
ENGROSSED SENATE BILL No. 390

DIGEST OF SB 390 (Updated February 20, 1998 4:33 pm - DI 97)

Citations Affected: IC 16-18; IC 16-22; IC 27-1; IC 27-12; IC 34-4; noncode.

Synopsis: Medical malpractice, county hospital privileges. Provides that a practitioner of chiropractic, optometry, or podiatry is eligible for privileges to provide patient care at a county hospital. Allows the hospital's governing board to establish certain standards and rules to govern a practitioner's practice in the hospital and the granting and retention of a practitioner's privileges. Allows a practitioner to appear before a peer review committee before being granted privileges and to have a hearing before a peer review committee before privileges are terminated. Exempts from civil liability the professional review activities of a peer review committee that are made in good faith.

(Continued next page)

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

Harrison, Lewis, Landske, Worman
(HOUSE SPONSORS — FRY, TORR)

January 12, 1998, read first time and referred to Committee on Insurance and Interstate Cooperation.

January 20, 1998, reported favorably — Do Pass.

January 27, 1998, read second time, ordered engrossed.

January 28, 1998, engrossed.

January 29, 1998, read third time, passed. Yeas 42, nays 6.

HOUSE ACTION

February 4, 1998, read first time and referred to Committee on Insurance, Corporations, and Small Business.

February 17, 1998, amended, reported — Do Pass.

February 20, 1998, read second time, amended, ordered engrossed.

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Digest Continued

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. Permits a medical malpractice insurer to settle the liability of the insured without the consent of the insured if there was a unanimous medical review panel opinion against the insured. 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 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 for calculation of the annual surcharge for physicians and hospitals. 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 panel. 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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Reprinted
February 23, 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 SENATE BILL No. 390

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 16-18-2-163, AS AMENDED BY P.L.188-1995,
2 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JANUARY 1, 1999]: Sec. 163. (a) "Health care provider", for purposes
4 of IC 16-21 and IC 16-41, means any of the following:
5 (1) An individual, a partnership, a corporation, a professional
6 corporation, a facility, or an institution licensed or legally
7 authorized by this state to provide health care or professional
8 services as a licensed physician, a psychiatric hospital, a hospital,
9 a health facility, an emergency ambulance service (IC 16-31-3),
10 a dentist, a registered or licensed practical nurse, a midwife, an
11 optometrist, a pharmacist, a podiatrist, a chiropractor, a physical
12 therapist, a respiratory care practitioner, an occupational therapist,
13 a psychologist, a paramedic, an emergency medical technician, or
14 an advanced emergency technician, or a person who is an officer,
15 employee, or agent of the individual, partnership, corporation,

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1 professional corporation, facility, or institution acting in the
2 course and scope of the person's employment.

3 (2) A college, university, or junior college that provides health
4 care to a student, a faculty member, or an employee, and the
5 governing board or a person who is an officer, employee, or agent
6 of the college, university, or junior college acting in the course
7 and scope of the person's employment.

8 (3) A blood bank, community mental health center, community
9 mental retardation center, community health center, or migrant
10 health center.

11 (4) A home health agency (as defined in IC 16-27-1-2).

12 (5) A health maintenance organization (as defined in
13 IC 27-13-1-19).

14 (6) A health care organization whose members, shareholders, or
15 partners are health care providers under subdivision (1).

16 (7) A corporation, partnership, or professional corporation not
17 otherwise qualified under this subsection that:

18 (A) provides health care as one (1) of the corporation's,
19 partnership's, or professional corporation's functions;

20 (B) is organized or registered under state law; and

21 (C) is determined to be eligible for coverage as a health care
22 provider under IC 27-12 for the corporation's, partnership's, or
23 professional corporation's health care function.

24 Coverage for a health care provider qualified under this
25 subdivision is limited to the health care provider's health care
26 functions and does not extend to other causes of action.

27 **(b) "Health care provider", for purposes of IC 16-22-3-9.5 and**
28 **IC 16-22-8-39.5, means an individual who holds a valid license**
29 **under Indiana law to practice:**

30 **(1) chiropractic;**

31 **(2) optometry; or**

32 **(3) podiatry.**

33 ~~(b)~~ (c) "Health care provider", for purposes of IC 16-35:

34 **(1) has the meaning set forth in subsection (a); However, for**
35 **purposes of IC 16-35, the term also and**

36 **(2) includes a health facility (as defined in section 167 of this**
37 **chapter).**

38 SECTION 2. IC 16-22-3-9.5 IS ADDED TO THE INDIANA CODE
39 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE
40 JANUARY 1, 1999]: **Sec. 9.5. (a) The governing board may**
41 **delineate privileges for the provision of patient care services by a**
42 **health care provider.**

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1 (b) A health care provider is eligible for privileges to provide
2 patient care services, but the board shall establish and enforce
3 reasonable standards and rules concerning a health care provider's
4 qualifications for the following:

- 5 (1) Practice in the hospital.
- 6 (2) The granting of privileges to a provider.
- 7 (3) The retention of privileges.

8 (c) The fact that an applicant for privileges to provide patient
9 care services is a health care provider may not serve as a basis for
10 denying the applicant privileges to provide patient care services
11 that are allowed under the professional license held by the
12 applicant.

13 (d) The board may determine the kinds of health care
14 procedures and treatments that are appropriate for an inpatient or
15 outpatient hospital setting.

16 (e) The standards and rules described in subsection (b) may, in
17 the interest of good patient care, allow the board to do the
18 following:

- 19 (1) Consider a health care provider's postgraduate education,
20 training, experience, and other facts concerning the provider
21 that may affect the provider's professional competence.
- 22 (2) Consider the scope of practice allowed under the
23 professional license held by a health care provider.
- 24 (3) Limit privileges for admitting patients to the hospital to
25 physicians licensed under IC 25-22.5.
- 26 (4) Limit responsibility for the management of a patient's care
27 to physicians licensed under IC 25-22.5.
- 28 (5) Limit or preclude a health care provider's performance of
29 x-rays or other imaging procedures in an inpatient or
30 outpatient hospital setting. However, this subdivision does not
31 affect the ability of a health care provider to order x-rays
32 under that provider's scope of practice.

33 (f) The standards and rules described in subsection (b) may
34 include a requirement for the following:

- 35 (1) Submitting proof that a health care provider is qualified
36 under IC 27-12-3-2.
- 37 (2) Performing patient care and related duties in a manner
38 that is not disruptive to the delivery of quality care in the
39 hospital setting.
- 40 (3) Maintaining standards of quality care that recognize the
41 efficient and effective utilization of hospital resources as
42 developed by the hospital's medical staff.



1 (g) The standards and rules described in subsection (b) must
 2 allow a health care provider who applies for privileges an
 3 opportunity to appear before a peer review committee that is
 4 established by the board to make recommendations regarding
 5 applications for privileges by health care providers before the peer
 6 review committee makes its recommendations regarding the
 7 applicant's request for privileges.

