April 6, 1999

ENGROSSED
HOUSE BILL No. 2043

DIGEST OF HB 2043 (Updated April 1, 1999 8:09 am - DI 88)

Citations Affected: IC 5-10; IC 27-6; IC 27-13; IC 34-18.

Synopsis: Various insurance matters. Provides that a current or former member of the general assembly may choose to participate in a state employee health benefit plan or the self insurance plan established by the state police department. Revises the composition of the board of directors of the Indiana Insurance Guaranty Association. Provides that a health maintenance organization may not discriminate against a provider acting within the scope of the provider's license or certificate on the basis of the provider's license or certificate. Specifies that the patient compensation fund surcharge for qualified providers other than physicians and hospitals may not exceed the actuarial risk posed to the fund by those qualified providers. Makes a conforming amendment to the medical malpractice act's settlement procedure by increasing the policy limit amount from $100,000 to $250,000.

Effective: July 1, 1999.

Fry

(SENATE SPONSORS — PAUL, HARRISON, LANANE)

January 27, 1999, read first time and referred to Committee on Insurance, Corporations and Small Business.
February 24, 1999, amended, reported — Do Pass.
March 3, 1999, read second time, amended, ordered engrossed.
March 4, 1999, engrossed.
March 8, 1999, read third time, passed. Yeas 94, nays 1.

SENATE ACTION

March 11, 1999, read first time and referred to Committee on Rules and Legislative Procedure.
March 18, 1999, reassigned to Committee on Health and Provider Services.
April 5, 1999, amended, reported favorably — Do Pass.

C o p y

April 6, 1999

First Regular Session 111th General Assembly (1999)

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 1998 General Assembly.

C o p y

ENGROSSED
HOUSE BILL No. 2043

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 5-10-8-6.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: **Sec. 6.5. (a) A member of the general assembly may elect to participate in either:**

(1) the plan of self-insurance established by the state police department under section 6 of this chapter;

(2) the plan of self-insurance established by the state personnel department under section 7 of this chapter; or

(3) a prepaid health care delivery plan established under section 7 of this chapter.

(b) A former member of the general assembly who meets the criteria for participation in a group health insurance program provided under section 8(e) or 8.1 of this chapter may elect to participate in either:

(1) the plan of self-insurance established by the state police

department under section 6 of this chapter; or

(2) a group health insurance program provided under section 8(e) or 8.1 of this chapter if the former member meets the criteria for participation in that program.

SECTION 2. IC 27-6-8-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 6. (a) The board of directors of the association shall consist of nine (9) member insurers one (1) of whom shall be selected by or from among each of the following groups representative of member insurers, such selection to be subject to the approval of the commissioner:

~~(i)~~ **(1)** One (1) person representing the American Insurance Association.

~~(ii)~~ **(2)** One (1) person representing the Alliance of American Insurers.

~~(iii)~~ **(3)** One (1) person representing the National Association of Independent Insurers.

~~(iv)~~ **(4)** One (1) person representing the National Association of Mutual Insurance Companies.

~~(v)~~ **(5)** One (1) person representing the Insurance Institute of Indiana.

~~(vi) One (1) person representing the domestic stock companies.~~

(6) Three (3) persons representing the:

(A) domestic stock companies;

(B) domestic mutual companies; or

(C) domestic reciprocal insurers;

with not more than two (2) persons representing any category.

~~(vii) One (1) person representing the domestic mutual companies~~.

~~(viii) One (1) person representing the domestic reciprocal insurers~~.

~~(ix)~~ **(7)** One (1) person representing independent unaffiliated stock, fire, and casualty companies to be appointed by the commissioner.

(b) Not more than one (1) member insurer in a group of insurers under the same management or ownership shall serve as a director at the same time.

(c) Directors shall serve such terms as shall be established in the plan of operation.

(d) Vacancies on the board shall be filled for the remaining period of the term in the same manner as the initial selection.

(e) If no directors are selected by March 1, 1972, the commissioner may appoint the initial members of the board of directors.

(f) In approving selections to the board, the commissioner shall

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consider among other things whether all member insurers are fairly represented.

(g) Directors may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors.

