# Indiana Lawmakers Face National Health Policy Issues

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## INTRODUCTION

Indiana, like other states, is struggling with the difficult health policy issues of how to assure access to affordable and high quality health care. Last year, Indiana lawmakers addressed aspects of the health policy issues in litigation and, to a lesser degree, in legislation concerning the termination of medical treatment, health care for the indigent, Medicaid reimbursement for nursing facilities, discrimination against AIDS victims by health insurers, and medical malpractice. It should be noted that in 1989, the Indiana legislature established the Indiana Commission on State Health Policy.[1] The Commission is currently analyzing problems of Indiana's health care system and developing strategies for reforms that the legislature could adopt to increase access to adequate, affordable, and high quality health care services for Indiana's residents.[2]

## I. RIGHT TO DIE

### A. *In re Lawrance*

In *In re Lawrance*,[3] the Indiana Supreme court faced the broad issue of whether parents may authorize the removal of artificially provided nutrition and hydration from their never competent daughter, Sue Ann,

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1. Act of May 5, 1989, Pub. L. No. 327, 1989 Ind. Acts 2103.

2. IND. COMM'N ON STATE HEALTH POLICY, SECOND INTERIM REPORT TO THE GOVERNOR AND GEN. ASSEMBLY OF 1991 (Nov. 1991). *See also Health Policy Commission Sees No Easy Answers*, 85 IND. MEDICINE 12 (1992).

3. 579 N.E.2d 32 (Ind. 1991).

who was in a persistent vegetative state.[4] The court considered three specific issues: (1) Whether the Health Care Consent Act (HCCA)[5] applies when the family of a patient in a persistent vegetative state seeks to withdraw the patient's artificially provided nutrition and hydration; (2) if the HCCA does apply, whether court proceedings are required to effectuate the will of decisionmakers; and (3) whether the trial court erred in appointing a temporary limited guardian for Sue Ann Lawrance.[6]

Regarding the first issue, the supreme court concluded that the HCCA is applicable to decisions involving family members who seek to refuse artificial nutrition and hydration on behalf of an incompetent patient.[7] The appellants argued that the provision in Indiana Code section 16-8-12-11 pertaining to the influence of the HCCA on Indiana law meant that the HCCA did not apply in this case. This section provides that nothing in the chapter including the HCCA will "affect Indiana law concerning an individual's authorization to make a health care decision for the individual or another individual, or to provide, withdraw, or withhold medical care necessary to prolong life."[8] The supreme court concluded that the language pertaining to the "affect" indicated the legislature's intent that the HCCA be a procedural statute and stated:

> The HCCA was hardly enacted in a legal vacuum. In recognition of existing law, the act is designed to establish procedures for health care decision making without altering the substantive rights of patients and their families. In this sense, the HCCA does not "affect" substantive Indiana law on withdrawal of treatment.[9]

The court went on to examine the relevant substantive law in Indiana on patient decisionmaking, noting at the onset that "the HCCA was written in a culture in which families typically make health care decisions when patients cannot."[10] The court then reviewed the state constitution[11]

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4. Prior to the supreme court hearing of this case, Sue Ann Lawrance died of natural causes. Technically, the case was moot. However, Indiana courts have long recognized that a case may be decided on its merits under an exception to the general mootness rule when the case involves questions of "great public interest." *Id.* at 37 (quoting Indiana Educ. Employment Relations Bd. v. Mill Creek Classroom Teachers Ass'n, 456 N.E.2d 709, 711-12 (Ind. 1983)). The court decided that the Lawrance case fell within this exception. *Id.*

5. IND. CODE §§ 16-8-12-1 to -22 (1988 & Supp. 1991).

6. *Lawrance*, 579 N.E.2d at 37-38.

7. *Id.* at 41.

8. IND. CODE § 16-8-12-11(a) (1988).

9. *In re* Lawrance, 579 N.E.2d 32, 38 (Ind. 1991).

10. *Id.*

11. IND. CONST. art. I, § 1.

and Indiana's Living Will Act[12] and Power of Attorney Act[13] and emphasized the consistent policy of patient autonomy reflected in the law.[14] The supreme court concluded:

> Respect for patient autonomy does not end when the patient becomes incompetent. In our society, health care decision making for patients typically transfers upon incompetence to the patient's family. . . . Even when they have not left formal advance directives or expressed particular opinions about life-sustaining medical treatment, most Americans want the decisions about their care, upon their incapacity, to be made for them by family and physician, rather than by strangers or by government. This preference is reflected in the HCCA's default provision, which says the patient's close family may make health care decisions when no other health care representative or guardian has been designated for the patient. This right to consent to the patient's course of treatment necessarily includes the right to refuse a course of treatment.[15]

The court then turned to the issue of whether one may decide to withdraw artificial nutrition and hydration. The court deferred to Indiana's medical community, the language of the HCCA, and decisions in other jurisdictions in deciding this issue.[16] The supreme court concluded that the administration of "artificially" provided nutrition and hydration is a medical treatment which could be refused by Sue Ann's parents.[17]

The medical community's opinions on this issue are quite consistent. The Indiana State Medical Association, as *amicus curiae*, took the position that "artificially" provided nutrition and hydration is a medical treatment that may be withdrawn from a person in a persistent vegetative state.[18] The court was persuaded by the precedents of numerous courts in which there was no distinction drawn between the withdrawal or withholding of artificial feeding or any other medical treatment.[19]