8 (h) The board must provide for a hearing before a peer review
 9 committee for a health care provider whose privileges have been
 10 recommended for termination.

11 SECTION 3. IC 16-22-8-39.5 IS ADDED TO THE INDIANA
 12 CODE AS A NEW SECTION TO READ AS FOLLOWS
 13 [EFFECTIVE JANUARY 1, 1999]: Sec. 39.5. (a) The governing
 14 board may delineate privileges for the provision of patient care
 15 services by a health care provider.

16 (b) A health care provider is eligible for privileges to provide
 17 patient care services, but the board shall establish and enforce
 18 reasonable standards and rules concerning a health care provider's
 19 qualifications for the following:

- 20 (1) Practice in the hospital.
- 21 (2) The granting of privileges to a provider.
- 22 (3) The retention of privileges.

23 (c) The fact that an applicant for privileges to provide patient
 24 care services is a health care provider may not serve as a basis for
 25 denying the applicant privileges to provide patient care services
 26 that are allowed under the professional license held by the
 27 applicant.

28 (d) The board may determine the kinds of health care
 29 procedures and treatments that are appropriate for an inpatient or
 30 outpatient hospital setting.

31 (e) The standards and rules described in subsection (b) may, in
 32 the interest of good patient care, allow the board to do the
 33 following:

- 34 (1) Consider a health care provider's postgraduate education,
 35 training, experience, and other facts concerning the provider
 36 that may affect the provider's professional competence.
- 37 (2) Consider the scope of practice allowed under the
 38 professional license held by a health care provider.
- 39 (3) Limit privileges for admitting patients to the hospital to
 40 physicians licensed under IC 25-22.5.
- 41 (4) Limit responsibility for the management of a patient's care
 42 to physicians licensed under IC 25-22.5.



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1 **(5) Limit or preclude a health care provider's performance of**
 2 **x-rays or other imaging procedures in an inpatient or**
 3 **outpatient hospital setting. However, this subdivision does not**
 4 **affect the ability of a health care provider to order x-rays**
 5 **under that provider's scope of practice.**

6 **(f) The standards and rules described in subsection (b) may**
 7 **include a requirement for the following:**

8 **(1) Submitting proof that a health care provider is qualified**
 9 **under IC 27-12-3-2.**

10 **(2) Performing patient care and related duties in a manner**
 11 **that is not disruptive to the delivery of quality care in the**
 12 **hospital setting.**

13 **(3) Maintaining standards of quality care that recognize the**
 14 **efficient and effective utilization of hospital resources as**
 15 **developed by the hospital's medical staff.**

16 **(g) The standards and rules described in subsection (b) must**
 17 **allow a health care provider who applies for privileges an**
 18 **opportunity to appear before a peer review committee that is**
 19 **established by the board to make recommendations regarding**
 20 **applications for privileges by health care providers before the peer**
 21 **review committee makes its recommendations regarding the**
 22 **applicant's request for privileges.**

23 **(h) The board must provide for a hearing before a peer review**
 24 **committee for a health care provider whose privileges have been**
 25 **recommended for termination.**

26 **SECTION 4. IC 27-1-13-7 IS AMENDED TO READ AS**
 27 **FOLLOWS [EFFECTIVE JANUARY 1, 1999]: Sec. 7. (a) No policy**
 28 **of insurance against loss or damage resulting from accident to, or death**
 29 **or injury suffered by, an employee or other person or persons and for**
 30 **which the person or persons insured are liable, or, against loss or**
 31 **damage to property resulting from collision with any moving or**
 32 **stationary object and for which loss or damage the person or persons**
 33 **insured is liable, shall be issued or delivered in this state by any**
 34 **domestic or foreign corporation, insurance underwriters, association,**
 35 **or other insurer authorized to do business in this state, unless there**
 36 **shall be contained within such policy a provision that the insolvency or**
 37 **bankruptcy of the person or persons insured shall not release the**
 38 **insurance carrier from the payment of damages for injury sustained or**
 39 **loss occasioned during the life of such policy, and stating that in case**
 40 **execution against the insured is returned unsatisfied in an action**
 41 **brought by the injured person or his or her personal representative in**
 42 **case death resulted from the accident because of such insolvency or**



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1 bankruptcy then an action may be maintained by the injured person, or
 2 his or her personal representative, against such domestic or foreign
 3 corporation, insurance underwriters, association or other insurer under
 4 the terms of the policy for the amount of the judgment in the said action
 5 not exceeding the amount of the policy. No such policy shall be issued
 6 or delivered in this state by any foreign or domestic corporation,
 7 insurance underwriters, association or other insurer authorized to do
 8 business in this state, unless there shall be contained within such policy
 9 a provision that notice given by or on behalf of the insured to any
 10 authorized agent of the insurer within this state, with particulars
 11 sufficient to identify the insured, shall be deemed to be notice to the
 12 insurer. No such policy shall be issued or delivered in this state to the
 13 owner of a motor vehicle, by any domestic or foreign corporation,
 14 insurance underwriters, association or other insurer authorized to do
 15 business in this state, unless there shall be contained within such policy
 16 a provision insuring such owner against liability for damages for death
 17 or injury to person or property resulting from negligence in the
 18 operation of such motor vehicle, in the business of such owner or
 19 otherwise, by any person legally using or operating the same with the
 20 permission, expressed or implied, of such owner. If a motor vehicle is
 21 owned jointly by a husband and wife, either spouse may, with the
 22 written consent of the other spouse, be excluded from coverage under
 23 the policy. A husband and wife may choose instead to have their
 24 liability covered under separate policies. A policy issued in violation
 25 of this section shall, nevertheless, be held valid but be deemed to
 26 include the provisions required by this section, and when any provision
 27 in such policy or rider is in conflict with the provision required to be
 28 contained by this section, the rights, duties and obligations of the
 29 insurer, the policyholder and the injured person or persons shall be
 30 governed by the provisions of this section.

31 **(b) No policy of insurance shall be issued or delivered in this**
 32 **state by any foreign or domestic corporation, insurance**
 33 **underwriters, association, or other insurer authorized to do**
 34 **business in this state, unless it contains a provision that authorizes**
 35 **such foreign or domestic corporation, insurance underwriters,**
 36 **association, or other insurer authorized to do business in this state**
 37 **to settle the liability of its insured under IC 27-12 without the**
 38 **consent of its insured when the unanimous opinion of the medical**
 39 **review panel is not in favor of the insured.**

40 SECTION 5. IC 27-12-2-24.5 IS ADDED TO THE INDIANA
 41 CODE AS A NEW SECTION TO READ AS FOLLOWS
 42 [EFFECTIVE JULY 1, 1998]: **Sec. 24.5. "Qualified provider" means**



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1 a health care provider that is qualified under this article by
2 complying with the procedures set forth in IC 27-12-3.

