined in
- 13 IC 27-13-34-4), the minimum annual aggregate insurance
- 14 amount is **one million seven hundred fifty** thousand dollars
- 15 (~~\$700,000~~): **(\$1,750,000)**.
- 16 (C) If the health care provider is a health facility, the minimum
- 17 annual aggregate insurance amount is as follows:
- 18 (i) For health facilities with not more than one hundred
- 19 (100) beds, ~~three seven~~ hundred **fifty** thousand dollars
- 20 (~~\$300,000~~): **(\$750,000)**.
- 21 (ii) For health facilities with more than one hundred (100)
- 22 beds, ~~five one million two~~ hundred **fifty** thousand dollars
- 23 (~~\$500,000~~): **(\$1,250,000)**.
- 24 (2) By filing and maintaining with the commissioner cash or
- 25 surety bond approved by the commissioner in the amounts set
- 26 forth in subdivision (1).
- 27 (3) If the health care provider is a hospital or a psychiatric
- 28 hospital, by submitting annually a verified financial statement
- 29 that, in the discretion of the commissioner, adequately
- 30 demonstrates that the current and future financial responsibility
- 31 of the health care provider is sufficient to satisfy all potential
- 32 malpractice claims incurred by the provider or the provider's
- 33 officers, agents, and employees while acting in the course and
- 34 scope of their employment up to a total of ~~one two~~ hundred **fifty**
- 35 thousand dollars (~~\$100,000~~) **(\$250,000)** per occurrence and
- 36 annual aggregates as follows:
- 37 (A) For hospitals of not more than one hundred (100) beds,
- 38 ~~two five~~ million dollars (~~\$2,000,000~~): **(\$5,000,000)**.
- 39 (B) For hospitals of more than one hundred (100) beds, ~~three~~
- 40 **seven million five hundred thousand** dollars (~~\$3,000,000~~):
- 41 **(\$7,500,000)**.
- 42 The commissioner may require the deposit of security to assure

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1 continued financial responsibility.

2 SECTION 4. IC 27-12-5-2 IS AMENDED TO READ AS  
3 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. (a) As used in  
4 this section, "actuarial program" means a program used or  
5 created by the department to determine the actuarial risk posed to  
6 the patient compensation fund under IC 27-12-6 by a hospital. The  
7 program must be:

8 (1) developed to calculate actuarial risk posed by a hospital,  
9 taking into consideration risk management programs used by  
10 the hospital;

11 (2) an efficient and accurate means of calculating a hospital's  
12 malpractice actuarial risk;

13 (3) publicly identified by the department by July 1 of each  
14 year, and

15 (4) made available to a hospital's malpractice insurance  
16 carrier for purposes of calculating the hospital's surcharge  
17 under subsection (g).

18 (b) Beginning July 1, 1999, the amount of the annual surcharge  
19 shall be set by a rule one hundred percent (100%) of the cost to each  
20 health care provider for maintenance of financial responsibility.  
21 Beginning July 1, 2001, the annual surcharge shall be set by a rule  
22 adopted by the commissioner under IC 4-22-2.

23 ~~(b)~~ (c) The amount of the surcharge shall be determined based upon  
24 actuarial principles and actuarial studies and must be adequate for the  
25 payment of claims and expenses from the patient's compensation fund.

26 ~~(c)~~ (d) The surcharge may not exceed two hundred percent (200%)  
27 the actuarial risk posed to the patient's compensation fund under  
28 IC 27-12 by qualified providers other than of the cost to each health  
29 care provider; a physician licensed under IC 25-22.5 and a hospital  
30 licensed under IC 16-21. for maintenance of financial responsibility.

31 ~~(d)~~ (e) There is imposed a minimum annual surcharge of twenty-five  
32 one hundred dollars (~~\$25~~). (\$100).