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12. IND. CODE § 16-8-11-1 to -22 (1988).
13. IND. CODE § 30-5-5-16(b)(2) (Supp. 1991).
14. *In re* Lawrance, 579 N.E.2d 32, 38-39 (Ind. 1991).
15. *Id.* (citations omitted).
16. *Id.* at 40.
17. *Id.* at 39.
18. *Id.* at 40 (quoting Brief of Amicus Curiae Indiana Medical Ass'n at 9).
19. *Id. See* Amicus Curiae Brief In Support of Appellee at 33, *In re* Lawrance, 579 N.E.2d 32 (Ind. 1991) (No. 29S04-9106-CV-460) (authored by Kenneth M. Stroud, Professor of Law, Indiana University School of Law—Indianapolis). Cases cited in the Amicus Brief which support the *Lawrance* decision include Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841 (1990); Mitchell *ex rel.* Rasmussen v. Fleming, 741 P.2d 674

Further, the court found that the broad scope of the HCCA confirms this position.[20] Pointing out that the HCCA defines "health care" broadly as "any care, treatment, service, or procedure,"[21] the court emphasized that the legislature did not limit the term "treatment" to medical treatment.[22] The court then concluded, "Read through the lens of the medical community's view, even a limitation to 'medical treatment' would include nutrition and hydration decisions."[23]

On the second issue, the court held that when family members are willing to act and agree with the physician to terminate medical treatment, a court proceeding is not required.[24] As the court stated, "The HCCA, written for a society in which health care decisions are routinely made by families on advice of physicians, is designed to resolve health care decisions without a need for court proceedings."[25] This view, according to the court, is consistent with decisions in other jurisdictions.[26] The court then found that the Lawrance family complied with the relevant provisions of the HCCA and therefore, a court proceeding was unnecessary in their case.[27]

The court emphasized the availability of numerous safeguards to protect helpless patients from potential harms which could arise when a health care decision is made by a third party.[28] First, the court noted a strong commitment from organized medical professional groups such as the American Medical Association (AMA), whose committees issue ethical guidelines for the medical profession and keep up with rapid progress in medical technology.[29] Second, the court noted that health

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(Ariz. 1987); *In re* Morrison, 253 Cal. Rptr. 530 (Cal. Ct. App. 1988); *In re* Drabick, 245 Cal. Rptr. 840 (Cal. Ct. App.), *cert. denied*, 488 U.S. 958 (1988); Barber v. Superior Ct., 195 Cal. Rptr. 484 (Cal. Ct. App. 1983); McConnell v. Beverly Enter.-Conn., 553 A.2d 596 (Conn. 1989); Corbet v. D'Alessandro, 487 So. 2d 368 (Fla. Dist. Ct. App. 1986); *In re* Estate of Greenspan, 558 N.E.2d 1194 (Ill. 1990); *In re* Estate of Longeway, 549 N.E.2d 292 (Ill. 1989); *In re* Swan, 569 A.2d 1202 (Me. 1990); *In re* Gardner, 534 A.2d 947 (Me. 1987); Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626 (Mass. 1986); *In re* Peter, 529 A.2d 419 (N.J. 1987); *In re* Jobes, 529 A.2d 434 (N.J. 1987); Delio v. Westchester County Medical Ctr., 516 N.Y.S.2d 677 (N.Y. App. Div. 1987).

20. *In re* Lawrance, 579 N.E.2d 32, 40 (Ind. 1991).

21. IND. CODE § 16-8-12-1(2) (1988).

22. *Lawrance*, 579 N.E.2d at 40.

23. *Id.*

24. *Id.* at 43.

25. *Id.* at 41.

26. *See, e.g.*, *In re* Drabick, 245 Cal. Rptr. 840 (Cal. Ct. App.), *cert. denied*, 488 U.S. 958 (1988); *In re* Jobes, 529 A.2d 434 (N.J. 1987).

27. *In re* Lawrance, 579 N.E.2d 32, 42 (Ind. 1991).

28. *Id.*

29. *Id.*

care providers involved in these types of treatment decisions act conservatively in light of internal constraints on their professional conduct.[30] Third, the court pointed to an HCCA provision which mandates good faith on the part of both family members and physicians when faced with difficult health care issues.[31] Finally, when there is disagreement amongst family and physician, the parties may seek redress from the courts.[32]

On the third issue, the court held that the appointment of a guardian for Sue Ann Lawrance constituted error.[33] The court recognized that four statutory requirements must be met before a court can appoint a guardian. These are: (1) a guardian has not been appointed for the incapacitated person or minor; (2) an emergency exists; (3) the welfare of the incapacitated person or minor requires immediate action; and (4) no other person appears to have authority to act under the circumstances.[34] The supreme court found that the fourth requirement was not met because the Lawrance family clearly appeared to have authority pursuant to the HCCA. The court also adhered to the HCCA requirement that petitioners be health care providers or interested individuals.[35] The court interpreted the word "interested" to mean "strangers need not apply."[36]

The *Lawrance* opinion clarifies some issues regarding the health care statutes and their impact on individuals and family members. The supreme court has clearly stated that artificially provided nutrition and hydration are medical treatments which can be withheld or withdrawn pursuant to the HCCA. Also clear is that Indiana's health care statutes are designed to provide individuals the opportunity to proclaim their health care wishes without having to go through formal court proceedings.