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

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

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

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

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

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

23 and

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

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

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

33 (2) **Twenty percent (20%) of the surcharge, if the proof of**
34 **financial responsibility and surcharge are received by the**
35 **commissioner at least one hundred twenty-one (121) days and**
36 **not more than one hundred fifty (150) days after the original**
37 **effective date of the policy.**

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



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1 SECTION 7. IC 27-12-4-1, AS AMENDED BY P.L.26-1994,
 2 SECTION 24, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 3 JULY 1, 1999]: Sec. 1. Financial responsibility of a health care
 4 provider and the provider's officers, agents, and employees while acting
 5 in the course and scope of their employment with the health care
 6 provider may be established under subdivision (1), (2), or (3):

7 (1) By the health care provider's insurance carrier filing with the
 8 commissioner proof that the health care provider is insured by a
 9 policy of malpractice liability insurance in the amount of at least
 10 ~~one two~~ **two hundred fifty** thousand dollars (~~\$100,000~~) (**\$250,000**)
 11 per occurrence and ~~three seven~~ **three hundred fifty** thousand dollars
 12 (~~\$300,000~~) (**\$750,000**) in the annual aggregate, except for the
 13 following:

14 (A) If the health care provider is a hospital, as defined in this
 15 article, the minimum annual aggregate insurance amount is as
 16 follows:

17 (i) For hospitals of not more than one hundred (100) beds,
 18 ~~two five~~ **two million** dollars (~~\$2,000,000~~) (**\$5,000,000**).

19 (ii) For hospitals of more than one hundred (100) beds, ~~three~~
 20 **seven million five hundred thousand** dollars (~~\$3,000,000~~)
 21 (**\$7,500,000**).

22 (B) If the health care provider is a health maintenance
 23 organization (as defined in IC 27-13-1-19) or a limited service
 24 health maintenance organization (as defined in
 25 IC 27-13-34-4), the minimum annual aggregate insurance
 26 amount is ~~one million~~ **one million seven hundred fifty** thousand dollars
 27 (~~\$700,000~~) (**\$1,750,000**).

28 (C) If the health care provider is a health facility, the minimum
 29 annual aggregate insurance amount is as follows:

30 (i) For health facilities with not more than one hundred
 31 (100) beds, ~~three seven~~ **three hundred fifty** thousand dollars
 32 (~~\$300,000~~) (**\$750,000**).

33 (ii) For health facilities with more than one hundred (100)
 34 beds, ~~five one million two~~ **five hundred fifty** thousand dollars
 35 (~~\$500,000~~) (**\$1,250,000**).

36 (2) By filing and maintaining with the commissioner cash or
 37 surety bond approved by the commissioner in the amounts set
 38 forth in subdivision (1).

39 (3) If the health care provider is a hospital or a psychiatric
 40 hospital, by submitting annually a verified financial statement
 41 that, in the discretion of the commissioner, adequately
 42 demonstrates that the current and future financial responsibility



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1 of the health care provider is sufficient to satisfy all potential
 2 malpractice claims incurred by the provider or the provider's
 3 officers, agents, and employees while acting in the course and
 4 scope of their employment up to a total of ~~one two~~ **two hundred fifty**
 5 **thousand dollars** (~~\$100,000~~) **(\$250,000)** per occurrence and
 6 annual aggregates as follows:

7 (A) For hospitals of not more than one hundred (100) beds,
 8 ~~two five~~ **million dollars** (~~\$2,000,000~~) **(\$5,000,000).**

9 (B) For hospitals of more than one hundred (100) beds, ~~three~~
 10 **seven million five hundred thousand** dollars (~~\$3,000,000~~)
 11 **(\$7,500,000).**

12 The commissioner may require the deposit of security to assure
 13 continued financial responsibility.

14 SECTION 8. IC 27-12-5-2 IS AMENDED TO READ AS
 15 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. (a) **As used in**
 16 **this section, "actuarial program" means a program used or**
 17 **created by the department to determine the actuarial risk posed to**
 18 **the patient compensation fund under IC 27-12-6 by a hospital. The**
 19 **program must be:**

20 (1) **developed to calculate actuarial risk posed by a hospital,**
 21 **taking into consideration risk management programs used by**
 22 **the hospital;**

23 (2) **an efficient and accurate means of calculating a hospital's**
 24 **malpractice actuarial risk;**

25 (3) **publicly identified by the department by July 1 of each**
 26 **year; and**

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

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

35 (c) The amount of the surcharge shall be determined based upon
 36 actuarial principles and actuarial studies and must be adequate for the
 37 payment of claims and expenses from the patient's compensation fund.

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



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

3 (f) Notwithstanding subsections (b), (c), and (e), beginning July
4 1, 1999, the surcharge for a qualified provider who is licensed
5 under IC 25-22.5 is calculated as follows:

6 (1) The commissioner shall contract with an actuary that has
7 experience in calculating the actuarial risks posed by
8 physicians. Not later than July 1 of each year, the actuary
9 shall calculate the median of the premiums paid for
10 malpractice liability policies to the three (3) malpractice
11 insurance carriers in the state that have underwritten the
12 most malpractice insurance policies for all physicians
13 practicing in the same specialty class in Indiana during the
14 previous twelve (12) month period. In calculating the median,
15 the actuary shall consider the:

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

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

20 (2) After making the calculation described in subdivision (1),
21 the actuary shall establish a uniform surcharge for all
22 licensed physicians practicing in the same specialty class. This
23 surcharge must be based on a percentage of the median
24 calculated in subdivision (1) for all licensed physicians
25 practicing in the same specialty class under rules adopted by
26 the commissioner under IC 4-22-2. The surcharge:

27 (A) must be sufficient to cover; and

28 (B) may not exceed;

29 the actuarial risk posed to the patient compensation fund
30 under IC 27-12-6 by physicians practicing in the specialty
31 class.