33 (f) Notwithstanding subsections (b), (c), and (e), beginning July  
34 1, 1999, the surcharge for a qualified provider who is licensed  
35 under IC 25-22.5 is calculated as follows:

36 (1) The commissioner shall contract with an actuary that has  
37 experience in calculating the actuarial risks posed by  
38 physicians. Not later than July 1 of each year, the actuary  
39 shall calculate the median of the premiums paid for  
40 malpractice liability policies to the three (3) malpractice  
41 insurance carriers in the state that have underwritten the  
42 most malpractice insurance policies for all physicians

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1 practicing in the same specialty class in Indiana during the  
 2 previous twelve (12) month period. In calculating the median,  
 3 the actuary shall consider the:

4 (A) manual rates of the three (3) leading malpractice  
 5 insurance carriers in the state; and

6 (B) aggregate credits or debits to the manual rates given  
 7 during the previous twelve (12) month period.

8 (2) After making the calculation described in subdivision (1),  
 9 the actuary shall establish a uniform surcharge for all  
 10 licensed physicians practicing in the same specialty class. This  
 11 surcharge must be based on a percentage of the median  
 12 calculated in subdivision (1) for all licensed physicians  
 13 practicing in the same specialty class under rules adopted by  
 14 the commissioner under IC 4-22-2. The surcharge:

15 (A) must be sufficient to cover; and

16 (B) may not exceed;

17 the actuarial risk posed to the patient compensation fund  
 18 under IC 27-12-6 by physicians practicing in the specialty  
 19 class.

20 (g) Beginning July 1, 1999, the surcharge for a hospital licensed  
 21 under IC 16-21 that establishes financial responsibility under  
 22 IC 27-12-4 after June 30, 1999, is established through the use of an  
 23 actuarial program. At the time financial responsibility is  
 24 established for the hospital, the hospital shall pay the surcharge  
 25 amount established for the hospital under this section. The  
 26 surcharge:

27 (1) must be sufficient to cover; and

28 (2) may not exceed;

29 the actuarial risk posed to the patient compensation fund under  
 30 IC 27-12-6 by the hospital.

31 (h) An actuarial program used or developed under subsection  
 32 (a) shall be treated as a public record under IC 5-14-3.

33 SECTION 5. IC 27-12-6-2 IS AMENDED TO READ AS  
 34 FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. (a) The  
 35 commissioner, using money from the fund, as considered necessary,  
 36 appropriate, or desirable, may purchase **or retain** the services of  
 37 persons, firms, and corporations to aid in protecting the fund against  
 38 claims. **The commissioner shall retain the services of counsel**  
 39 **described in subsection (b) to represent the department when a**  
 40 **trial court determination will be necessary to resolve a claim**  
 41 **against the patient's compensation fund.**

42 (b) When retaining legal services under subsection (a), the

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1 commissioner shall retain competent and experienced legal counsel  
 2 licensed to practice law in Indiana to assist in litigation or other  
 3 matters pertaining to the fund.

4 (c) The commissioner has sole authority for the following:

5 (1) Making a decision regarding the settlement of a claim  
 6 against the patient compensation fund.

7 (2) Determining the reasonableness of any fee submitted to the  
 8 department of insurance by an attorney who defends the  
 9 patient compensation fund under this section.

10 (d) All expenses of collecting, protecting, and administering the  
 11 fund shall be paid from the fund.

12 SECTION 6. IC 27-12-8-7 IS ADDED TO THE INDIANA CODE  
 13 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY  
 14 1, 1998]: Sec. 7. (a) Notwithstanding section 4 of this chapter,  
 15 beginning July 1, 1999, a claimant may commence an action in  
 16 court for malpractice at the same time the claimant's proposed  
 17 complaint is being considered by a medical review panel. In order  
 18 to comply with this section, the:

19 (1) complaint filed in court may not contain information that  
 20 would allow a third party to identify the defendant;

21 (2) claimant is prohibited from pursuing the action; and

22 (3) court is prohibited from taking any action except setting  
 23 a date for trial, an action under IC 27-12-8-8, or an action  
 24 under IC 27-12-11;

25 until section 4 of this chapter has been satisfied.

