HOUSE BILL No. 1286

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-12.

Synopsis: Medical malpractice. 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

(Continued next page)

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

Fry

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

C o p y

Digest Continued

$2,000,000 and $3,000,000, respectively.) Increases from $25 to $100 the minimum annual surcharge each health care provider is required to pay. Provides methods for the commissioner of the department of insurance to calculate the annual surcharge for physicians and hospitals. Requires the commissioner to pay an attorney to protect the patient compensation fund. 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. 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. Requires an attorney to complete at least 12 hours of continuing legal education in matters relating to the administration of medical malpractice cases in order to serve as a medical review panel chairman in cases where the parties are unable to select a panel chairman by agreement. 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.

C o p y

Introduced

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.

C o p y

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:

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

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

(1) By the health care provider's insurance carrier filing with the commissioner proof that the health care provider is insured by a policy of malpractice liability insurance in the amount of at least ~~one~~ **two** hundred **fifty** thousand dollars ~~($100,000)~~ **($250,000)**

per occurrence and ~~three~~ **seven** hundred **fifty** thousand dollars ~~($300,000)~~ **($750,000)** in the annual aggregate, except for the following:

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

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

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

(B) If the health care provider is 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), the minimum annual aggregate insurance amount is seven hundred thousand dollars ($700,000).

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

(i) For health facilities with not more than one hundred (100) beds, three hundred thousand dollars ($300,000).

(ii) For health facilities with more than one hundred (100) beds, five hundred thousand dollars ($500,000).

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

(3) If the health care provider is a hospital or a psychiatric hospital, by submitting annually a verified financial statement that, in the discretion of the commissioner, adequately demonstrates that the current and future financial responsibility of the health care provider is sufficient to satisfy all potential malpractice claims incurred by the provider or the provider's officers, agents, and employees while acting in the course and scope of their employment up to a total of ~~one~~ **two** hundred **fifty** thousand dollars ~~($100,000)~~ **($250,000)** per occurrence and annual aggregates as follows:

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

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

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

C o p y

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

(1) developed to calculate actuarial risk;

(2) widely recognized as being an efficient and accurate means of calculating a hospital's malpractice actuarial risk; and

(3) publicly identified by the department by July 1 of each year.

(b) The amount of the annual surcharge shall be set by a rule adopted by the commissioner under IC 4-22-2.

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

~~(c)~~ **(d)** The surcharge may not exceed two hundred percent (200%) of the cost to each health care provider, **except for a physician licensed under IC 25-22.5 and a hospital licensed under IC 16-21** for maintenance of financial responsibility.

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

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

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

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

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

(2) After making the calculation described in subdivision (1), the actuary shall establish a uniform surcharge for all licensed physicians practicing in the same medical specialty or

Copy

discipline. This surcharge must be based on a percentage of the median calculated in subdivision (1) for all licensed physicians practicing in the same medical specialty or discipline under rules adopted by the commissioner under IC 4-22-2. The surcharge:

(A) must be sufficient to cover; and

(B) may not exceed;

the actuarial risk posed to the patient compensation fund under IC 27-12-6 by physicians practicing in the medical specialty or discipline.

(g) Beginning July 1, 1999, the surcharge for a hospital licensed under IC 16-21 that establishes financial responsibility under IC 27-12-4 after June 30, 1999, is established by the department through the use of an actuarial program. The surcharge determined for a hospital as provided in this subsection shall be based on the most recent information submitted for the hospital to the department under subsection (h). At the time financial responsibility is established for the hospital, the hospital shall pay the surcharge amount established for the hospital under this section. The surcharge:

(1) must be sufficient to cover; and

(2) may not exceed;

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

(h) Beginning July 1, 1998, an insurance carrier issuing a policy covering malpractice liability claims for a hospital licensed under IC 16-21 shall collect and submit to the department hospital specific information for use by the actuarial program. A hospital licensed under IC 16-21 that establishes financial responsibility under IC 27-12-4-1(3) shall collect and submit to the department hospital specific information for use by the actuarial program.

(i) The commissioner shall adopt rules under IC 4-22-2 to carry out this section, including the following:

(1) Specifying information that a hospital or an insurance carrier must submit under subsection (g) for use by the actuarial program.

(2) Determining a timetable for the submission of a hospital's information under subsection (g) so that a hospital's surcharge may be calculated and paid before the hospital's financial responsibility lapses.

(3) Establishing a procedure that coordinates the collection and submission of information described under subsection (h)

C o p y

with the process by which a hospital licensed under IC 16-21:

(A) submits the hospital's application for malpractice liability insurance coverage to the insurance carrier issuing the hospital's malpractice liability insurance policy; and

(B) that establishes financial responsibility under IC 27-12-4-1(3) submits the hospital's information for establishing financial responsibility.

(4) Determining a timetable for the submission of a hospital's information under subsection (h), and the calculation of the hospital's surcharge, so that a hospital is notified in writing of the hospital's surcharge not less than six (6) months before the date the hospital's surcharge is due under subsection (g).

(j) A hospital may appeal the determination of the hospital's surcharge under this section on the grounds that the surcharge was improperly calculated. An appeal under this subsection is governed by IC 4-21.5. At the discretion of the department, the department may compel a hospital appealing the calculation of the hospital's surcharge to pay the surcharge under protest so that the appeal takes place after the surcharge is paid. A hospital that successfully appeals the calculation of the hospital's surcharge is entitled to:

(1) a refund of any surcharge amounts improperly paid by the hospital; and

(2) interest on the payment under subdivision (1) that is calculated from the date of the improper payment.