32 (g) Beginning July 1, 1999, the surcharge for a hospital licensed
33 under IC 16-21 that establishes financial responsibility under
34 IC 27-12-4 after June 30, 1999, is established by the department
35 through the use of an actuarial program. At the time financial
36 responsibility is established for the hospital, the hospital shall pay
37 the surcharge amount established for the hospital under this
38 section. The surcharge:

39 (1) must be sufficient to cover; and

40 (2) may not exceed;

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



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

3 SECTION 9. IC 27-12-6-2 IS AMENDED TO READ AS
 4 FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. **(a)** The
 5 commissioner, using money from the fund, as considered necessary,
 6 appropriate, or desirable, may purchase **or retain** the services of
 7 persons, firms, and corporations to aid in protecting the fund against
 8 claims. **The commissioner shall retain the services of counsel**
 9 **described in subsection (b) to represent the department when a**
 10 **trial court determination will be necessary to resolve a claim**
 11 **against the patient's compensation fund.**

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

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

17 **(1) Making a decision regarding the settlement of a claim**
 18 **against the patient compensation fund.**

19 **(2) Determining the reasonableness of any fee submitted to the**
 20 **department of insurance by an attorney who defends the**
 21 **patient compensation fund under this section.**

22 **(d) All expenses of collecting, protecting, and administering the**
 23 **fund shall be paid from the fund.**

24 SECTION 10. IC 27-12-8-7 IS ADDED TO THE INDIANA CODE
 25 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
 26 1, 1998]: Sec. 7. **(a) Notwithstanding section 4 of this chapter,**
 27 **beginning July 1, 1999, a claimant may commence an action in**
 28 **court for malpractice at the same time the claimant's proposed**
 29 **complaint is being considered by a medical review panel. In order**
 30 **to comply with this section, the:**

31 **(1) complaint filed in court may not contain any information**
 32 **that would allow a third party to identify the defendant;**

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

34 **(3) court is prohibited from taking any action except setting**
 35 **a date for trial, an action under IC 27-12-8-8, or an action**
 36 **under IC 27-12-11;**

37 **until section 4 of this chapter has been satisfied.**

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

41 SECTION 11. IC 27-12-8-8 IS ADDED TO THE INDIANA CODE
 42 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE



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1 UPON PASSAGE]: **Sec. 8. If action has not been taken in a case**
 2 **before the department of insurance for a period of at least two (2)**
 3 **years, the commissioner, on the:**

4 **(1) motion of a party; or**

5 **(2) commissioner's own initiative;**

6 **may file a motion in Marion county circuit court to dismiss the case**
 7 **under Rule 41(E) of the Indiana rules of trial procedure.**

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

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

24 (1) The nature of the claim.

25 (2) The damages asserted and the alleged injury.

26 (3) The attorney's fees and expenses incurred in connection with
 27 the claim or defense.

28 (4) The amount of the settlement or judgment.

29 SECTION 13. IC 27-12-9-4 IS AMENDED TO READ AS
 30 FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 4. (a) ~~The~~
 31 ~~commissioner shall forward the name of every health care provider;~~
 32 ~~except a hospital; against whom a settlement is made or judgment is~~
 33 ~~rendered under this article to the appropriate board of professional~~
 34 ~~registration and examination for review of the fitness of the health care~~
 35 ~~provider to practice the health care provider's profession. The medical~~
 36 ~~review panel (as described in IC 27-12-10) shall make a separate~~
 37 ~~determination, at the time that it renders its opinion under~~
 38 ~~IC 27-12-10-22, as to whether the name of the defendant health~~
 39 ~~care provider should be forwarded to the appropriate board of~~
 40 ~~professional registration for review of the health care provider's~~
 41 ~~fitness to practice the health care provider's profession. The~~
 42 ~~commissioner shall forward the name of the defendant health care~~



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1 **provider if the medical review panel unanimously determines that**
 2 **it should be forwarded. The medical review panel determination**
 3 **concerning the forwarding of the name of the defendant health**
 4 **care provider is not admissible as evidence in a civil action.** In each
 5 case involving review of a health care provider's fitness to practice
 6 forwarded under this section, the appropriate board of professional
 7 registration and examination may, in appropriate cases, take the
 8 following disciplinary action:

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

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

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

20 SECTION 14. IC 27-12-10-25 IS AMENDED TO READ AS
 21 FOLLOWS [EFFECTIVE JANUARY 1, 1999]: Sec. 25. (a) Each
 22 health care provider member of the medical review panel is entitled to
 23 be paid:

- 24 (1) up to three hundred fifty dollars (\$350) for all work performed
 25 as a member of the panel, exclusive of time involved if called as
 26 a witness to testify in court; and
 27 (2) reasonable travel expense.

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

- 29 (1) at the rate of two hundred fifty dollars (\$250) per diem, not to
 30 exceed ~~one two thousand two hundred fifty~~ dollars (~~\$1,250~~);
 31 **(\$2,000);** and
 32 (2) reasonable travel expenses.

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

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

40 SECTION 15. IC 27-12-14-3 IS AMENDED TO READ AS
 41 FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 3. (a) The total amount
 42 recoverable for an injury or death of a patient may not exceed **the**

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following:

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

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

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

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

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

(b) A health care provider qualified under this article is not liable
for an amount in excess of ~~one two~~ **hundred fifty** thousand dollars
~~(\$100,000)~~ **(\$250,000)** for an occurrence of malpractice.

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

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

SECTION 16. IC 27-12-14-4 IS AMENDED TO READ AS
FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 4. (a) If the possible
liability of the health care provider to the patient is discharged solely
through an immediate payment, the limitations on recovery from a
health care provider stated in section 3(b) and 3(d) of this chapter apply
without adjustment.

(b) If the health care provider agrees to discharge its possible
liability to the patient through a periodic payments agreement, the
amount of the patient's recovery from a health care provider in a case
under this subsection is the amount of any immediate payment made by
the health care provider or the health care provider's insurer to the
patient, plus the cost of the periodic payments agreement to the health

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1 care provider or the health care provider's insurer. For the purpose of
 2 determining the limitations on recovery stated in section 3(b) and 3(d)
 3 of this chapter and for the purpose of determining the question under
 4 IC 27-12-15-3 of whether the health care provider or the health care
 5 provider's insurer has agreed to settle its liability by payment of its
 6 policy limits, the sum of:

7 (1) the present payment of money to the patient (or the patient's
 8 estate) by the health care provider (or the health care provider's
 9 insurer); plus

10 (2) the cost of the periodic payments agreement expended by the
 11 health care provider (or the health care provider's insurer);
 12 must exceed ~~seventy-five~~ **one hundred eighty-seven** thousand dollars
 13 (~~\$75,000~~): **(\$187,000)**.

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

22 SECTION 17. IC 34-4-12.6-1, AS AMENDED BY P.L.147-1997,
 23 SECTION 74, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 24 JANUARY 1, 1999]: Sec. 1. (a) As used in this chapter, "professional
 25 health care provider" means:

- 26 (1) a physician licensed under IC 25-22.5;
 27 (2) a dentist licensed under IC 25-14;
 28 (3) a hospital licensed under IC 16-21;
 29 (4) a podiatrist licensed under IC 25-29;
 30 (5) a chiropractor licensed under IC 25-10;
 31 (6) an optometrist licensed under IC 25-24;
 32 (7) a psychologist licensed under IC 25-33;
 33 (8) a pharmacist licensed under IC 25-26;
 34 (9) a health facility licensed under IC 16-28-2;
 35 (10) a registered or licensed practical nurse licensed under
 36 IC 25-23;
 37 (11) a physical therapist licensed under IC 25-27;
 38 (12) a home health agency licensed under IC 16-27-1;
 39 (13) a community mental health center (as defined in
 40 IC 12-7-2-38);
 41 (14) a health care organization whose members, shareholders, or
 42 partners are:



