
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.

SE 390—LS 7200/DI 88+



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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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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.

SENATE ENROLLED ACT No. 390

AN ACT to amend the Indiana Code concerning insurance.

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

SECTION 1. IC 27-1-13-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 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

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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 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 34-18 without the consent of its insured when the unanimous opinion of the medical review panel under IC 34-18-10-22(b)(1) is that the evidence supports the conclusion that the defendant failed to comply with the appropriate standard of care as charged in the complaint.

SECTION 2. 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 program used or**



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created 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 posed by a hospital, taking into consideration risk management programs used by the hospital;
- (2) an efficient and accurate means of calculating a hospital's malpractice actuarial risk;
- (3) publicly identified by the department by July 1 of each year; and
- (4) made available to a hospital's malpractice insurance carrier for purposes of calculating the hospital's surcharge under subsection (g).

(b) **Beginning July 1, 1999**, the amount of the annual surcharge shall be set by a rule **one hundred percent (100%) of the cost to each health care provider for maintenance of financial responsibility. Beginning July 1, 2001, 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, 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 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



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(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 specialty class. This surcharge must be based on a percentage of the median calculated in subdivision (1) for all licensed physicians practicing in the same specialty class 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 specialty class.

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

SECTION 3. IC 27-12-8-8 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 8. 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;

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 4. IC 34-18-2-24.5 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 (or by IC 27-12 before its repeal) by complying with the procedures set forth in IC 34-18-3 (or IC 27-12-3 before its repeal).**



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SECTION 5. IC 34-18-3-5, AS ADDED BY HEA 1011-1998, 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) erred in transmitting the surcharge in a timely manner.

(c) If the commissioner accepts a filing as timely under subsection (b), the filing must, in addition to any penalties under IC 34-18-5-3, 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 not more than one hundred eighty (180) days after the original effective date of the policy.

SECTION 6. IC 34-18-4-1, AS ADDED BY HEA 1011-1998, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:



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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 ~~one million~~ seven hundred **fifty** thousand dollars ~~(\$700,000)~~ **(\$1,750,000)**.

(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~~ **seven hundred fifty** thousand dollars ~~(\$300,000)~~ **(\$750,000)**.

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

(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



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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.

SECTION 7. IC 34-18-5-2, AS ADDED BY HEA 1011-1998, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]:
Sec. 2. (a) **As used in this section, "actuarial program" means a program used or created by the department to determine the actuarial risk posed to the patient compensation fund under IC 34-18-6 (or IC 27-12-6 before its repeal) by a hospital. The program must be:**

- (1) **developed to calculate actuarial risk posed by a hospital, taking into consideration risk management programs used by the hospital;**
- (2) **an efficient and accurate means of calculating a hospital's malpractice actuarial risk;**
- (3) **publicly identified by the department by July 1 of each year; and**
- (4) **made available to a hospital's malpractice insurance carrier for purposes of calculating the hospital's surcharge under subsection (g).**

(b) **Beginning July 1, 1999, the amount of the annual surcharge shall be set by a rule one hundred percent (100%) of the cost to each health care provider for maintenance of financial responsibility. Beginning July 1, 2001, 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%) the actuarial risk posed to the patient's compensation fund under IC 34-18 (or IC 27-12 before its repeal) by qualified providers. of the cost to each health care provider, for maintenance of financial responsibility.**

~~(d)~~ (e) There is imposed a minimum annual surcharge of ~~twenty-five~~



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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 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 specialty class. This surcharge must be based on a percentage of the median calculated in subdivision (1) for all licensed physicians practicing in the same specialty class 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 34-18-6 (or IC 27-12-6 before its repeal) by physicians practicing in the specialty class.

(g) Beginning July 1, 1999, the surcharge for a hospital licensed under IC 16-21 that establishes financial responsibility under IC 34-18-4 after June 30, 1999, is established by the department through the use of an actuarial program. 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 34-18-6 by the hospital.

(h) An actuarial program used or developed under subsection



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(a) shall be treated as a public record under IC 5-14-3.

SECTION 8. IC 34-18-6-2, AS ADDED BY HEA 1011-1998, 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 **or retain** the services of persons, firms, and corporations to aid in protecting the fund against claims. **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.**

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

(c) 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.

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

SECTION 9. IC 34-18-8-7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]:
 Sec. 7. **(a)** 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 setting a date for trial, an action under IC 34-18-8-8 (or IC 27-12-8-8 before its repeal), or an action under IC 34-18-11 (or IC 27-12-11 before its repeal);

until section 4 of this chapter has been satisfied.

(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.

SECTION 10. IC 34-18-8-8 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY



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1, 1998]: **Sec. 8. 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;**

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 11. IC 34-18-9-3, AS ADDED BY HEA 1011-1998, 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.

SECTION 12. IC 34-18-9-4, AS ADDED BY HEA 1011-1998, 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 or IC 27-12 before its repeal 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 34-18-10) shall make a separate determination, at the time that it renders its opinion under IC 34-18-10-22, 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~~



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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.

(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.

SECTION 13. IC 34-18-10-25, AS ADDED BY HEA 1011-1998, 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 (1/2)~~ **fifty percent (50%)** of the cost.

SECTION 14. IC 34-18-14-3, AS ADDED BY HEA 1011-1998, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 3. (a) The total amount recoverable for an injury or death of a



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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 (or IC 27-12 before its repeal) 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 34-18-15.

(d) If a health care provider qualified under this article (or IC 27-12 before its repeal) 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 (or IC 27-12 before its repeal), 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 15. IC 34-18-14-4, AS ADDED BY HEA 1011-1998, 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



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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 34-18-15-3 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 thousand~~ **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 thousand dollar~~ **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 16. IC 34-18-6-3 IS REPEALED [EFFECTIVE JANUARY 1, 1999].

SECTION 17. [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 July 1, 1999.**

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

SECTION 18. [EFFECTIVE UPON PASSAGE] (a) **After the department establishes the annual surcharge for physicians under IC 27-12-5-2, as amended by this act, or, after June 30, 1998, IC 34-18-5-2, the department shall publish in the Indiana Register an estimated surcharge for all physicians practicing in the same specialty class.**

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

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

SECTION 19. **An emergency is declared for this act.**



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