26 (b) Upon satisfaction of section 4 of this chapter, the identifying  
 27 information described in subsection (a)(1) shall be added to the  
 28 complaint by the court.

29 SECTION 7. IC 27-12-8-8 IS ADDED TO THE INDIANA CODE  
 30 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE  
 31 UPON PASSAGE]: Sec. 8. If action has not been taken in a case  
 32 before the department of insurance for a period of at least two (2)  
 33 years, the commissioner, on the:

34 (1) motion of a party; or

35 (2) commissioner's own initiative;

36 may file a motion in Marion County Circuit Court to dismiss the  
 37 case under Rule 41(E) of the Indiana Rules of Trial Procedure.

38 SECTION 8. IC 27-12-9-3 IS AMENDED TO READ AS  
 39 FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 3. (a) A health care  
 40 provider's insurer shall notify the commissioner of any malpractice case  
 41 upon which the insurer has placed a reserve of at least fifty one  
 42 hundred twenty-five thousand dollars (~~\$50,000~~): (\$125,000). The



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1 insurer shall give notice to the commissioner under this subsection  
 2 immediately after placing the reserve. The notice and all  
 3 communications and correspondence relating to the notice are  
 4 confidential and may not be made available to any person or any public  
 5 or private agency.

6 (b) All malpractice claims settled or adjudicated to final judgment  
 7 against a health care provider shall be reported to the commissioner by  
 8 the plaintiff's attorney and by the health care provider or the health care  
 9 provider's insurer or risk manager within sixty (60) days following final  
 10 disposition of the claim. The report to the commissioner must state the  
 11 following:

- 12 (1) The nature of the claim.
- 13 (2) The damages asserted and the alleged injury.
- 14 (3) The attorney's fees and expenses incurred in connection with  
 15 the claim or defense.
- 16 (4) The amount of the settlement or judgment.

17 SECTION 9. IC 27-12-9-4 IS AMENDED TO READ AS  
 18 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 4. (a) **The medical  
 19 review panel (as described in IC 27-12-10) shall make a separate  
 20 determination at the time that it renders its opinion under  
 21 IC 27-12-10-22 as to whether the name of the defendant health care  
 22 provider should be forwarded to the appropriate board of  
 23 professional registration for review of the health care provider's  
 24 fitness to practice the health care provider's profession. The name  
 25 of the defendant health care provider shall be forwarded if the  
 26 medical review panel unanimously determines that it should be  
 27 forwarded. The medical review panel determination is not  
 28 admissible as evidence in a civil action.** the commissioner shall  
 29 forward the name of every health care provider, except a hospital,  
 30 against whom a settlement is made or judgment is rendered under this  
 31 article to the appropriate board of professional registration and  
 32 examination for review of the fitness of the health care provider to  
 33 practice the health care provider's profession. In each case involving  
 34 review of a health care provider's fitness to practice forwarded under  
 35 this section, the appropriate board of professional registration and  
 36 examination may, in appropriate cases, take the following disciplinary  
 37 action:

- 38 (1) censure;
- 39 (2) imposition of probation for a determinate period;
- 40 (3) suspension of the health care provider's license for a  
 41 determinate period; or
- 42 (4) revocation of the license.



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1 (b) Review of the health care provider's fitness to practice shall be  
2 conducted in accordance with IC 4-21.5.

3 (c) The appropriate board of professional registration and  
4 examination shall report to the commissioner the board's findings, the  
5 action taken, and the final disposition of each case involving review of  
6 a health care provider's fitness to practice forwarded under this section.

7 SECTION 10. IC 27-12-10-25 IS AMENDED TO READ AS  
8 FOLLOWS [EFFECTIVE JANUARY 1, 1999]: Sec. 25. (a) Each  
9 health care provider member of the medical review panel is entitled to  
10 be paid:

11 (1) up to three hundred fifty dollars (\$350) for all work performed  
12 as a member of the panel, exclusive of time involved if called as  
13 a witness to testify in court; and

14 (2) reasonable travel expense.