The court's approach to these delicate issues is consistent with that of other states, including the famous 1976 New Jersey Supreme Court decision in *In re Quinlan*[37] granting authority to a parent to remove his comatose daughter from a ventilator. Since then, numerous states have held that the withdrawal of nutrition and hydration is allowed when a patient is in a persistent vegetative state.[38] Furthermore, the Council on Ethical and Judicial Affairs of the American Medical Association has

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30. *Id.*
31. *Id.* at 43.
32. *Id.*
33. *Id.*
34. IND. CODE § 29-3-3-4(a) (Supp. 1991).
35. *Id.* § 16-8-12-7(a)
36. *In re* Lawrance, 579 N.E.2d 32, 44 (Ind. 1991).
37. 355 A.2d 647 (N.J. 1976).
38. *See* cases cited *supra* note 19.

stated that it is not unethical to discontinue all means of life-prolonging treatment, including nutrition and hydration, for patients who are either terminally ill or in an irreversible coma.[39]

To conclude, the *Lawrance* decision strikes a balance in favor of private decisionmaking when there is unanimity among the truly interested parties — the close family and the physician. A pivotal fact in this case was that the health care providers and the Lawrance family "unanimously" agreed on what was best for Sue Ann.[40] The Indiana Supreme Court has clearly stated that courts, unless needed to resolve disputes in major decisions, do not have a role in medical decisionmaking under the HCCA. Furthermore, outsiders, such as the advocacy group that petitioned to become Sue Ann's guardian, clearly do not have a role. In clarifying these questions, the supreme court has greatly assured the privacy of medical decisionmaking in Indiana.

### *B. Amendments to the Power of Attorney Act*

In 1991, the Indiana General Assembly added an important provision to the Power of Attorney Act to address the consent or refusal of health care.[41] The provision specifically empowers the attorney-in-fact to make decisions in the name of the principal regarding the withdrawal of health care.[42] Before this power can be invoked, section 30-5-5-17(a) requires that the power of attorney document contain specific language or its substantial equivalent.[43] In essence, the new provision incorporates health care decisionmaking into the power of attorney document. As a result,

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39. American Medical Ass'n, Council on Ethical and Judicial Affairs, Current Opinions § 2.18 (amended Mar. 15, 1980).

40. *Lawrance*, 579 N.E.2d at 43.

41. IND. CODE § 30-5-5-17 (Supp. 1991).

42. *Id.*

43. The specific language recommended by the statute is as follows:

> I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial, or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.
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> My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others, to the extent they are available.

*Id.* § 30-5-5-17(a).

the power of attorney has becomes a more complete document by encompassing a wider range of powers into a single document.

## II. Indiana's Hospital Care for the Indigent and the Medicaid Program

A crushing responsibility for states in recent years has been financing health care for the indigent through Medicaid and other state programs such as Indiana's Hospital Care for the Indigent (HCI) program.[44] The HCI program provides benefits for poor Indiana residents, who without immediate medical attention, might die, suffer serious impairment to bodily functions, or suffer from serious dysfunction of a bodily organ.[45] Like other states, Indiana has faced serious cost pressures in its Medicaid and HCI programs. Thus, it is not surprising that Indiana courts have adjudicated cases involving cost containment issues in these programs.

In *Lutheran Hospital of Fort Wayne, Inc. v. Indiana Department of Public Welfare*,[46] the Indiana Supreme Court interpreted the HCI Act with respect to hospital expenses of a county jail inmate hospitalized pursuant to a detention order after attempting suicide. In August 1986, Michael Campbell was transferred from the Noble County Jail to Lutheran Hospital under a seventy-two hour emergency admittance following two suicide attempts within two days. After Campbell's discharge, the hospital requested benefits under the HCI Act.

Noble County denied the hospital's request, stating that the Act does not cover mental health problems. On administrative appeal to the Department of Public Welfare, the State Board of Public Welfare upheld an administrative law judge's decision denying HCI payment to the hospital, reasoning that Campbell's medical condition did not meet the medical criteria established in the HCI. On judicial review, the Steuban Circuit Court and the court of appeals affirmed. The court of appeals also ruled that Campbell failed to meet the nonmedical criteria because his status as a county jail inmate was analogous to a noneligible department of correction's inmate.

The Indiana Supreme Court's standard for judicial review was whether the Board's decision was arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.[47] The substantive issues before the supreme court were whether Campbell was eligible for benefits under the HCI Act in accordance with the medical and nonmedical requirements and if eligible, for what benefits.

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44. Ind. Code §§ 12-5-6-1 to -8 (1988 & Supp. 1991).
45. Ind. Code § 12-5-6-2.1(a) (1988).
46. 571 N.E.2d 542 (Ind. 1991).
47. *Id.* at 544. *See also* Ind. Code § 4-21.5-5-14(d)(1) (1988).