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- 1 (A) professional health care providers described in
- 2 subdivisions (1) through (13);
- 3 (B) professional corporations comprised of health care
- 4 professionals (as defined in IC 23-1.5-1-8); or
- 5 (C) professional health care providers described in
- 6 subdivisions (1) through (13) and professional corporations
- 7 comprised of persons described in subdivisions (1) through
- 8 (13);
- 9 (15) a private psychiatric hospital licensed under IC 12-25;
- 10 (16) a preferred provider organization (including a preferred
- 11 provider arrangement or reimbursement agreement under
- 12 IC 27-8-11);
- 13 (17) a health maintenance organization (as defined in
- 14 IC 27-13-1-19) or a limited service health maintenance
- 15 organization (as defined in IC 27-13-34-4);
- 16 (18) a respiratory care practitioner certified under IC 25-34.5;
- 17 (19) an occupational therapist certified under IC 25-23.5;
- 18 (20) a state institution (as defined in IC 12-7-2-184);
- 19 (21) a clinical social worker who is licensed under
- 20 IC 25-23.6-5-2;
- 21 (22) a managed care provider (as defined in IC 12-7-2-127(b)); or
- 22 (23) a nonprofit health care organization affiliated with a hospital
- 23 that is owned or operated by a religious order, whose members are
- 24 members of that religious order.
- 25 (b) As used in this chapter, "evaluation of patient care" relates to:
- 26 (1) the accuracy of diagnosis;
- 27 (2) the propriety, appropriateness, quality, or necessity of care
- 28 rendered by a professional health care provider; and
- 29 (3) the reasonableness of the utilization of services, procedures,
- 30 and facilities in the treatment of individual patients.
- 31 As used in this chapter, the term does not relate to charges for services
- 32 or to methods used in arriving at diagnoses.
- 33 (c) As used in this chapter, "peer review committee" means a
- 34 committee that:
- 35 (1) has the responsibility of evaluation of:
- 36 (A) qualifications of professional health care providers;
- 37 (B) patient care rendered by professional health care
- 38 providers; or
- 39 (C) the merits of a complaint against a professional health care
- 40 provider that includes a determination or recommendation
- 41 concerning the complaint, and the complaint is based on the
- 42 competence or professional conduct of an individual health

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- 1 care provider which competence or conduct affects or could
- 2 affect adversely the health or welfare of a patient or patients;
- 3 and
- 4 (2) meets the following criteria:
- 5 (A) The committee is organized:
- 6 (i) by a state, regional, or local organization of professional
- 7 health care providers or by a nonprofit foundation created by
- 8 the professional organization for purposes of improvement
- 9 of patient care;
- 10 (ii) by the professional staff of a hospital, another health care
- 11 facility, a nonprofit health care organization (under
- 12 subsection (a)(23)), or a professional health care
- 13 organization;
- 14 (iii) by state or federal law or regulation;
- 15 (iv) by a governing board of a hospital, a nonprofit health
- 16 care organization (under subsection (a)(23)), or professional
- 17 health care organization;
- 18 (v) as a governing board or committee of the board of a
- 19 hospital, a nonprofit health care organization (under
- 20 subsection (a)(23)), or professional health care organization;
- 21 (vi) by an organization, a plan, or a program described in
- 22 subsection (a)(16) through (a)(17);
- 23 (vii) as a hospital or a nonprofit health care organization
- 24 (under subsection (a)(23)) medical staff or a section of that
- 25 staff; or
- 26 (viii) as a governing board or committee of the board of a
- 27 professional health care provider (as defined in subsection
- 28 (a)(16) through (a)(17)).
- 29 (B) At least fifty percent (50%) of the committee members are:
- 30 (i) individual professional health care providers, the
- 31 governing board of a hospital, the governing board of a
- 32 nonprofit health care organization (under subsection
- 33 (a)(23)), or professional health care organization, or the
- 34 governing board or a committee of the board of a
- 35 professional health care provider (as defined in subsection
- 36 (a)(16) through (a)(17)); or
- 37 (ii) individual professional health care providers and the
- 38 committee is organized as an interdisciplinary committee to
- 39 conduct evaluation of patient care services.
- 40 However, "peer review committee" does not include a medical review
- 41 panel created under IC 27-12-10.
- 42 (d) As used in this chapter, "professional staff" means:

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- (1) all individual professional health care providers authorized to provide health care in a hospital or other health care facility; or
- (2) the multidisciplinary staff of a community mental health center (as defined in IC 12-7-2-38).

(e) As used in this chapter, "personnel of a peer review committee" means not only members of the committee but also all of the committee's employees, representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves a peer review committee in any capacity.

(f) As used in this chapter, "in good faith" refers to an act taken without malice after a reasonable effort to obtain the facts of the matter and in the reasonable belief that the action taken is warranted by the facts known. In all actions to which this chapter applies, good faith shall be presumed, and malice shall be required to be proven by the person aggrieved.

(g) As used in this chapter, "professional health care organization" refers to an organization described in subsection (a)(14).

(h) As used in this chapter, "professional review activity" means an activity of a peer review committee of a hospital licensed under IC 16-21 with respect to a professional health care provider to:

- (1) determine whether the professional health care provider may have privileges with respect to the hospital;**
- (2) determine the scope or conditions of the privileges; or**
- (3) change or modify the privileges.**

The term includes the establishment and enforcement of standards and rules by the governing board of a hospital concerning practice in the hospital and the granting and retention of privileges within the hospital.

SECTION 18. IC 34-4-12.6-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]: Sec. 3. (a) There shall be no liability on the part of, and no action of any nature shall arise against, **an organization, a peer review committee, or** the personnel of a peer review committee for any act, statement made in the confines of the **organization or** committee, or proceeding ~~thereof of the organization or committee~~ made in good faith in regard to:

- (1) evaluation of patient care as that term is defined and limited in section 1(b) of this chapter; or**
- (2) professional review activity as defined and limited in section 1(h) of this chapter.**

(b) Notwithstanding any other law, a peer review committee, an organization, or any other person who, in good faith and as a witness or in some other capacity, furnishes records, information, or assistance

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to a peer review committee that is engaged in:
(1) the evaluation of the qualifications, competence, or professional conduct of a professional health care provider; or
(2) the evaluation of patient care;
is immune from any civil action arising from the furnishing of the records, information, or assistance, unless the person knowingly furnishes false records or information.

(c) The personnel of a peer review committee shall be immune from any civil action arising from any determination made in good faith in regard to evaluation of patient care as that term is defined and limited in section 1(b) of this chapter.

(d) No restraining order or injunction shall be issued against a peer review committee or any of the personnel thereof of the committee to interfere with the proper functions of the committee acting in good faith in regard to evaluation of patient care as that term is defined and limited in section 1(b) of this chapter.

