

# 1985 Amendments to the Indiana Medical Malpractice Act

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## I. INTRODUCTION

The 1985 amendments to the Indiana Medical Malpractice Act<sup>1</sup> (the "Act") represent the most comprehensive set of amendments since the Act was passed in 1975. The amendments were enacted as four separate bills<sup>2</sup> and are in large part the product of the hearings and deliberations of the Interim Committee on Medical Malpractice.<sup>3</sup>

The purpose of this Article is to identify the changes that have been made in the Act and to comment, where appropriate, on possible effects of these changes. Editorial comments have been confined to the concluding section of this Article. The changes in each chapter are, for the most part, discussed in the same sequence as each chapter appears in the Act.<sup>4</sup> Changes reflecting merely "language clean-up" are not addressed in this Article.

## II. CHAPTER 1 - DEFINITIONS AND GENERAL APPLICATIONS

Indiana Code section 16-9.5-1-1, the general definition section of

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<sup>1</sup>IND. CODE §§ 16-9.5-1-1 to 10-5-5 (Supp. 1985).

<sup>2</sup>H. 1298 was enacted as Pub. L. No. 177 (1985); H. 1944 was enacted as Pub. L. No. 178 (1985); S. 443 was enacted as Pub. L. No. 179 (1985); H. 1929 was enacted as Pub. L. No. 180 (1985).

<sup>3</sup>The Interim Study Committee on Medical Malpractice consisted of six Indiana State Senators, six Indiana State Representatives, and two lay members (both of whom are doctors). The Committee met five times throughout the summer and fall of 1984, and heard testimony from twenty-two witnesses. All the proposals which had unanimous Committee support were incorporated into one bill (the "consensus bill"). The other proposals which had majority support were incorporated into three other bills. The Committee's "Legislative Council Directive" was

to study problems related to medical malpractice. In particular, the committee shall examine the financial status of the patient's compensation fund as of June 30, 1984, recommend procedures for handling claims of less than \$25,000, review recent medical malpractice court decisions, explore ways to address catastrophic losses, and make recommendations concerning structured settlements.

Legislative Council Directive, Interim Study Committee on Medical Malpractice (available in *Indiana Law Review Office*).

<sup>4</sup>Chapters five, seven, eight, and ten were not amended.

the Act, underwent several changes as a result of two separate bills.<sup>5</sup> In the list of "health care providers," "a person" was changed to "an individual."<sup>6</sup> "Community mental health clinic" was deleted from the list and "community health center" and "migrant health center" were added.<sup>7</sup> "Physician" was changed from "a person" to "an individual,"<sup>8</sup> and definitions of "community health center" and "migrant health center" were added.<sup>9</sup> Also added as a new additional definition of "health care provider" is "a health care organization whose members, shareholders, or partners are health care providers under subdivision (1)."<sup>10</sup> Finally, the definition of "community mental retardation center" was expanded to include those centers dealing with "other developmental disabilities."<sup>11</sup>

Indiana Code section 16-9.5-1-6, which previously prohibited the inclusion of a dollar amount in the prayer for damages in a complaint controlled by the Act, was amended to reflect a new scheme providing an alternative procedure for "small claims" in an amount no greater than fifteen thousand dollars.<sup>12</sup> Indiana Code section 16-9.5-1-6 now excludes these "small claims" from the prohibition of specific dollar amount prayers for damages.<sup>13</sup>

Indiana Code section 16-9.5-1-8<sup>14</sup> was added to exempt certain expenditures by the Insurance Commissioner from state procurement re-

<sup>5</sup>Pub. L. No. 177 (1985) and Pub. L. No. 28 (1985).

<sup>6</sup>IND. CODE § 16-9.5-1-1(a)(1) (Supp. 1985).

<sup>7</sup>IND. CODE § 16-9.5-1-1(a)(3) (Supp. 1985).

<sup>8</sup>IND. CODE § 16-9.5-1-1(b) (Supp. 1985).