The supreme court ruled that Campbell met the medical and nonmedical criteria for HCI benefits, but remanded for consideration of the requisite financial eligibility.[48] The supreme court stated that "the statute relates to emergency care, not preventive care, and that attempted suicide meets the definition of emergency care under HCI."[49] The court also stated that attempted suicide "appears to be 'placing the person's life in jeopardy' and therefore, meets the emergency medical situation contemplated by the HCI."[50] Furthermore, the court found nothing in the words or purpose of the statute that suggests that emergencies, as contemplated under the HCI, apply exclusively to a person's physical health. Therefore, the court held that when a patient is admitted to a hospital pursuant to a seventy-two hour detention order, the patient's mental condition, even in the absence of a physical illness, can form the basis of a valid claim for benefits under HCI.[51]

The court also ruled that Campbell, as an inmate of a county jail, could qualify for HCI benefits because he met the nonmedical criteria of the Act.[52] The State attempted to equate Campbell's status as an inmate at the county jail to that of a noneligible inmate of the Department of Correction.[53] The court rejected this analogy because the statute clearly states that a person is subject to the Department of Correction only after conviction.[54] Therefore, Campbell was not an inmate of the Department of Correction even though he was an inmate at the county jail.[55]

The court then considered the second issue regarding the amount of benefits the hospital was entitled to receive. The hospital contended that it was entitled to payments for Campbell's entire stay because the Act permits coverage for all medical costs incurred from the direct consequence of an emergency medical condition. To further support its claim, the hospital asserted that the statute permits HCI payments until the patient is "medically stable and can safely be discharged."[56] The State argued that once HCI benefits are approved, the benefits do not automatically continue until the patient is discharged. The State pointed

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48. *Lutheran Hosp.*, 571 N.E.2d at 544-45.

49. *Id.*

50. *Id.* at 545.

51. *Id.*

52. *Id.*

53. IND. CODE § 12-5-6-2.1(e) (1988) provides: "This chapter does not apply to inmates and patients of institutions of the department of corrections, the state board of health, or the department of mental health."

54. Lutheran Hosp. of Fort Wayne, Inc. v. Indiana Dep't of Pub. Welfare, 571 N.E.2d 542, 545 (Ind. 1991). *See* IND. CODE § 11-8-1-9 (1988).

55. *Lutheran Hosp.*, 571 N.E.2d at 545.

56. *Id.* at 546. IND. CODE § 12-5-6-12(b) (1988).

out that the legislature has mandated limitations on the duration of services through regulations.[57] The State then invoked Department of Public Welfare regulations which provide that HCI benefits "shall be available, consistent with reasonable medical necessity, until such time as the patient is medically stable and can be safely discharged."[58] The regulation defines "stable" as "the alleviation of the condition which prompted the hospitalization."[59]

The supreme court concluded that HCI benefits terminate when a patient becomes medically stable and that it is the hospital's responsibility to document fully the condition of the patient through the person's hospital stay so that the Welfare Department can determine the patient's eligibility for HCI benefits.[60] Based on the record, the court concluded that proof of Campbell's continued hospital stay, without more, was not sufficient evidence that his condition continued to be unstable and remanded to determine whether his hospital stay in excess of seventy-two hours was medically necessary.[61]

This decision established that a person suffering solely from a mental condition could qualify for HCI benefits provided that other HCI eligibility criteria are met. This is an important expansion of the HCI program in practice. The supreme court also confirmed that HCI benefits are available only for the period of time in which the patient remains medically unstable and that the hospital has the burden of documenting this condition for HCI payment purposes.

Of note is a preliminary ruling of the court of appeals in *Indiana State Board of Public Welfare v. Tioga Pines Living Center, Inc.*,[62] a major provider challenge to Medicaid payment levels under the Boren Amendment. The Boren Amendment requires that a state's Medicaid payment methodology result in rates that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards."[63] The *Tioga Pines* case was a challenge by Indiana's nursing

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57. *See* IND. CODE § 12-5-6-12(a)(2) (1988).

58. *Lutheran Hosp.*, 571 N.E.2d at 545 (quoting IND. ADMIN. CODE tit. 470, r. 11.1-2-1(b) (1988)).

59. *Id.*

60. *Id.*

61. *Id.*

62. 575 N.E.2d 303 (Ind. Ct. App. 1991).

63. 42 U.S.C. § 1396a(a)(13)(A) (1988). *See generally* Eleanor D. Kinney, *Rule and Policy Making Under the Medicaid Program: A Challenge to Federalism*, 51 OHIO ST. L.J. 855, 872 (1990) [hereinafter Kinney, *Rule and Policy Making*].

facilities to the Department of Public Welfare's regulations enacted as a result of the Boren Amendment that link increases in Medicaid reimbursement for nursing facilities to the Gross National Product Implicit Price Deflator[64] thereby reducing reimbursement to nursing homes by an estimated $4,000,000 per month.

The trial court granted a preliminary injunction which required the state to pay into escrow the difference between the amounts paid under the new cap rate and the amount which would have been paid under the previous formula. The court also certified the cause as a class action as to the issues and the damages. On appeal, the court of appeals considered whether the trial court erred in granting the preliminary injunction, whether judicial review was available to the nursing facilities before they had exhausted their administrative remedies, and whether the trial court erred by certifying 785 skilled nursing facilities as a class pursuant to Indiana Trial Rule 23(B)(3).

In determining the first issue, the court stated that a preliminary injunction is proper only when there is no adequate remedy at law available.[65] After reviewing the trial court's findings, the court found that the only harm the nursing homes would suffer before a final judgment was entered would be monetary.[66] It has been held that mere economic injury does not warrant the granting of a preliminary injunction, even if the sale or closing of some facilities would result without an adequate remedy at law.[67] Conforming to this principle, the court of appeals held that the trial court's grant of the injunction was clearly erroneous because the nursing facilities had an adequate remedy at law.[68]

Regarding the issue of exhaustion of administrative remedies, the court recognized three exceptions to the general proposition that litigants must exhaust administrative remedies before seeking judicial relief. Specifically, direct resort to the courts is justified when compliance with a rule will be futile, when the statute is charged to be void on its face, or when irreparable injury will result.[69] The court then determined that the instant challenge to the rule establishing Indiana's rate caps was analogous to a challenge to the validity of a statute and therefore, fell within one of the exceptions to the exhaustion requirement.[70]

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64. *See* IND. ADMIN. CODE tit. 470, r. 5-4.1-9(c)(3) (Supp. 1991).