(e) If the action of the peer review committee meets the standards specified by this chapter and the federal Health Care Quality Improvement Act of 1986, P.L.99-660, the following persons are not liable for damages under any federal, state, or local law with respect to the action:

- (1) The peer review committee.
- (2) Any person acting as a member or staff to the peer review committee.
- (3) Any person under a contract or other formal agreement with the peer review committee.
- (4) Any person who participates with or assists the peer review committee with respect to the action.

(f) Subsection (e) does not apply to damages under any federal or state law relating to the civil rights of a person including:

- (1) the federal Civil Rights Act of 1964, 42 U.S.C. 2000e, et seq.; and
- (2) the federal Civil Rights Act, 42 U.S.C. 1981, et seq.

SECTION 19. IC 27-12-6-3 IS REPEALED [EFFECTIVE JANUARY 1, 1999].

SECTION 20. [EFFECTIVE JULY 1, 1998] (a) **IC 27-1-13-7, as amended by this act, applies to all medical malpractice liability insurance policies issued, delivered, or renewed after January 1, 1999.**

(b) **This SECTION expires January 1, 2000.**

SECTION 21. [EFFECTIVE UPON PASSAGE] (a) **After the department establishes the annual surcharge for physicians under**

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1 **IC 27-12-5-2, as amended by this act, the department shall publish**
2 **in the Indiana Register an estimated surcharge for all physicians**
3 **practicing in the same specialty class.**

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

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

8 **SECTION 22. An emergency is declared for this act.**

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SENATE MOTION

Mr. President: I move that Senator Lewis be added as coauthor of Senate Bill 390.

HARRISON

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COMMITTEE REPORT

Mr. President: The Senate Committee on Insurance and Interstate Cooperation, to which was referred Senate Bill 390, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill DO PASS.

(Reference is made to Senate Bill 390 as introduced.)

WORMAN, Chairperson

Committee Vote: Yeas 6, Nays 1.

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SENATE MOTION

Mr. President: I move that Senator Landske be added as second author of Senate Bill 390.

HARRISON

SENATE MOTION

Mr. President: I move that Senator Landske be removed as second author of Senate Bill 390 and that Senator Lewis be substituted therefor and that Senator Landske be added as coauthor.

HARRISON

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, Corporations and Small Business, to which was referred Senate Bill 390, 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 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 16-18-2-163, AS AMENDED BY P.L.188-1995, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]: Sec. 163. (a) "Health care provider", for purposes of IC 16-21 and IC 16-41, means any of the following:

- (1) An individual, a partnership, a corporation, a professional corporation, a facility, or an institution licensed or legally authorized by this state to provide health care or professional services as a licensed physician, a psychiatric hospital, a hospital, a health facility, an emergency ambulance service (IC 16-31-3), a dentist, a registered or licensed practical nurse, a midwife, an optometrist, a pharmacist, a podiatrist, a chiropractor, a physical therapist, a respiratory care practitioner, an occupational therapist, a psychologist, a paramedic, an emergency medical technician, or an advanced emergency technician, or a person who is an officer, employee, or agent of the individual, partnership, corporation, professional corporation, facility, or institution acting in the course and scope of the person's employment.
- (2) A college, university, or junior college that provides health care to a student, a faculty member, or an employee, and the governing board or a person who is an officer, employee, or agent of the college, university, or junior college acting in the course and scope of the person's employment.
- (3) A blood bank, community mental health center, community mental retardation center, community health center, or migrant health center.
- (4) A home health agency (as defined in IC 16-27-1-2).
- (5) A health maintenance organization (as defined in IC 27-13-1-19).
- (6) A health care organization whose members, shareholders, or partners are health care providers under subdivision (1).
- (7) A corporation, partnership, or professional corporation not otherwise qualified under this subsection that:
 - (A) provides health care as one (1) of the corporation's, partnership's, or professional corporation's functions;
 - (B) is organized or registered under state law; and

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(C) is determined to be eligible for coverage as a health care provider under IC 27-12 for the corporation's, partnership's, or professional corporation's health care function.

Coverage for a health care provider qualified under this subdivision is limited to the health care provider's health care functions and does not extend to other causes of action.

(b) "Health care provider", for purposes of IC 16-22-3-9.5 and IC 16-22-8-39.5, means an individual who holds a valid license under Indiana law to practice:

- (1) chiropractic;**
- (2) optometry; or**
- (3) podiatry.**

~~(b)~~ **(c) "Health care provider", for purposes of IC 16-35:**

- (1) has the meaning set forth in subsection (a); However, for purposes of IC 16-35, the term also and**
- (2) includes a health facility (as defined in section 167 of this chapter).**

SECTION 2. IC 16-22-3-9.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]: **Sec. 9.5. (a) The governing board may delineate privileges for the provision of patient care services by a health care provider.**

(b) A health care provider is eligible for privileges to provide patient care services, but the board shall establish and enforce reasonable standards and rules concerning a health care provider's qualifications for the following:

- (1) Practice in the hospital.**
- (2) The granting of privileges to a provider.**
- (3) The retention of privileges.**

(c) The fact that an applicant for privileges to provide patient care services is a health care provider may not serve as a basis for denying the applicant privileges to provide patient care services that are allowed under the professional license held by the applicant.

(d) The board may determine the kinds of health care procedures and treatments that are appropriate for an inpatient or outpatient hospital setting.

(e) The standards and rules described in subsection (b) may, in the interest of good patient care, allow the board to do the following:

- (1) Consider a health care provider's postgraduate education, training, experience, and other facts concerning the provider**



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that may affect the provider's professional competence.

(2) Consider the scope of practice allowed under the professional license held by a health care provider.

(3) Limit privileges for admitting patients to the hospital to physicians licensed under IC 25-22.5.

(4) Limit responsibility for the management of a patient's care to physicians licensed under IC 25-22.5.

(5) Limit or preclude a health care provider's performance of x-rays or other imaging procedures in an inpatient or outpatient hospital setting. However, this subdivision does not affect the ability of a health care provider to order x-rays under that provider's scope of practice.

(f) The standards and rules described in subsection (b) may include a requirement for the following:

(1) Submitting proof that a health care provider is qualified under IC 27-12-3-2.

(2) Performing patient care and related duties in a manner that is not disruptive to the delivery of quality care in the hospital setting.

(3) Maintaining standards of quality care that recognize the efficient and effective utilization of hospital resources as developed by the hospital's medical staff.

(g) The standards and rules described in subsection (b) must allow a health care provider who applies for privileges an opportunity to appear before a peer review committee that is established by the board to make recommendations regarding applications for privileges by health care providers before the peer review committee makes its recommendations regarding the applicant's request for privileges.

(h) The board must provide for a hearing before a peer review committee for a health care provider whose privileges have been recommended for termination.