<sup>9</sup>IND. CODE § 16-9.5-1-1(q)-(r) (Supp. 1985). Definitions previously designated as (r) and (s) were redesignated (s) and (t). "'Community health center' means a provider of primary health care organized as a not-for-profit corporation under IC § 23-7-1.1 and governed by a board of directors, at least fifty-one percent (51%) of whom are representatives of consumers." IND. CODE § 16-9.5-1-1(9) (Supp. 1985). "'Migrant health center' means a provider of primary health care organized as a not-for-profit corporation under IC § 23-7-1.1 and governed by a board of directors, at least fifty-one percent (51%) of whom are representatives of consumers and funded under Section 329 of the U.S. Public Health Service Act." IND. CODE § 16-9.5-1-1(r) (Supp. 1985).

<sup>10</sup>IND. CODE § 16-9.5-1-1(a)(6) (Supp. 1985). IND. CODE § 16-9.5-1-1(a)(1) lists as health care providers:

[a]n individual, partnership, corporation, professional corporation, facility, or institution licensed or legally authorized by this state to provide health care or professional services as a physician, psychiatric hospital, hospital, dentist, registered or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist, or psychologist, or as an officer, employee, or agent thereof acting in the course and scope of his employment.

<sup>11</sup>IND. CODE § 16-9.5-1-1(p) (Supp. 1985).

<sup>12</sup>IND. CODE § 16-9.5-9-2.1(a) (Supp. 1985).

<sup>13</sup>The new "small claims" provision of the Act is discussed in more detail below. See *infra* notes 65-70 and accompanying text.

<sup>14</sup>IND. CODE § 16-9.5-1-8 (Supp. 1985). The designation of this new section as 16-9.5-1-8 poses a problem in that IND. CODE § 16-9.5-1-8 (1982) is currently in force as a

quirements.<sup>15</sup> This new section exempts expenditures for technical contractual personnel and services retained for protecting and administering the Patients Compensation Fund<sup>16</sup> ("Fund") and expenditures for purchasing financing vehicles for structuring settlements.

### III. CHAPTER 2 - LIMITATIONS OF RECOVERY

Indiana Code section 16-9.5-2 was greatly expanded as a result of passage of the so-called "Vobach bill."<sup>17</sup> The existing provisions<sup>18</sup> of this chapter were left unchanged. Four new sections<sup>19</sup> were added to: (1) clarify the Insurance Commissioner's authority to enter into structured settlements; (2) define the respective roles of the Fund and the health care providers in combined structured settlements; and (3) define the effects of various elements of the settlement structure.

Indiana Code section 16-9.5-2-2.1 refers to a structured settlement as a "periodic payments agreement," and defines such an agreement as:

[a] contract between a health care provider (or its insurer) and the patient (or the patient's estate), whereby the health care provider is relieved from possible liability in consideration of:

- (1) a present payment of money to the patient (or the patient's estate); and
- (2) one (1) or more payments to the patient (or the patient's estate) in the future;

whether or not some or all of the payments are contingent upon the patient's survival to the proposed date of payment.<sup>20</sup>

This section further states that the "cost" of a periodic payments agreement under the Act is the amount paid, at the time the agreement is entered into, to obtain the commitment of a third party to make the payments.<sup>21</sup> Indiana Code section 16-9.5-2-2.1(b) also provides that the

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separate statutory provision and has not been repealed or redesignated by the 1984 Legislature which created the new subsection 8. New subsection 8 is distinct from the previous subsection 8. Apparently the Legislature intended to designate this new section as 16-9.5-1-8.1 or by some other such distinguishing characteristic. However, at present, the Indiana Code contains two official statutes designated as § 16-9.5-1-8. The Legislature should correct these confused designations at its earliest opportunity.

<sup>15</sup>Expenditures exempted would otherwise be covered by Article 13.4 of title 4 of the Indiana Code.

<sup>16</sup>IND. CODE § 16-9.5-4-1 (1982). See *infra* notes 45-57 and accompanying text.

<sup>17</sup>Senator William Vobach was the major proponent of structured settlement provisions in the Act.