15 (b) The chairman of the panel is entitled to be paid:

16 (1) at the rate of two hundred fifty dollars (\$250) per diem, not to  
17 exceed ~~one thousand two hundred fifty dollars (\$1,250);~~  
18 **(\$2,000);** and

19 (2) reasonable travel expenses.

20 (c) The chairman shall keep an accurate record of the time and  
21 expenses of all the members of the panel. The record shall be submitted  
22 to the parties for payment with the panel's report.

23 (d) Fees of the panel, including travel expenses and other expenses  
24 of the review, shall be paid by the side in whose favor the majority  
25 opinion is written. If there is no majority opinion, each side shall pay  
26 ~~one-half (1/2)~~ **fifty percent (50%)** of the cost.

27 SECTION 11. IC 27-12-14-3 IS AMENDED TO READ AS  
28 FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 3. (a) The total amount  
29 recoverable for an injury or death of a patient may not exceed ~~the~~  
30 **following:**

31 (1) Five hundred thousand dollars (\$500,000) ~~except that, as to~~  
32 **for an act of malpractice that occurs on or after before** January 1,  
33 1990. ~~the total amount recovered for an injury or death may not~~  
34 ~~exceed~~

35 (2) Seven hundred fifty thousand dollars (\$750,000) **for an act of**  
36 **malpractice that occurs:**

37 (A) **after December 31, 1989; and**

38 (B) **before July 1, 1999.**

39 (3) **One million two hundred fifty thousand dollars**  
40 **(\$1,250,000) for an act of malpractice that occurs after June**  
41 **30, 1999.**

42 (b) A health care provider qualified under this article is not liable

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1 for an amount in excess of ~~one~~ **two** hundred **fifty** thousand dollars  
 2 (~~\$100,000~~) (**\$250,000**) for an occurrence of malpractice.

3 (c) Any amount due from a judgment or settlement that is in excess  
 4 of the total liability of all liable health care providers, subject to  
 5 subsections (a), (b), and (d), shall be paid from the patient's  
 6 compensation fund under IC 27-12-15.

7 (d) If a health care provider qualified under this article admits  
 8 liability or is adjudicated liable solely by reason of the conduct of  
 9 another health care provider who is an officer, agent, or employee of  
 10 the health care provider acting in the course and scope of employment  
 11 and qualified under this article, the total amount that shall be paid to  
 12 the claimant on behalf of the officer, agent, or employee and the health  
 13 care provider by the health care provider or its insurer is ~~one~~ **two**  
 14 hundred **fifty** thousand dollars (~~\$100,000~~) (**\$250,000**). The balance of  
 15 an adjudicated amount to which the claimant is entitled shall be paid  
 16 by other liable health care providers or the patient's compensation fund,  
 17 or both.

18 SECTION 12. IC 27-12-14-4 IS AMENDED TO READ AS  
 19 FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 4. (a) If the possible  
 20 liability of the health care provider to the patient is discharged solely  
 21 through an immediate payment, the limitations on recovery from a  
 22 health care provider stated in section 3(b) and 3(d) of this chapter apply  
 23 without adjustment.

24 (b) If the health care provider agrees to discharge its possible  
 25 liability to the patient through a periodic payments agreement, the  
 26 amount of the patient's recovery from a health care provider in a case  
 27 under this subsection is the amount of any immediate payment made by  
 28 the health care provider or the health care provider's insurer to the  
 29 patient, plus the cost of the periodic payments agreement to the health  
 30 care provider or the health care provider's insurer. For the purpose of  
 31 determining the limitations on recovery stated in section 3(b) and 3(d)  
 32 of this chapter and for the purpose of determining the question under  
 33 IC 27-12-15-3 of whether the health care provider or the health care  
 34 provider's insurer has agreed to settle its liability by payment of its  
 35 policy limits, the sum of:

36 (1) the present payment of money to the patient (or the patient's  
 37 estate) by the health care provider (or the health care provider's  
 38 insurer); plus

39 (2) the cost of the periodic payments agreement expended by the  
 40 health care provider (or the health care provider's insurer);

41 must exceed ~~seventy-five~~ **one hundred eighty-seven** thousand dollars  
 42 (~~\$75,000~~) (**\$187,000**).