65. *Tioga Pines*, 575 N.E.2d at 306.

66. *Id.*

67. *Id.* (citing Whiteco Indus., Inc. v. Nickolick, 549 N.E.2d 396, 399 (Ind. Ct. App. 1990)).

68. *Id.*

69. *Id.* at 307 (citing Indiana High Sch. Athletic Ass'n v. Raike, 329 N.E.2d 66, 82 (Ind. Ct. App. 1975)).

70. *Id.*

The court also pointed out the decision of the United States Supreme Court in *Wilder v. Virginia Hospital Association*,[71] holding that the Boren Amendment created privately enforceable rights under 42 U.S.C. § 1983.[72] The court emphasized the implications of the *Virginia Hospital* decision for the *Tioga Pines* case: "Even if valid, state regulations providing for review of individual claims for payment do not foreclose resort to § 1983 relief. Thus, the trial court also has § 1983 jurisdiction to entertain this case."[73] Finally, the court of appeals, relying on Indiana Trial Rule 23(B)(3), held that the class certification was proper because all of the nursing homes would be affected by the questioned regulations.[74]

The *Tioga Pines* decision affirms that a preliminary injunction can only be issued when a party does not have an adequate remedy at law, and the fact that the a party will suffer monetary injury, no matter how severe, does not warrant the issuance of a preliminary injunction. However, the decision recognizes that challenges to Medicaid regulations are analogous to challenges to the validity of statutes and may fall under an exception to the administrative exhaustion requirement. Further, 42 U.S.C. § 1983 provides a basis for challenging state medical payment policies that do not comport with federal statutory requirements set forth in the Boren Amendment. The decision also clarifies the requirements needed for class certification. A decision on the merits in this case will have important implications for future Medicaid payment policy in Indiana.

## III. AIDS and Access to Private Health Insurance

The key case *Westhoven v. Lincoln Foodservice Products, Inc.*,[75] before the Indiana Civil Rights Commission (ICRC), concerns the alleged discrimination against an AIDS victim in obtaining health insurance. In January 1988, Lincoln established a new plan which was generous for most catastrophic illnesses, but placed severe restrictions and limitations on benefits for individuals with AIDS or AIDS-Related Complex (ARC). Prior to 1988, Lincoln's plan contained no exclusion or limitation on expenses resulting from AIDS or ARC. Westhoven charged that his

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71. 110 S. Ct. 2510 (1990).

72. *See* 42 U.S.C. § 1983 (1988). *See also* Kinney, *Rule and Policy Making*, *supra* note 63, at 872.

73. Indiana State Bd. of Pub. Welfare v. Tioga Pines Living Ctr., Inc., 575 N.E.2d 303, 307-08 (Ind. Ct. App. 1991) (citations omitted).

74. *Id.* at 308.

75. No. EMha89030350 (Ind. Civil Rts. Comm'n Mar. 22, 1991) (on file with author) [hereinafter Findings of Fact], *rev'd*, No. 35C01-9109-CP-00396 (Huntington Cir. Ct. Feb. 18, 1992).

employer's health insurance plan discriminated against him on the basis of his handicap in violation of the Indiana Civil Rights Law (ICRL).[76] The ICRL prohibits discrimination on the basis of handicap, defined as a "physical condition" that constitutes a "substantial disability."[77] The ICRL defines unlawful discriminatory practices to include the "exclusion of a person" or "a system that excludes persons" from "equal opportunities" because of "handicap" or other characteristics.[78]

The new Lincoln plan included a $50,000 maximum lifetime benefit to employees whose conditions are caused by AIDS or ARC. With the exception of mental illness, the plan allowed a maximum lifetime benefit of $1,000,000 for all other health conditions. The plan placed a $25,000 annual maximum on expenses related to AIDS or ARC, but contained no such calendar year maximum on benefits for other medical conditions. Further, the plan's major medical benefit was sharply curtailed for AIDS and ARC claims. Specifically, for all other conditions, the plan paid twenty percent of the first $2,000 of covered expenses above the deductible and one hundred percent thereafter. For mental illness, AIDS, or ARC, the plan paid only eighty percent of in-patient services and fifty percent of out-patient services for all covered expenses in excess of the deductible.

The Commission's administrative law judge ruled that the ICRL applied and that discrimination against Westhoven occurred in this case, stating:

> The Plan provides lesser major medical benefits to the class of handicapped employees who suffer from AIDS or ARC than it provides to employees not so handicapped. This disparity of treatment based solely upon the handicap of the employee causes the exclusion of the employee, Westhoven, from equal opportunities in employment solely because of his handicap, AIDS, and therefore, is a discriminatory practice.[79]

The Commission also concluded that the plan "on its face classifies and limits benefits to employees whose handicap is AIDS solely on the basis of the handicap."[80] Therefore, the plan was a "'system that excludes

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76. *See* Ind. Code § 22-9-1-3 (1988).