<sup>18</sup>IND. CODE §§ 16-9.5-2-1 to -2 (1982).

<sup>19</sup>IND. CODE §§ 16-9.5-2-2.1 to -2.4 (Supp. 1985).

<sup>20</sup>IND. CODE § 16-9.5-2-2.1(a) (Supp. 1985).

<sup>21</sup>IND. CODE § 16-9.5-2-2.1(b) (Supp. 1985).

total of the future payments may exceed the health care provider's (or its insurer's)<sup>22</sup> liability limit of \$100,000 and the Fund's liability limit of \$400,000.<sup>23</sup>

Two points are of special note regarding this new section. First, there must be a present payment of money to the patient or the patient's estate,<sup>24</sup> although no specific amount or percentage is mandated. Practical considerations would seem to dictate that this present payment would usually be at least enough to cover the patient's legal fees and expenses of litigation. Second, subsection (b) of Indiana Code section 16-9.5-2-2.1, in defining "the cost of the periodic payments agreement," refers specifically to the amount paid by the health care provider, by the Fund, or by the Fund and the health care provider jointly, *to a third party* who, in turn, commits to make the future payments to the patient (or the patient's estate).<sup>25</sup> Although this third party ultimate payor is not referred to in subsection (a) of Indiana Code section 16-9.5-2-2.1, which defines "periodic payments agreement," both subsections read together indicate that the future payments cannot be paid from the funds of the health care provider or the Fund, but must instead be derived from the funds of a third party whose commitment to make the future payments is purchased by the health care provider or the Fund.<sup>26</sup>

Indiana Code section 16-9.5-2-2.2 details several requirements relating to periodic payments by the health care provider. New subsection 2.2 first states that the previously established limits<sup>27</sup> on recovery from a health care provider apply without change where possible liability of the health care provider is discharged entirely through an immediate pay-

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<sup>22</sup>Throughout this Article, references to payments by the health care provider also include the health care provider's insurer.

<sup>23</sup>IND. CODE § 16-9.5-2-2.1(b) (Supp. 1985). (IND. CODE § 16-9.5-2-2 states that the "total amount recoverable for an injury or death of a patient may not exceed five hundred thousand dollars (\$500,000)," however, the future payments may now exceed this limited liability amount.)

<sup>24</sup>IND. CODE § 16-9.5-2-2.1(a)(1) (Supp. 1985).

<sup>25</sup>Throughout this Article, references to payments made to, or claims made by, the patient also include those of the patient's estate.

<sup>26</sup>Although this "third party payor" requirement provision is limited in its applicability, by its own language, to Chapter 2, it does refer specifically to amounts expended by the Commissioner (which means out of the Fund). As a result, it seems to raise a conflict with the provisions of new IND. CODE § 16-9.5-4-4 (Supp. 1985). An alternative reading of this section would allow future payments directly from the funds of the health care provider (or its insurer) or the Fund, but disallow the inclusion of these amounts in the calculation of the "cost" of the periodic payments agreement. This alternative reading makes little sense, given the significance of the "costs" concept in other determinations within the Act.

<sup>27</sup>This amount is one hundred thousand dollars (\$100,000), as set forth in IND. CODE § 16-9.5-2-2(b) and (d) (1982).

ment.<sup>28</sup> Subsection (b) of Indiana Code section 16-9.5-2-2.2 provides that for the dual purposes of determining the health care provider's maximum liability<sup>29</sup> and whether the health care provider has agreed to settle its liability by payment of policy limits,<sup>30</sup> the sum of the present payment plus the cost of the periodic payments agreement must exceed \$75,000.<sup>31</sup> If this sum does exceed \$75,000, the patient will have met the dollar amount requirement necessary to proceed against the Fund. This new subsection provides statutory guidelines for a settlement approach previously approved by the Commissioner. Clearly, the health care providers, or more specifically their insurers, benefit from this provision. If they can convince the patient to accept a periodic payments agreement, they can settle large claims and give the patient access to the Fund for an amount significantly discounted from their otherwise statutorily mandated maximum liability of \$100,000. On one hand, the patient benefits from the change by gaining easier access to the Fund because of the lower threshold of out-of-pocket expenditure by the health care provider. To gain this benefit, however, the patient must accept a periodic payments agreement from the health care provider. The clear loser in this change in the Act is the Patient's Compensation Fund. The health care provider's threshold cost for allowing patient access to the Fund is substantially decreased. Therefore, if patients prove willing to accept periodic payments agreements with the health care provider, the patients will have easier access to the Fund, and more settlements providing access to the Fund can be anticipated.