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1 (c) More than one (1) health care provider may contribute to the cost  
 2 of a periodic payments agreement, and in such an instance the sum of  
 3 the amounts expended by each health care provider for immediate  
 4 payments and for the cost of the periodic payments agreement shall be  
 5 used to determine whether the ~~seventy-five~~ **one hundred eighty-seven**  
 6 thousand dollar ~~(\$75,000)~~ **(\$187,000)** requirement in subsection (b) has  
 7 been satisfied. However, one (1) health care provider or its insurer  
 8 must be liable for at least fifty thousand dollars (\$50,000).

9 SECTION 13. IC 27-12-6-3 IS REPEALED [EFFECTIVE  
 10 JANUARY 1, 1999].

11 SECTION 14. [EFFECTIVE UPON PASSAGE] (a) **After the**  
 12 **department establishes the annual surcharge for physicians under**  
 13 **IC 27-12-5-2, as amended by this act, the department shall publish**  
 14 **in the Indiana Register an estimated surcharge for all physicians**  
 15 **practicing in the same specialty class.**

16 (b) **The department of insurance shall publish the estimated**  
 17 **surcharges under subsection (a) in the Indiana Register not later**  
 18 **than February 1, 1999.**

19 (c) **This SECTION expires January 1, 2000.**

20 SECTION 15. **An emergency is declared for this act.**

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## COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, Corporations and Small Business, to which was referred House Bill 1286, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 3, line 3, delete "commercially available".

Page 3, line 4, after "used" insert "**or created**".

Page 3, line 8, delete "widely recognized as being".

Page 4, line 13, delete "by the department".

Page 4, line 14, delete "The surcharge".

Page 4, delete lines 15 through 16.

Page 4, line 17, delete "the department under subsection (h)".

Page 4, delete lines 25 through 42.

Page 5, delete lines 1 through 25.

Page 5, line 28, reset in roman "as considered necessary,".

Page 5, line 29, reset in roman line 29.

Page 5, line 29, after "purchase" insert "**or retain**".

Page 5, line 30, reset in roman "and corporations to aid in protecting".

Page 5, line 30, delete "shall pay an attorney who is".

Page 5, line 31, delete "licensed to practice law in Indiana to protect".

Page 5, line 31, after "claims" insert ".".

Page 5, delete lines 32 through 42, begin a new paragraph and insert:

**"(b) When retaining legal services under subsection (a), the commissioner shall retain competent and experienced legal counsel licensed to practice law in Indiana to assist in litigation or other matters pertaining to the fund."**

Page 6, delete lines 1 through 2.

Page 6, line 3, delete "(b)" and insert "(c)".

Page 6, line 9, delete "(c)" and insert "(d)".

Page 6, line 18, delete "any".

Page 6, line 21, after "except" insert "**setting a date for trial, an action under IC 27-12-8-8, or**".

Page 6, line 25, delete "JULY" and insert "UPON PASSAGE]".

Page 6, line 26, delete "1, 1998]".

Page 6, line 26, delete "(a) Beginning July 1, 1999, if" and insert "**It**".

Page 6, delete lines 31 through 42, begin a new line blocked left and insert: "**may file a motion in Marion County Circuit Court to dismiss the case under Rule 41(E) of the Indiana Rules of Trial**

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**Procedure."**

Delete page 7.

Page 8, delete lines 1 through 21.

Page 10, delete lines 26 through 30.

Page 10, line 31, delete "The actuary" and insert "**After the department**".

Page 10, line 32, delete "that".

Page 10, line 33, after "act," insert "**the department**".

Page 10, line 33, delete "provide" and insert "**publish in the Indiana Register**".

Page 10, line 35, delete "to the department of insurance not later than" and insert ".".

Page 10, delete line 36.

Page 10, line 37, delete "mail" and insert "**publish**".