SECTION 3. IC 27-13-36-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: **Sec. 2.5. (a) A health maintenance organization may not discriminate against a provider acting within the scope of the provider's license or certification with respect to:**

(1) participation;

(2) reimbursement;

(3) indemnification; or

(4) scope of care;

solely on the basis of the provider's license or certification.

(b) This section does not require a health maintenance organization to enter into a contract with a provider that would allow the provider to enter the health maintenance organization network.

SECTION 4. IC 34-18-5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: 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 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.

(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.

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(d) The surcharge **for qualified providers other than:**

(1) physicians licensed under IC 25-22.5; and

(2) hospitals licensed under IC 16-21;

may not exceed the actuarial risk posed to the patient's compensation fund under IC 34-18 (or IC 27-12 before its repeal) by qualified providers **other than physicians licensed under IC 25-22.5 and hospitals licensed under IC 16-21.**

(e) There is imposed a minimum annual surcharge of one hundred dollars ($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

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

SECTION 5. IC 34-18-15-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 3. If a health care provider or its insurer has agreed to settle its liability on a claim by payment of its policy limits of ~~one~~ **two** hundred **fifty** thousand dollars ~~($100,000),~~ **($250,000),** and the claimant is demanding an amount in excess of that amount, the following procedure must be followed:

(1) A petition shall be filed by the claimant in the court named in the proposed complaint, or in the circuit or superior court of Marion County, at the claimant's election, seeking:

(A) approval of an agreed settlement, if any; or

(B) demanding payment of damages from the patient's compensation fund.

(2) A copy of the petition with summons shall be served on the commissioner, the health care provider, and the health care provider's insurer, and must contain sufficient information to inform the other parties about the nature of the claim and the additional amount demanded.

(3) The commissioner and either the health care provider or the insurer of the health care provider may agree to a settlement with the claimant from the patient's compensation fund, or the commissioner, the health care provider, or the insurer of the health care provider may file written objections to the payment of the amount demanded. The agreement or objections to the payment demanded shall be filed within twenty (20) days after service of summons with copy of the petition attached to the summons.

(4) The judge of the court in which the petition is filed shall set the petition for approval or, if objections have been filed, for hearing, as soon as practicable. The court shall give notice of the hearing to the claimant, the health care provider, the insurer of the health care provider, and the commissioner.

(5) At the hearing, the commissioner, the claimant, the health care provider, and the insurer of the health care provider may introduce relevant evidence to enable the court to determine

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whether or not the petition should be approved if the evidence is submitted on agreement without objections. If the commissioner, the health care provider, the insurer of the health care provider, and the claimant cannot agree on the amount, if any, to be paid out of the patient's compensation fund, the court shall, after hearing any relevant evidence on the issue of claimant's damage submitted by any of the parties described in this section, determine the amount of claimant's damages, if any, in excess of the ~~one~~ **two** hundred **fifty** thousand dollars ~~($100,000)~~ **($250,000)** already paid by the insurer of the health care provider. The court shall determine the amount for which the fund is liable and make a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the patient's compensation fund, the court shall consider the liability of the health care provider as admitted and established.

(6) A settlement approved by the court may not be appealed. A judgment of the court fixing damages recoverable in a contested proceeding is appealable pursuant to the rules governing appeals in any other civil case tried by the court.

(7) A release executed between the parties does not bar access to the patient's compensation fund unless the release specifically provides otherwise.

C o p y

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, Corporations and Small Business, to which was referred House Bill 2043, 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:

Delete pages 1 through 3.

Page 4, delete lines 1 through 21.

Page 4, between lines 30 and 31, begin a new paragraph and insert:

"SECTION 2. IC 27-1-1-6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: **Sec. 6. (a) All employees of the department except:**

(1) the commissioner;

(2) the chief deputy commissioner;

(3) other deputy commissioners; and

(4) clerical staff;

shall comply with the continuing education requirements established for a licensed insurance agent under IC 27-1-15.5-7.1.

(b) This section does not require employees of the department to obtain an insurance agent's license.

(c) The department shall, not later than July 1 of each year, submit a report to the legislative council regarding compliance with this section.

(d) All costs associated with this section shall be paid from the department of insurance fund established under IC 27-1-3-28.".

Page 4, delete lines 31 through 42.

Delete page 5.

Page 6, delete lines 1 through 37.

Page 7, between lines 12 and 13, begin a new line block indented and insert:

"**(6) To pay the costs associated with IC 27-1-1-6 concerning continuing education of department employees.**".