SECTION 3. IC 16-22-8-39.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]: **Sec. 39.5.** (a) The governing board may delineate privileges for the provision of patient care services by a health care provider.

(b) A health care provider is eligible for privileges to provide patient care services, but the board shall establish and enforce reasonable standards and rules concerning a health care provider's qualifications for the following:

(1) Practice in the hospital.



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(2) The granting of privileges to a provider.

(3) The retention of privileges.

(c) The fact that an applicant for privileges to provide patient care services is a health care provider may not serve as a basis for denying the applicant privileges to provide patient care services that are allowed under the professional license held by the applicant.

(d) The board may determine the kinds of health care procedures and treatments that are appropriate for an inpatient or outpatient hospital setting.

(e) The standards and rules described in subsection (b) may, in the interest of good patient care, allow the board to do the following:

(1) Consider a health care provider's postgraduate education, training, experience, and other facts concerning the provider that may affect the provider's professional competence.

(2) Consider the scope of practice allowed under the professional license held by a health care provider.

(3) Limit privileges for admitting patients to the hospital to physicians licensed under IC 25-22.5.

(4) Limit responsibility for the management of a patient's care to physicians licensed under IC 25-22.5.

(5) Limit or preclude a health care provider's performance of x-rays or other imaging procedures in an inpatient or outpatient hospital setting. However, this subdivision does not affect the ability of a health care provider to order x-rays under that provider's scope of practice.

(f) The standards and rules described in subsection (b) may include a requirement for the following:

(1) Submitting proof that a health care provider is qualified under IC 27-12-3-2.

(2) Performing patient care and related duties in a manner that is not disruptive to the delivery of quality care in the hospital setting.

(3) Maintaining standards of quality care that recognize the efficient and effective utilization of hospital resources as developed by the hospital's medical staff.

(g) The standards and rules described in subsection (b) must allow a health care provider who applies for privileges an opportunity to appear before a peer review committee that is established by the board to make recommendations regarding applications for privileges by health care providers before the peer

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review committee makes its recommendations regarding the applicant's request for privileges.

(h) The board must provide for a hearing before a peer review committee for a health care provider whose privileges have been recommended for termination.

SECTION 4. IC 27-1-13-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]: Sec. 7. (a) 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. If a motor vehicle is

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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.

(b) No policy of insurance 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 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 without the consent of its insured when the unanimous opinion of the medical review panel is not in favor of the insured."

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 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, 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.

Page 6, delete lines 1 through 2.

Page 6, between lines 2 and 3, 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



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matters pertaining to the fund."

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

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

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

Replace the effective date in SECTION 6 with "[EFFECTIVE UPON PASSAGE]".

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

Page 6, between lines 30 and 31, 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 procedure.

SECTION 7. IC 27-12-9-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 4. (a) ~~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. 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 commissioner shall forward the name of the defendant health care provider if the medical review panel unanimously determines that it should be forwarded. The medical review panel determination concerning the forwarding of the name of the defendant health care provider is not admissible as evidence in a civil action.~~ 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.

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(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."

Page 6, delete lines 31 through 42.

Delete page 7.

Page 8, delete lines 1 through 21.

Page 10, between lines 23 and 24, begin a new paragraph and insert:
"SECTION 16. IC 34-4-12.6-1, AS AMENDED BY P.L.147-1997, SECTION 74, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]: Sec. 1. (a) As used in this chapter, "professional health care provider" means:

- (1) a physician licensed under IC 25-22.5;
- (2) a dentist licensed under IC 25-14;
- (3) a hospital licensed under IC 16-21;
- (4) a podiatrist licensed under IC 25-29;
- (5) a chiropractor licensed under IC 25-10;
- (6) an optometrist licensed under IC 25-24;
- (7) a psychologist licensed under IC 25-33;
- (8) a pharmacist licensed under IC 25-26;
- (9) a health facility licensed under IC 16-28-2;
- (10) a registered or licensed practical nurse licensed under IC 25-23;
- (11) a physical therapist licensed under IC 25-27;
- (12) a home health agency licensed under IC 16-27-1;
- (13) a community mental health center (as defined in IC 12-7-2-38);
- (14) a health care organization whose members, shareholders, or partners are:
 - (A) professional health care providers described in subdivisions (1) through (13);
 - (B) professional corporations comprised of health care professionals (as defined in IC 23-1.5-1-8); or
 - (C) professional health care providers described in subdivisions (1) through (13) and professional corporations comprised of persons described in subdivisions (1) through (13);
- (15) a private psychiatric hospital licensed under IC 12-25;
- (16) a preferred provider organization (including a preferred provider arrangement or reimbursement agreement under IC 27-8-11);

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(17) a health maintenance organization (as defined in IC 27-13-1-19) or a limited service health maintenance organization (as defined in IC 27-13-34-4);

(18) a respiratory care practitioner certified under IC 25-34.5;

(19) an occupational therapist certified under IC 25-23.5;

(20) a state institution (as defined in IC 12-7-2-184);

(21) a clinical social worker who is licensed under IC 25-23.6-5-2;

(22) a managed care provider (as defined in IC 12-7-2-127(b)); or

(23) a nonprofit health care organization affiliated with a hospital that is owned or operated by a religious order, whose members are members of that religious order.

(b) As used in this chapter, "evaluation of patient care" relates to:

(1) the accuracy of diagnosis;

(2) the propriety, appropriateness, quality, or necessity of care rendered by a professional health care provider; and

(3) the reasonableness of the utilization of services, procedures, and facilities in the treatment of individual patients.

As used in this chapter, the term does not relate to charges for services or to methods used in arriving at diagnoses.

(c) As used in this chapter, "peer review committee" means a committee that:

(1) has the responsibility of evaluation of:

(A) qualifications of professional health care providers;

(B) patient care rendered by professional health care providers; or

(C) the merits of a complaint against a professional health care provider that includes a determination or recommendation concerning the complaint, and the complaint is based on the competence or professional conduct of an individual health care provider which competence or conduct affects or could affect adversely the health or welfare of a patient or patients; and

(2) meets the following criteria:

(A) The committee is organized:

(i) by a state, regional, or local organization of professional health care providers or by a nonprofit foundation created by the professional organization for purposes of improvement of patient care;

(ii) by the professional staff of a hospital, another health care facility, a nonprofit health care organization (under subsection (a)(23)), or a professional health care

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organization;

(iii) by state or federal law or regulation;

(iv) by a governing board of a hospital, a nonprofit health care organization (under subsection (a)(23)), or professional health care organization;

(v) as a governing board or committee of the board of a hospital, a nonprofit health care organization (under subsection (a)(23)), or professional health care organization;

(vi) by an organization, a plan, or a program described in subsection (a)(16) through (a)(17);

(vii) as a hospital or a nonprofit health care organization (under subsection (a)(23)) medical staff or a section of that staff; or

(viii) as a governing board or committee of the board of a professional health care provider (as defined in subsection (a)(16) through (a)(17)).