77. *Id.*

78. *Id.*

79. Proposed Findings of Fact, Conclusions of Law, and Order at 11, Westhoven v. Lincoln Foodservice Prods., Inc., No. EMha89030350 (Ind. Civil Rts. Comm'n Dec. 3, 1990) [hereinafter Proposed Findings]. The Proposed Findings, written by the hearing officer who heard initial arguments in *Westhoven*, were adopted by the Civil Rights Commission as part of its final ruling in the case. Findings of Fact, *supra* note 75, at 3.

80. Findings of Fact, *supra* note 75, at 11.

persons from equal opportunities because of handicap' and, therefore, constituted a discriminatory practice'' in violation of Indiana law.[81] The administrative law judge also ruled that the federal Employee Retirement Income Security Act of 1972 (ERISA)[82] does not preempt the application of the ICRL in this case.[83]

On August 29, 1990, the Commission considered whether it had subject matter jurisdiction over Lincoln's self-funded insurance plan or whether it was preempted by ERISA.[84] ERISA preempts state laws that relate to employee benefit plans.[85] However, ERISA specifically exempts from the preemption clause state laws that regulate insurance,[86] but it also provides that state insurance laws cannot deem an employee benefit plan to be an insurance company and so regulate the employee benefit plan.[87]

In determining whether the ICRC had subject matter jurisdiction, the Commission relied heavily on *Shaw v. Delta Air Lines, Inc.*[88] In *Shaw*, the United States Supreme Court held that New York's Human Rights Law was preempted to the extent it prohibited practices that were lawful under ERISA.[89] Applying *Shaw*, the Commission concluded that it had subject matter jurisdiction over the case and that the Indiana Civil Rights Law does not prohibit practices that are permitted under federal law.[90]

Having decided that ERISA does not preempt Indiana's civil rights laws in this case, the Commission addressed the question of whether federal or state law allowed Lincoln to discriminate against Westhoven under its self-funded insurance plan. The ICRC then ruled that Lincoln's new plan violated the Indiana Civil Rights Law[91] in that the plan intentionally provided for lesser benefits to those suffering from AIDS.[92]

The next issue was whether the practice described is permitted under any federal law. The Commission concluded that only the federal Vo-

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81. *See* IND. CODE § 22-9-1-3(A)(2) (1988).

82. 29 U.S.C. §§ 1001-1461 (1988 & Supp. I 1989).

83. Proposed Findings, *supra* note 79, at 11-12.

84. Both parties agreed that the insurance plan was a welfare benefit plan as defined by ERISA. ERISA covers all employee benefit plans which are either established or maintained by any employer who is engaged in commerce, industry, or any activity which affects commerce.

85. 29 U.S.C. § 1144(a) (1988).

86. *Id.* § 1144(b)(2)(A).

87. *Id.* § 1144(b)(2)(B).

88. 463 U.S. 85 (1983).

89. *Id.* at 108.

90. Order, Westhoven v. Lincoln Foodservice Prods., Inc., No. EMha89030350, slip op. at 12 (Ind. Civil Rts. Comm'n Aug. 29, 1990).

91. *See* IND. CODE § 22-9-1-3 (1988).

92. Findings of Fact, *supra* note 75, at 3.

cational Rehabilitation Act of 1973,[93] which prohibits discrimination by employers on the basis of handicap, was applicable.[94] Several federal court cases have clearly stated that AIDS constitutes a handicap under the Rehabilitation Act.[95] Section 794(a) of the Act prohibits discrimination on the basis of handicap in programs and activities receiving federal funding issued by various agencies.[96] Pursuant to this section, the Department of Justice issued Guidelines on Nondiscrimination on the Basis of Handicap in Federally Assisted Programs.[97] Subsections 41.52(b), (c), and (d) of the guidelines specifically prohibit activities which adversely affect compensation and fringe benefits of handicapped employees.[98] Because Lincoln's practice is prohibited under federal law, and because Indiana's civil rights laws are consistent with the applicable federal law, the ICRC determined it had subject matter jurisdiction over Westhoven's claim.

On judicial review of the Commission's decision, the Huntington County Circuit Court ruled that ERISA preempts Indiana's handicap discrimination laws and that consequently, the ICRC did not have jurisdiction to regulate Lincoln's self-funded plan.[99] The court also ruled that it had concurrent jurisdiction with the federal courts to decide ERISA claims.[100] This decision is consistent with recent decisions from other jurisdictions determining whether state civil rights authorities protect employees from discrimination under employer health insurance plans.[101]

It is important to note that this issue has been addressed by the Americans with Disabilities Act. Specifically, the Act, which prohibits discrimination against the disabled in employment, public services, and accommodations and telecommunications, expressly exempts any "insurer, hospital, or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering

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93. 28 U.S.C. §§ 701-796 (1988 & Supp. I 1989).

94. Proposed Findings, *supra* note 79, at 15-17 (citing 29 U.S.C. §§ 706, 793, 794 (1988)).

95. *See, e.g.,* Doe v. Garrett, 903 F.2d 1455, 1459 (11th Cir. 1988) (citing School Bd. of Nassau County v. Arline, 480 U.S. 273 (1987)); Martinez v. Hillsborough County Sch. Bd., 861 F.2d 1502 (11th Cir. 1988).

96. *See* 28 U.S.C. § 794(a) (1988).

97. 28 C.F.R. §§ 41.1 to -.7 (1991).

98. *Id.* § 41.52(b)-(d).