Page 7, line 16, reset in roman "IC 27-1-3-15(d).".

Page 7, line 16, delete "IC 27-1-3-15(c).".

Page 7, line 18, reset in roman "IC 27-1-3-15(c).".

Page 7, line 18, delete "IC 27-1-3-15(d).".

Page 7, between lines 32 and 33, begin a new paragraph and insert:

"SECTION 4. IC 27-13-36-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: **Sec. 2.5. A health maintenance organization may not discriminate against a provider acting within the scope of the provider's license or certification with respect to:**

(1) participation;

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(2) reimbursement;
(3) indemnification; or
(4) scope of care;
solely on the basis of the provider's license or certification.".

Page 7, delete lines 33 through 42.
Delete pages 8 through 83
Page 84, delete lines 1 through 30.
Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 2043 as introduced.)

FRY, Chair

Committee Vote: yeas 14, nays 0.

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HOUSE MOTION

Mr. Speaker: I move that House Bill 2043 be amended to read as follows:

Page 3, line 10, before "A" insert "**(a)**".

Page 3, between lines 17 and 18, begin a new paragraph and insert:

"**(b) This section does not require a health maintenance organization to enter into a contract with a provider that would allow the provider to enter the health maintenance organization network.**".

(Reference is to HB 2043 as printed February 25, 1999.)

SMITH M

HOUSE MOTION

Mr. Speaker: I move that House Bill 2043 be amended to read as follows:

Page 3, between lines 17 and 18, begin a new paragraph and insert:

"SECTION 5. IC 34-18-5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: 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 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.

(c) The amount of the surcharge shall be determined based upon actuarial principles and actuarial studies and must be adequate for the

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payment of claims and expenses from the patient's compensation fund.

(d) The surcharge **for qualified providers other than:**

(1) physicians licensed under IC 25-22.5; and

(2) hospitals licensed under IC 16-21;

may not exceed the actuarial risk posed to the patient's compensation fund under IC 34-18 (or IC 27-12 before its repeal) by qualified providers **other than physicians licensed under IC 25-22.5 and hospitals licensed under IC 16-21.**

(e) There is imposed a minimum annual surcharge of one hundred dollars ($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

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

Renumber all SECTIONS consecutively.

(Reference is to HB 2043 as printed February 25, 1999.)

FRY

HOUSE MOTION

Mr. Speaker: I move that House Bill 2043 be amended to read as follows:

Page 3, between lines 7 and 8, begin a new paragraph and insert:

"SECTION 4. IC 27-6-8-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 6. (a) The board of directors of the association shall consist of nine (9) member insurers one (1) of whom shall be selected by or from among each of the following groups representative of member insurers, such selection to be subject to the approval of the commissioner:

~~(i)~~ **(1)** One (1) person representing the American Insurance Association.

~~(ii)~~ **(2)** One (1) person representing the Alliance of American Insurers.

~~(iii)~~ **(3)** One (1) person representing the National Association of Independent Insurers.

~~(iv)~~ **(4)** One (1) person representing the National Association of Mutual Insurance Companies.

~~(v)~~ **(5)** One (1) person representing the Insurance Institute of Indiana.

~~(vi) One (1) person representing the domestic stock companies.~~

(6) Three (3) persons representing the:

(A) domestic stock companies;

(B) domestic mutual companies; or

(C) domestic reciprocal insurers;

with not more than two (2) persons representing each category.

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~~(vii) One (1) person representing the domestic mutual companies.~~
~~(viii) One (1) person representing the domestic reciprocal insurers.~~
~~(ix)~~ **(7)** One (1) person representing independent unaffiliated stock, fire, and casualty companies to be appointed by the commissioner.

(b) Not more than one (1) member insurer in a group of insurers under the same management or ownership shall serve as a director at the same time.

(c) Directors shall serve such terms as shall be established in the plan of operation.

(d) Vacancies on the board shall be filled for the remaining period of the term in the same manner as the initial selection.

(e) If no directors are selected by March 1, 1972, the commissioner may appoint the initial members of the board of directors.

(f) In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.

(g) Directors may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors.".

Renumber all SECTIONS consecutively.

(Reference is to HB 2043 as printed February 25, 1999.)