Page 10, line 38, delete "to each licensed physician" and insert "**in the Indiana Register**".

Page 10, line 39, delete "March" and insert "**February**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to House Bill 1286 as introduced.)

FRY, Chair

Committee Vote: yeas 14, nays 0.

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## HOUSE MOTION

Mr. Speaker: I move that House Bill 1286 be amended to read as follows:

Page 5, between lines 20 and 21, begin a new paragraph and insert:

SECTION 7. IC 27-12-9-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 4. (a) **Subject to subsection (d)**, the commissioner shall forward the name of every health care provider, except a hospital, against whom a settlement is made or judgment is rendered under this article to the appropriate board of professional registration and examination for review of the fitness of the health care provider to practice the health care provider's profession. In each case involving review of a health care provider's fitness to practice forwarded under this section, the appropriate board of professional registration and examination may, in appropriate cases, take the following disciplinary action:

- (1) censure;
- (2) imposition of probation for a determinate period;
- (3) suspension of the health care provider's license for a determinate period; or
- (4) revocation of the license.

(b) Review of the health care provider's fitness to practice shall be conducted in accordance with IC 4-21.5.

(c) The appropriate board of professional registration and examination shall report to the commissioner the board's findings, the action taken, and the final disposition of each case involving review of a health care provider's fitness to practice forwarded under this section.

**(d) The commissioner shall forward the name of a health care provider under subsection (a) only if the medical review panel reviewing the health care provider under IC 27-12-10-22 has unanimously determined that the appropriate board of professional registration should examine the health care provider's fitness to practice.**

**(e) A medical review panel determination made under subsection (d):**

- (1) must be a separate opinion from the medical review panel opinion under IC 27-12-10-22; and**
- (2) is not admissible as evidence in a civil action."**

Re-number all SECTIONS consecutively.

(Reference is to House Bill 1286 as printed January 23, 1998.)

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## HOUSE MOTION

Mr. Speaker: I move that House Bill 1286 be amended to read as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

SECTION 1. IC 27-1-13-7 IS AMENDED TO READ AS FOLLOWS: Sec. 7. No policy of insurance against loss or damage resulting from accident to, or death or injury suffered by, an employee or other person or persons and for which the person or persons insured are liable, or, against loss or damage to property resulting from collision with any moving or stationary object and for which loss or damage the person or persons insured is liable, shall be issued or delivered in this state by any domestic or foreign corporation, insurance underwriters, association, or other insurer authorized to do business in this state, unless there shall be contained within such policy a provision that the insolvency or bankruptcy of the person or persons insured shall not release the insurance carrier from the payment of damages for injury sustained or loss occasioned during the life of such policy, and stating that in case execution against the insured is returned unsatisfied in an action brought by the injured person or his or her personal representative in case death resulted from the accident because of such insolvency or bankruptcy then an action may be maintained by the injured person, or his or her personal representative, against such domestic or foreign corporation, insurance underwriters, association or other insurer under the terms of the policy for the amount of the judgment in the said action not exceeding the amount of the policy. No such policy shall be issued or delivered in this state by any foreign or domestic corporation, insurance underwriters, association or other insurer authorized to do business in this state, unless there shall be contained within such policy a provision that notice given by or on behalf of the insured to any authorized agent of the insurer within this state, with particulars sufficient to identify the insured, shall be deemed to be notice to the insurer. No such policy shall be issued or delivered in this state to the owner of a motor vehicle, by any domestic or foreign corporation, insurance underwriters, association or other insurer authorized to do business in this state, unless there shall be contained within such policy a provision insuring such owner against liability for damages for death or injury to person or property resulting from negligence in the operation of such motor vehicle, in the business of such owner or otherwise, by any person legally using or operating the same with the permission, expressed or implied, of such owner. **No policy of insurance shall be issued or delivered in this state by any**