(B) At least fifty percent (50%) of the committee members are:

(i) individual professional health care providers, the governing board of a hospital, the governing board of a nonprofit health care organization (under subsection (a)(23)), or professional health care organization, or the governing board or a committee of the board of a professional health care provider (as defined in subsection (a)(16) through (a)(17)); or

(ii) individual professional health care providers and the committee is organized as an interdisciplinary committee to conduct evaluation of patient care services.

However, "peer review committee" does not include a medical review panel created under IC 27-12-10.

(d) As used in this chapter, "professional staff" means:

(1) all individual professional health care providers authorized to provide health care in a hospital or other health care facility; or

(2) the multidisciplinary staff of a community mental health center (as defined in IC 12-7-2-38).

(e) As used in this chapter, "personnel of a peer review committee" means not only members of the committee but also all of the committee's employees, representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves a peer review committee in any capacity.

(f) As used in this chapter, "in good faith" refers to an act taken without malice after a reasonable effort to obtain the facts of the matter and in the reasonable belief that the action taken is warranted by the

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facts known. In all actions to which this chapter applies, good faith shall be presumed, and malice shall be required to be proven by the person aggrieved.

(g) As used in this chapter, "professional health care organization" refers to an organization described in subsection (a)(14).

(h) As used in this chapter, "professional review activity" means an activity of a peer review committee of a hospital licensed under IC 16-21 with respect to a professional health care provider to:

- (1) determine whether the professional health care provider may have privileges with respect to the hospital;**
- (2) determine the scope or conditions of the privileges; or**
- (3) change or modify the privileges.**

The term includes the establishment and enforcement of standards and rules by the governing board of a hospital concerning practice in the hospital and the granting and retention of privileges within the hospital.

SECTION 17. IC 34-4-12.6-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]: Sec. 3. (a) There shall be no liability on the part of, and no action of any nature shall arise against, **an organization, a peer review committee, or** the personnel of a peer review committee for any act, statement made in the confines of the **organization or** committee, or proceeding ~~thereof of the organization or committee~~ made in good faith in regard to:

- (1) evaluation of patient care as that term is defined and limited in section 1(b) of this chapter; or**
- (2) professional review activity as defined and limited in section 1(h) of this chapter.**

(b) Notwithstanding any other law, a peer review committee, an organization, or any other person who, in good faith and as a witness or in some other capacity, furnishes records, information, or assistance to a peer review committee that is engaged in:

- (1) the evaluation of the qualifications, competence, or professional conduct of a professional health care provider; or
- (2) the evaluation of patient care;

is immune from any civil action arising from the furnishing of the records, information, or assistance, unless the person knowingly furnishes false records or information.

(c) The personnel of a peer review committee shall be immune from any civil action arising from any determination made in good faith in regard to evaluation of patient care as that term is defined and limited in section 1(b) of this chapter.

(d) No restraining order or injunction shall be issued against a peer



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review committee or any of the personnel ~~thereof~~ **of the committee** to interfere with the proper functions of the committee acting in good faith in regard to evaluation of patient care as that term is defined and limited in section 1(b) of this chapter.

(e) If the action of the peer review committee meets the standards specified by this chapter and the federal Health Care Quality Improvement Act of 1986, P.L.99-660, the following persons are not liable for damages under any federal, state, or local law with respect to the action:

- (1) The peer review committee.
- (2) Any person acting as a member or staff to the peer review committee.
- (3) Any person under a contract or other formal agreement with the peer review committee.
- (4) Any person who participates with or assists the peer review committee with respect to the action.

(f) Subsection (e) does not apply to damages under any federal or state law relating to the civil rights of a person including:

- (1) the federal Civil Rights Act of 1964, 42 U.S.C. 2000e, et seq.; and
- (2) the federal Civil Rights Act, 42 U.S.C. 1981, et seq."

Page 10, between lines 25 and 26, begin a new paragraph and insert:
"SECTION 18. [EFFECTIVE JULY 1, 1998] (a) IC 27-1-13-7, as amended by this act, applies to all medical malpractice liability insurance policies issued, delivered, or renewed after January 1, 1999.

(b) This SECTION expires January 1, 2000."

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**".



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and when so amended that said bill do pass.

(Reference is to Senate Bill 390 as printed January 21, 1998.)

FRY, Chair

Committee Vote: yeas 8, nays 4.

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HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 390 be amended to read as follows:

Page 7, between lines 2 and 3, begin a new paragraph and insert:

"SECTION 6. 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 complies 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 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



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not more than one hundred eighty (180) days after the original effective date of the policy."

Page 7, line 28, after "is" insert "**one million**".

Page 7, line 28, after "hundred" insert "**fifty**".

Page 7, line 28, strike "\$700,000)." and insert "**(\$1,750,000).**".

Page 7, line 32, strike "three" and insert "**seven**".

Page 7, line 32, after "hundred" insert "**fifty**".

Page 7, line 32, strike "\$300,000)." and insert "**(\$750,000).**".

Page 7, line 34, strike "five" and insert "**one million two**".

Page 7, line 34, after "hundred" insert "**fifty**".

Page 7, line 34, strike "\$500,000)." and insert "**(\$1,250,000).**".

Page 8, line 19, after "risk" insert "**posed by a hospital, taking into consideration risk management programs used by the hospital**".

Page 8, line 21, delete "and".

Page 8, line 23, delete "." and insert "**; and**".

Page 8, between lines 23 and 24, 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 8, line 24, after "(b)" insert "**Beginning July 1, 1999,**".

Page 8, line 24, delete "The" and insert "the".

Page 8, line 24, 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 8, line 25, before "adopted" insert "**Beginning July 1, 2001, the annual surcharge shall be set by a rule**".

Page 8, line 29, 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 8, line 30, strike "of the cost to each health care provider,".

Page 8, line 30, delete "except for".

Page 8, line 31, after "16-21" insert ".".

Page 8, strike line 32.

Page 9, line 3, delete "or discipline".

Page 9, line 12, delete "medical".

Page 9, line 12, delete "or" and insert "**class**".

Page 9, line 13, delete "discipline".

Page 9, line 15, delete "medical".

Page 9, line 15, delete "or" and insert "**class**".

Page 9, line 16, delete "discipline".

Page 9, line 21, delete "medical".



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Page 9, line 22, delete "or discipline" and insert "**class**".

Page 9, between lines 33 and 34, 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 9, line 39, 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 10, line 12, before "Notwithstanding" insert "(a)".

Page 10, between lines 23 and 24, 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 10, between lines 32 and 33, begin a new paragraph and insert:

"SECTION 12. 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."

Page 18, line 7, delete "medical".

Page 18, line 7, delete "or discipline" and insert "**class**".

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Renumber all SECTIONS consecutively.

(Reference is to Engrossed Senate Bill 390 as printed February 17, 1998.)

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