FRY

HOUSE MOTION

Mr. Speaker: I move that House Bill 2043 be amended to read as follows:

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

"SECTION 1. IC 5-10-8-6.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: **Sec. 6.5. (a) A member of the general assembly may elect to participate in either:**

(1) the plan of self-insurance established by the state police department under section 6 of this chapter;

(2) the plan of self-insurance established by the state personnel department under section 7 of this chapter; or

(3) a prepaid health care delivery plan established under section 7 of this chapter.

C o p y

(b) A former member of the general assembly who meets the criteria for participation in a group health insurance program provided under section 8(e) or 8.1 of this chapter may elect to participate in either:

(1) the plan of self-insurance established by the state police department under section 6 of this chapter; or

(2) a group health insurance program provided under section 8(e) or 8.1 of this chapter if the former member meets the criteria for participation in that program.".

Renumber all SECTIONS consecutively.

(Reference is to HB 2043 as printed February 25, 1999.)

FRY

HOUSE MOTION

Mr. Speaker: I move that House Bill 2043 be amended to read as follows:

Page 3, between lines 17 and 18, begin a new paragraph and insert:

"SECTION 5. IC 34-18-15-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 3. If a health care provider or its insurer has agreed to settle its liability on a claim by payment of its policy limits of ~~one~~ **two** hundred **fifty** thousand dollars ~~($100,000),~~ **($250,000),** and the claimant is demanding an amount in excess of that amount, the following procedure must be followed:

(1) A petition shall be filed by the claimant in the court named in the proposed complaint, or in the circuit or superior court of Marion County, at the claimant's election, seeking:

(A) approval of an agreed settlement, if any; or

(B) demanding payment of damages from the patient's compensation fund.

(2) A copy of the petition with summons shall be served on the commissioner, the health care provider, and the health care provider's insurer, and must contain sufficient information to inform the other parties about the nature of the claim and the additional amount demanded.

(3) The commissioner and either the health care provider or the insurer of the health care provider may agree to a settlement with the claimant from the patient's compensation fund, or the commissioner, the health care provider, or the insurer of the health care provider may file written objections to the payment of

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the amount demanded. The agreement or objections to the payment demanded shall be filed within twenty (20) days after service of summons with copy of the petition attached to the summons.

(4) The judge of the court in which the petition is filed shall set the petition for approval or, if objections have been filed, for hearing, as soon as practicable. The court shall give notice of the hearing to the claimant, the health care provider, the insurer of the health care provider, and the commissioner.

(5) At the hearing, the commissioner, the claimant, the health care provider, and the insurer of the health care provider may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if the evidence is submitted on agreement without objections. If the commissioner, the health care provider, the insurer of the health care provider, and the claimant cannot agree on the amount, if any, to be paid out of the patient's compensation fund, the court shall, after hearing any relevant evidence on the issue of claimant's damage submitted by any of the parties described in this section, determine the amount of claimant's damages, if any, in excess of the ~~one~~ **two** hundred **fifty** thousand dollars ~~($100,000)~~ **($250,000)** already paid by the insurer of the health care provider. The court shall determine the amount for which the fund is liable and make a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the patient's compensation fund, the court shall consider the liability of the health care provider as admitted and established.

(6) A settlement approved by the court may not be appealed. A judgment of the court fixing damages recoverable in a contested proceeding is appealable pursuant to the rules governing appeals in any other civil case tried by the court.

(7) A release executed between the parties does not bar access to the patient's compensation fund unless the release specifically provides otherwise.".

Renumber all SECTIONS consecutively.

(Reference is to HB 2043 as printed February 25, 1999.)

FRY

C o p y

SENATE MOTION

Mr. President: I move that House Bill 2043, currently assigned to the Committee on Rules and Legislative Procedure, be reassigned to the Committee on Health and Provider Services.

GARTON

C o p y

COMMITTEE REPORT

Mr. President: The Senate Committee on Health and Provider Services, to which was referred House Bill No. 2043, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 2, delete lines 5 through 42.
Page 3, delete lines 1 through 26.
Page 4, line 6, delete "each" and insert "**any**".
Page 8, delete lines 3 through 9.
Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 2043 as reprinted March 4, 1999.)

MILLER, Chairperson

Committee Vote: Yeas 6, Nays 2.

C o p y