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foreign or domestic corporation, insurance underwriters, association or other insurer authorized to do business in this state, unless it contains a provision that authorizes such foreign or domestic corporation, insurance underwriters, association or other insurer authorized to do business in this state to settle the liability of its insured under IC 27-12 et seq. without the consent of its insured when the unanimous opinion of the medical review panel is not in favor of the insured. This provision applies to all medical malpractice insurance policies issued or renewed after January 1, 1999. If a motor vehicle is owned jointly by a husband and wife, either spouse may, with the written consent of the other spouse, be excluded from coverage under the policy. A husband and wife may choose instead to have their liability covered under separate policies. A policy issued in violation of this section shall, nevertheless, be held valid but be deemed to include the provisions required by this section, and when any provision in such policy or rider is in conflict with the provision required to be contained by this section, the rights, duties and obligations of the insurer, the policyholder and the injured person or persons shall be governed by the provisions of this section.

Renumber all SECTIONS consecutively.

(Reference is to House Bill 1286 as printed January 23, 1998.)

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SENATE MOTION

Mr. President: I move that Senator Lewis be added as second sponsor of Engrossed House Bill 1286.

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SENATE MOTION

Mr. President: I move that Senator Landske be added as cosponsor of Engrossed House Bill 1286.

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## COMMITTEE REPORT

Mr. President: The Senate Committee on Insurance and Interstate Cooperation, to which was referred House Bill 1286, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, delete lines 1 through 15.

Page 2, delete lines 1 through 41.

Page 3, between lines 4 and 5, begin a new paragraph and insert:

"SECTION 2. IC 27-12-3-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 5. (a) **Except as provided in subsection (b)**, the receipt of proof of financial responsibility and the surcharge constitutes compliance with section 2 of this chapter:

(1) as of the date on which they are received; or

(2) as of the effective date of the policy;

if this proof is filed with and the surcharge paid to the department of insurance not later than ninety (90) days after the effective date of the insurance policy. ~~If proof of financial responsibility and the payment of the surcharge is not made within ninety (90) days after the policy effective date, compliance occurs on the date when proof is filed and the surcharge is paid:~~

**(b) If an insurer files proof of financial responsibility and makes payment of the surcharge to the department of insurance at least ninety-one (91) days but not more than one hundred eighty (180) days after the policy effective date, the health care provider is in compliance with section 2 of this chapter, if the insurer demonstrates to the satisfaction of the commissioner that the insurer:**

(1) received the premium and surcharge in a timely manner; and

(2) failed to transmit the surcharge in a timely manner.

**(c) If the commissioner accepts a filing as timely under subsection (b), the filing must be accompanied by a penalty amount as follows:**

(1) Ten percent (10%) of the surcharge, if the proof of financial responsibility and surcharge are received by the commissioner at least ninety-one (91) days and not more than one hundred twenty (120) days after the original effective date of the policy.

(2) Twenty percent (20%) of the surcharge, if the proof of financial responsibility and surcharge are received by the



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commissioner at least one hundred twenty-one (121) days and not more than one hundred fifty (150) days after the original effective date of the policy.

**(3) Fifty percent (50%) of the surcharge, if the proof of financial responsibility and surcharge are received by the commissioner at least one hundred fifty-one (151) days and not more than one hundred eighty (180) days after the original effective date of the policy."**

Page 3, line 30, after "is" insert "**one million**".

Page 3, line 30, after "hundred" insert "**fifty**".

Page 3, line 30, strike "\$700,000)." and insert "**(\$1,750,000)**".

Page 3, line 34, strike "three" and insert "**seven**".

Page 3, line 34, after "hundred" insert "**fifty**".

Page 3, line 34, strike "\$300,000)." and insert "**(\$750,000)**".

Page 3, line 36, strike "five" and insert "**one million two**".

Page 3, line 36, after "hundred" insert "**fifty**".

Page 3, line 36, strike "\$500,000)." and insert "**(\$1,250,000)**".

Page 4, line 21, after "risk" insert "**posed by a hospital, taking into consideration risk management programs used by the hospital**".

Page 4, line 23, delete "and".

Page 4, line 25, delete "." and insert "**; and**".