SECTION 4. IC 27-12-6-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2. **(a)** The commissioner, using money from the fund, ~~as considered necessary, appropriate, or desirable, may purchase the services of persons, firms, and corporations to aid in protecting~~ **shall pay an attorney who is licensed to practice law in Indiana to protect** the fund against claims **made against a health care provider. The attorney must also meet the following qualifications:**

(1) Must have spent a majority of working time during five (5) years of the most recent seven (7) year period defending actions brought under this article.

(2) Must be recommended by at least one (1) of the five (5) malpractice insurance carriers that underwrite the most malpractice insurance policies in Indiana for the type of provider against whom the current action is brought, to the greatest extent possible.

The commissioner shall pay the attorney an amount equal to the

C o p y

hourly rate paid by the health care provider's malpractice insurance company.

(b) The commissioner has sole authority for the following:

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

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

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

SECTION 5. IC 27-12-8-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 7. Notwithstanding section 4 of this chapter, beginning July 1, 1999, a claimant may commence an action in court for malpractice at the same time the claimant's proposed complaint is being considered by a medical review panel. In order to comply with this section, the:**

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

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

(3) court is prohibited from taking any action except an action under IC 27-12-11;

until section 4 of this chapter has been satisfied.

SECTION 6. IC 27-12-8-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 8. (a) Beginning July 1, 1999, if action has not been taken in a case before the department of insurance for a period of at least two (2) years, the commissioner, on the:**

(1) motion of a party; or

(2) commissioner's own initiative;

shall order a hearing for the purpose of dismissing the case for lack of prosecution.

(b) After a hearing held under subsection (a), the commissioner may dismiss the case.

SECTION 7. IC 27-12-10-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]: Sec. 4. A medical review panel shall be selected in the following manner:

(1) Within fifteen (15) days after the filing of a request for formation of a medical review panel under section 2 of this chapter, the parties shall select a panel chairman by agreement. If no agreement on a panel chairman can be reached, either party may request the clerk of the supreme court to draw at random a

C o p y

list of five (5) names of attorneys who:

(A) are qualified to practice;

(B) are presently on the rolls of the supreme court; and

(C) ~~maintain offices in the county of venue designated in the proposed complaint or in a contiguous county.~~ **satisfy the requirements for certification as a medical review chairman that are prescribed by section 4.5 of this chapter.**

(2) Before selecting the random list, the clerk shall collect a twenty-five dollar ($25) medical review panel selection fee from the party making the request for the formation of the random list.

(3) The clerk shall notify the parties, and the parties shall then strike names alternately with the plaintiff striking first until one (1) name remains. The remaining attorney shall be the chairman of the panel.

(4) After the striking, the plaintiff shall notify the chairman and all other parties of the name of the chairman.

(5) If a party does not strike a name within five (5) days after receiving notice from the clerk:

(A) the opposing party shall, in writing, request the clerk to strike for the party; and

(B) the clerk shall strike for that party.

(6) When one (1) name remains, the clerk shall within five (5) days notify the chairman and all other parties of the name of the chairman.

(7) Within fifteen (15) days after being notified by the clerk of being selected as chairman, the chairman shall:

(A) send a written acknowledgment of appointment to the clerk; or

(B) show good cause for relief from serving as provided in section 12 of this chapter.

SECTION 8. IC 27-12-10-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1999]: **Sec. 4.5. (a) In order to serve as a medical review panel chairman under section 4(1)(C) of this chapter, an attorney must complete at least twelve (12) hours of continuing legal education certified by the Indiana Commission for Continuing Legal Education that includes the following:**

(1) An examination of instructions and materials designed to assist in the selection of appropriate health care provider medical review panel members.

(2) A review of case law pertaining to the responsibilities and authority of a medical review panel chairman and the medical

C o p y

review panel.

(3) A review of the entire Indiana medical malpractice law.

(4) An examination of the forms and instructions commonly used by a medical review panel chairman.

(5) A review of the legal ethics involved in serving as a medical review panel chairman.

(b) An attorney who:

(1) completes the continuing legal education hours required by subsection (a); and

(2) satisfies the requirements of section 4(1) of this chapter;

may submit to the clerk of the supreme court verification from the Indiana Commission on Continuing Legal Education that the attorney has completed the continuing legal education requirements described in subsection (a). Upon receiving this verification, the clerk of the supreme court shall place the attorney's name on the list of certified medical review panel chairmen.

(c) An attorney who knowingly or intentionally:

(1) claims to be certified under this section; and

(2) does not satisfy the requirements of subsection (b);

commits a Class C misdemeanor.

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

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

(2) reasonable travel expense.

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

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

(2) reasonable travel expenses.

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

(d) Fees of the panel, including travel expenses and other expenses of the review, shall be paid by the side in whose favor the majority opinion is written. If there is no majority opinion, each side shall pay ~~one-half (½)~~ **fifty percent (50%)** of the cost.

SECTION 10. IC 27-12-14-3 IS AMENDED TO READ AS

Copy

FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 3. (a) The total amount recoverable for an injury or death of a patient may not exceed **the 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 11. 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

Copy

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

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

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

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

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

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

SECTION 13. [EFFECTIVE UPON PASSAGE] **(a) Before December 31, 1998, the commissioner of the Indiana department of insurance shall adopt rules under IC 4-22-2 to implement IC 27-12-5-2, as amended by this act.**

(b) This SECTION expires January 1, 2000.

SECTION 14. [EFFECTIVE UPON PASSAGE] **(a) The actuary that establishes the annual surcharge for physicians under IC 27-12-5-2, as amended by this act, shall provide an estimated surcharge for all physicians practicing in the same medical specialty or discipline to the department of insurance not later than February 1, 1999.**

(b) The department of insurance shall mail the estimated surcharges under subsection (a) to each licensed physician not later than March 1, 1999.

(c) This SECTION expires January 1, 2000.

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

C o p y