99. Lincoln Foodservice Prods., Inc. v. Westhoven, No. 35C01-9109-CP-00396, slip op. at 2 (Huntington Cir. Ct. Feb. 18, 1992).

100. *Id.*

101. *See* McGann v. H&H Music Co., 946 F.2d 401 (5th Cir. 1991); Owens v. Storehouse, Inc., 773 F. Supp. 416 (N.D. Ga. 1991). *See generally* Mary Ann Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. Davis L. Rev. 255 (1990); Milt Freudenheim, *Employers Winning Right to Cut Back Medical Insurance*, N.Y. Times, Mar. 29, 1992, at A1.

such risks that are based on or not inconsistent with state law."[102] Thus, the Act specifically declines to address barriers to access to health insurance for the disabled that are based on current principles of medical underwriting. However, the Act does prohibit employers from discriminating against disabled individuals who might be high users of health insurance plans in making hiring decisions.[103] Important language in the report of the House Judiciary Committee on the Act confirms congressional intent in this regard:

> For example, an employer could not deny a qualified applicant a job because the employer's current insurance plan does not cover the person's disability or because of an anticipated increase in the costs of the insurance. Moreover, while a plan which limits certain kinds of coverage based on classification of risk would be allowed under this section, the plan may not refuse to insure or refuse to continue to insure, or limit the amount, extent or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of a physical or mental impairment, except where the refusal, limitation, or rate differential is based on sound actuarial principles, or is related to actual or reasonably anticipated experience.[104]

## IV. Medical Malpractice

During the past year, the court of appeals decided several important decisions in the medical malpractice field. Although procedural in nature, these decisions will have crucial implications for how Indiana's malpractice compensation system will operate in the future.

In *Eakin v. Reed*,[105] the court of appeals considered whether a loan receipt agreement qualified as a payment to settle the provider's liability in a large claim. In deciding the issue, the court interpreted the meaning of "payment" as used in the Indiana Patient Compensation Fund's (PCF) settlement procedures.[106]

Reed brought a medical malpractice action against a hospital and physician after receiving treatment for injuries sustained in an automobile

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102. Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327, 369-70 (to be codified at 42 U.S.C. § 12101).

103. *Id.*, 104 Stat. 369, § 501(c)(1).

104. H.R. Rep. No. 485, 101st Cong., 2d Sess. 71 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 494.

105. 567 N.E.2d 148 (Ind. Ct. App. 1991).

106. Ind. Code § 16-9.5-4-3 (1988). *See* Eleanor D. Kinney et al., *Indiana's Medical Malpractice Act: Results of a Three-Year Study*, 24 Ind. L. Rev. 1275 (1991) [hereinafter Kinney, *Study*].

accident. Reed also filed a products liability claim against Ford Motor Company in federal court. After both claims were filed, Reed entered into a loan receipt agreement with the hospital and the physician providing that the health care providers would make a present payment of slightly more than $75,000 toward a periodic payment plan which would total $101,000 in interest-free loans. Both parties agreed that the payment would satisfy any liability on the part of the health care providers. Furthermore, Reed promised to reimburse the health care providers for their payments if he was successful in his suit against Ford Motor Company. Based on the loan receipt agreement, Reed then sought a settlement of $400,000 from the Patient Compensation Fund.[107]

The trial court held that Reed met the statutory requirements to recover from the Fund because the periodic payment plan discussed would total $101,000, which met the statutory amount needed before payment from the Fund is allowed. On appeal, the Insurance Commissioner argued that Reed did not meet the statutory requirements because the conditional nature of the payments could relieve the health care providers of their statutory financial obligation if Reed successfully recovered on his products liability suit against Ford Motor Company.

The court of appeals reversed the trial court's decision and remanded with instructions to hold Reed's complaint for excess damages in abeyance until the products liability claim was decided or until the health care providers' payments were made irrevocable.[108] The court of appeals based its decision on legislative intent. The court reiterated the primary objective of the statute as articulated by the court's 1990 decision in *Eakin v. Mitchell-Leech*,[109] in which Judge Garrard said that "the statute clearly and unambiguously requires that the health care provider or its insurer shall have paid the maximum $100,000 . . . before access may be had to the fund."[110] Therefore, the court in *Reed* held that the word "payment" means "the permanent transfer of money from the health care providers to the claimant."[111] To hold otherwise would render the Fund responsible for damages without any statutorily required contribution from the health care providers.[112] *Reed* strengthens the Act's requirements by clarifying that the payment must be a permanent and irrevocable transfer of money before the Fund can be accessed.

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107. To be eligible for PCF payment, one or more defendants must pay at least $75,000 in present dollars with a future value of $100,000. IND. CODE § 16-9.5-2-2.2 (1988). *See* Kinney, *Study*, *supra* note 106, at 1280.

108. *Eakin*, 567 N.E.2d at 150.

109. 557 N.E.2d 1057 (Ind. Ct. App. 1990).

110. *Id.* at 1063 (Garrard, J., dissenting).

111. *See* Eakin v. Reed, 567 N.E.2d 148, 150 (Ind. Ct. App. 1991).

112. *Id.*

The second important medical malpractice case during the survey period was *Galindo v. Christensen*,[113] in which the court of appeals addressed whether the Marion County Circuit Court had subject matter jurisdiction over a motion for a preliminary determination of law, whether the trial court had the statutory authority to dismiss a proposed complaint, and whether the trial court abused its discretion when it ordered a dismissal of Galindo's proposed complaint.