Page 4, between lines 25 and 26, begin a new line block indented and insert:

**"(4) made available to a hospital's malpractice insurance carrier for purposes of calculating the hospital's surcharge under subsection (g)."**

Page 4, line 26, after "(b)" insert "**Beginning July 1, 1999,**".

Page 4, line 26, delete "The" and insert "the".

Page 4, line 26, strike "set by a rule" and insert "**one hundred percent (100%) of the cost to each health care provider for maintenance of financial responsibility.**".

Page 4, line 27, before "adopted" insert "**Beginning July 1, 2001, the annual surcharge shall be set by a rule**".

Page 4, line 31, strike "two hundred percent (200%)" and insert "**the actuarial risk posed to the patient's compensation fund under IC 27-12 by qualified providers other than**".

Page 4, line 32, strike "of the cost to each health care provider,".

Page 4, line 32, delete "except for".

Page 4, line 33, after "16-21" insert ".".

Page 4, strike line 34.

Page 5, line 5, delete "or discipline".

Page 5, line 14, delete "medical".

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Page 5, line 14, delete "or" and insert "**class**".

Page 5, line 15, delete "discipline".

Page 5, line 17, delete "medical".

Page 5, line 17, delete "or" and insert "**class**".

Page 5, line 18, delete "discipline".

Page 5, line 23, delete "medical".

Page 5, line 24, delete "or discipline" and insert "**class**".

Page 5, between lines 35 and 36, begin a new paragraph and insert:

**"(h) An actuarial program used or developed under subsection (a) shall be treated as a public record under IC 5-14-3."**

Page 5, line 41, after "claims." insert "**The commissioner shall retain the services of counsel described in subsection (b) to represent the department when a trial court determination will be necessary to resolve a claim against the patient's compensation fund.**".

Page 6, line 14, before "Notwithstanding" insert "**(a)**".

Page 6, between lines 25 and 26, begin a new paragraph and insert:

**"(b) Upon satisfaction of section 4 of this chapter, the identifying information described in subsection (a)(1) shall be added to the complaint by the court."**

Page 6, between lines 34 and 35, begin a new paragraph and insert:

"SECTION 8. IC 27-12-9-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 3. (a) A health care provider's insurer shall notify the commissioner of any malpractice case upon which the insurer has placed a reserve of at least **fifty one hundred twenty-five** thousand dollars ~~(\$50,000)~~: **(\$125,000)**. The insurer shall give notice to the commissioner under this subsection immediately after placing the reserve. The notice and all communications and correspondence relating to the notice are confidential and may not be made available to any person or any public or private agency.

(b) All malpractice claims settled or adjudicated to final judgment against a health care provider shall be reported to the commissioner by the plaintiff's attorney and by the health care provider or the health care provider's insurer or risk manager within sixty (60) days following final disposition of the claim. The report to the commissioner must state the following:

- (1) The nature of the claim.
- (2) The damages asserted and the alleged injury.
- (3) The attorney's fees and expenses incurred in connection with the claim or defense.
- (4) The amount of the settlement or judgment."



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Page 6, line 36, delete "Subject to" and insert "**The medical review panel (as described in IC 27-12-10) shall make a separate determination at the time that it renders its opinion under IC 27-12-10-22 as to whether the name of the defendant health care provider should be forwarded to the appropriate board of professional registration for review of the health care provider's fitness to practice the health care provider's profession. The name of the defendant health care provider shall be forwarded if the medical review panel unanimously determines that it should be forwarded. The medical review panel determination is not admissible as evidence in a civil action.**".

Page 6, line 37, delete "subsection (d)".

Page 6, line 37, strike "the commissioner shall forward the name of every".

Page 6, strike lines 38 through 41.

Page 6, line 42, strike "profession."

Page 7, delete lines 15 through 25.

Page 9, line 34, delete "medical".

Page 9, line 34, delete "or discipline" and insert "**class**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to House Bill 1286 as reprinted January 30, 1998.)

WORMAN, Chairperson

Committee Vote: Yeas 6, Nays 2.

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