Indiana Code section 16-9.5-2-2.2 also provides that the \$75,000 threshold for patient access to the Fund under a periodic payments agreement can be satisfied by the sum of the amounts contributed by more than one health care provider, as long as one health care provider contributes at least \$50,000 to the immediate payment and the cost of the periodic payments.<sup>32</sup> Prior to this amendment, the Insurance Commissioner required that the patient obtain the full \$100,000 from a single health care provider before the patient could gain access to the Fund. Obtaining a total of \$100,000 from contributions from two or more health care providers was previously not sufficient to gain access to the Fund. Under Indiana Code section 16-9.5-2-2.2(c), patients can now

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<sup>28</sup>IND. CODE § 16-9.5-2-2.2(a) (Supp. 1985).

<sup>29</sup>This amount is one hundred thousand dollars (\$100,000), as set forth in IND. CODE § 16-9.5-2-2(b) and (d) (1982).

<sup>30</sup>An agreement by the health care provider to settle its liability by payment of its policy limits of one hundred thousand dollars (\$100,000) is a requirement of IND. CODE § 16-9.5-4-3 (1982), which must be met before the patient (or the patient's estate) can proceed against the Fund after settlement of a claim.

<sup>31</sup>IND. CODE § 16-9.5-2-2.2(b) (Supp. 1985).

<sup>32</sup>IND. CODE § 16-9.5-2-2.2(c) (Supp. 1985).

combine health care provider contributions and reach the Fund if these contributions total in excess of \$75,000. Again, the price the patient must pay for this easier access to the Fund is the acceptance of a periodic payments agreement.

Indiana Code section 16-9.5-2-2.3 controls periodic payments from the Fund in a manner similar to the way Indiana Code section 16-9.5-2-2.2 controls periodic payments from health care providers. If the possible liability of the Fund is discharged completely through an immediate payment, the previously established limit on recovery from the Fund<sup>33</sup> applies without change.<sup>34</sup> If the Fund's possible liability is discharged through a periodic payments agreement, the patient's recovery is calculated as the sum of the immediate payment from the Fund plus the cost of the periodic payments agreement paid out of the Fund.<sup>35</sup> This amount will be used to determine the maximum recovery allowable from the Fund. Negotiators representing the Fund can be expected to push for periodic payments agreements in an effort to reduce the amounts of cash disbursements from the Fund. Patients can be expected to resist these efforts unless they can obtain agreements offering financial benefits in significant excess of what the patients can obtain through their own management of a lump sum immediate payment.

Section 2.4 authorizes the discharge of the Fund's possible liability through periodic payments agreements, notwithstanding the Act's general requirement that all claims against the Fund that become final be paid in full during one of two periods each year.<sup>36</sup> Subsection (2) of this new Code provision allows the Insurance Commissioner to combine money from the Fund with the money from the health care provider to pay the cost of the periodic payments agreement, as long as the money from the Fund does not exceed eighty percent of the total amount paid for the agreement.<sup>37</sup>

Indiana Code section 16-9.5-2-6 alters the financial responsibility of hospitals and creates a financial responsibility requirement for prepaid health care delivery plans. For hospitals of one hundred or fewer beds, the previous \$2,000,000 annual aggregate limit<sup>38</sup> was changed to a min-

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<sup>33</sup>The provisions of IND. CODE § 16-9.5-2-2 (1982) establish a maximum recovery from the Fund of four hundred thousand dollars (\$400,000). (The maximum recoverable amount is \$500,000, and the maximum recoverable amount against the health care provider is limited to \$100,000, thus the Fund's liability is limited to \$400,000.).