On December 23, 1985, Galindo filed a complaint for damages with the Commissioner of Insurance under the Indiana Medical Malpractice Act against Dr. Christensen and Ball Memorial Hospital. On November 15, 1988, nearly three years after Galindo's complaint was filed, the parties tentatively selected a medical review panel and panel chair. The chair directed Galindo to submit his evidence by January 20, 1989. Galindo did not submit his evidence within the allotted time period or within the 180-day time period required under the Act for the review panel to render its written opinion.[114] In September 1989, the Marion County Circuit Court dismissed Galindo's complaint pursuant to a defense motion.

On appeal, Galindo argued that the trial court did not have subject matter jurisdiction over the pending motion because Christensen and Ball Memorial Hospital failed to issue and serve summonses upon the Commissioner and the panel chair as required by statute.[115] The court, construing the statute according to its plain, ordinary, and usual meaning, concluded that the trial court had subject matter jurisdiction to consider Galindo's proposed complaint and held that the issuance and service of a summons was not a prerequisite to bestowing the trial court with subject matter jurisdiction.[116] Rather, "the filing of the copy of the proposed complaint and motion with the clerk" conferred subject matter jurisdiction upon the court.[117]

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113. 569 N.E.2d 702 (Ind. Ct. App. 1991).

114. *See* IND. CODE § 16-9.5-9-3.5(a) (1988).

115. The statute provides:

> Any party to a proceeding commenced under this article . . . may invoke the jurisdiction of the court by paying the statutory filing fee to the clerk and filing a copy of the proposed complaint and motion with the clerk. The filing of a copy of the proposed complaint and motion with the clerk shall confer jurisdiction upon the court over the subject matter and the parties to the proceeding for the limited purposes stated in this chapter. . . . The moving party or his attorney shall cause as many summonses as are necessary to be issued by the clerk and served on the commissioner, each non-moving party to the proceedings and the chairman of the medical review panel.

*Id.* § 16-9.5-10-2.

116. *Galindo*, 569 N.E.2d at 704 (citing Merit Bd. v. Peoples Broadcasting Corp., 547 N.E.2d 235 (Ind. 1989)).

117. *Id.*

Galindo also argued that the trial court did not have the statutory authority to dismiss the proposed complaint because the motion did not fall within the court's limited jurisdiction. The court of appeals observed that the exclusionary provision of Indiana Code section 16-9.5-10-1 was inapplicable because dismissal of a proposed complaint for failure to submit evidence in a timely manner is not an issue reserved for the medical review panel.[118] Rather, the medical review panel may only decide whether "the defendant or defendants acted or failed to act within the appropriate standards of care as charged in the complaint."[119] Furthermore, because the Medical Malpractice Act empowers the trial court to impose sanctions for failure to proceed with evidence, the trial court had jurisdiction to address the issue of dismissal.[120]

Finally, Galindo argued that the trial court abused its discretion in ordering dismissal of his proposed complaint with prejudice. The court of appeals held that trial courts have the statutory authority to impose appropriate sanctions upon a party who, without good cause, fails to act as required by the Medical Malpractice Act.[121] Furthermore, the court stated that "dismissal is a sanction which a trial court has inherent authority to order in its discretion."[122] However, a court must conduct a hearing before imposing sanctions to allow the party against whom sanctions are sought an opportunity to show that the failure to act was for good cause.[123] In the instant case, Galindo was not provided with this opportunity.

In this decision, the court of appeals made it clear that trial courts have subject matter jurisdiction under the Act to determine preliminary questions of law and can dismiss a proposed medical malpractice action, as well as levy other appropriate sanctions on a party, because of failure to comply with the Act. However, a trial court must conduct a hearing which allows a party to show why his inaction was for good cause prior to dismissing the proposed action or applying sanctions.

In a subsequent decision on the same issue, *Ground v. Methodist Hospital of Indiana, Inc.*,[124] the court of appeals upheld the grant of the defendant's motion to dismiss the complaint for failure to prosecute pursuant to Indiana Trial Rule 41(E).[125] In dismissing the compliant, the trial court concluded that the plaintiff "had failed to act in accordance

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118. *Id.* at 705. *See* IND. CODE § 16-9.5-9-7 (1988).
119. Galindo v. Christensen, 569 N.E.2d 702, 705 (Ind. Ct. App. 1991).
120. *Id.*
121. *Id.* at 706.
122. *Id.* (citing IND. T. R. 37).
123. *Id. See* IND. CODE § 16-9.5-9-3.5(b) (1988).
124. 576 N.E.2d 611 (Ind. 1991).
125. *Id.* at 614.

with I.C. 16-9.5-9-3.5."[126] The court of appeals concluded that the trial court's action fell well within its powers to sanction litigants who fail to comply with court rules and other requirements.[127]

*Galindo* and *Ground* are potentially important cases for making Indiana's medical malpractice reforms more efficient. Major concerns about Indiana's system have been the slowness of the medical review process,[128] as well as the large backlog of open claims.[129] *Galindo* and *Ground* will allow courts and parties to make cases move more quickly and thereby address these concerns.

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126. *Id.* at 612.

127. *Id.* at 614.

128. Kinney, *Study, supra* note 106, at 1303.

129. *Id.* at 1304 (finding that about two-thirds of Indiana's claims filed between 1975 and December 1988 has not closed according to the records of the Indiana Department of Insurance).