<sup>34</sup>IND. CODE § 16-9.5-2-2.3(a) (Supp. 1985).

<sup>35</sup>IND. CODE § 16-9.5-2-2.3(b) (Supp. 1985).

<sup>36</sup>IND. CODE § 16-9.5-2-2.4 (Supp. 1985). IND. CODE § 16-9.5-4-1(j) (Supp. 1985) and § 16-9.5-4-2 (Supp. 1985) contain specific payment rules which apply to lump sum immediate payments. For a more specific discussion, see *infra* text accompanying notes 45-57.

<sup>37</sup>IND. CODE § 16-9.5-2-2.4(2) (Supp. 1985).

<sup>38</sup>IND. CODE § 16-9.5-2-6(a)(1) (1984), amended by IND. CODE § 16-9.5-2-6 (Supp. 1985).

imum annual aggregate insurance amount.<sup>39</sup> The same change was made for the \$3,000,000 requirement for hospitals of more than one hundred beds.<sup>40</sup> For prepaid health care delivery plans,<sup>41</sup> the minimum annual aggregate insurance amount is set at \$700,000.<sup>42</sup>

#### IV. CHAPTER 3 - STATUTE OF LIMITATIONS

Indiana Code section 16-9.5-3-1, the general statute of limitations section, was amended by the addition of a subsection<sup>43</sup> which clarifies the statute of limitations applicable to patients who first file an action under the new "small claims" provisions,<sup>44</sup> but then during the pendency of the action discover their claim is worth more than \$15,000 and dismiss the action for the purpose of commencing the action through the medical review panel process. The statute of limitations under these circumstances will be discussed below in the explanation of the new "small claims" provision.<sup>45</sup>

The members of the Interim Committee on Medical Malpractice considered a proposal by some of the members to change the medical malpractice statute of limitations from an "occurrence" statute to a "discovery" statute.<sup>46</sup> Although several members of the Committee expressed philosophical and equitable preferences for a "discovery" statute, concerns expressed about difficulties in predicting future claims expense led to a Committee vote not to draft a proposed change.<sup>47</sup>

#### V. CHAPTER 4 - PATIENT'S COMPENSATION FUND

Chapter Four of the Act underwent several changes relating to the administration and solvency of the Fund. The limitation that the surcharge

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<sup>39</sup>IND. CODE § 16-9.5-2-6(1)(A)(i) (Supp. 1985).

<sup>40</sup>IND. CODE § 16-9.5-2-6(1)(A)(ii) (Supp. 1985).

<sup>41</sup>See IND. CODE § 27-8-7-1(h) (1982) which defines a "prepaid health care delivery plan" as:

an undertaking to provide, directly or through arrangements with providers, health care services to individuals voluntarily enrolled with such an organization on a per capita or a predetermined, fixed prepayment basis and includes a health maintenance organization plan. A prepaid health care delivery plan does not include payments made in advance of service to a provider for health services relating to a single operation or procedure, such as services provided before, during, or following a surgical procedure or the delivery of a child.

<sup>42</sup>IND. CODE § 16-9.5-2-6(1)(B) (Supp. 1985).

<sup>43</sup>IND. CODE § 16-9.5-3-1(b) (Supp. 1985).

<sup>44</sup>IND. CODE § 16-9.5-9-2.1 (Supp. 1985).

<sup>45</sup>See *infra* note 59 and accompanying text.

<sup>46</sup>Minutes of the Interim Committee on Medical Malpractice 5 (Sept. 14, 1985) (available in *Indiana Law Review Office*). A "discovery" statute is one whereby the statute of limitations does not begin to run until the alleged act, omission, or neglect is discovered by the claimant.

<sup>47</sup>Minutes of the Interim Committee on Medical Malpractice 5 (Sept. 14, 1985) (available in *Indiana Law Review Office*).

levied against the health care providers not exceed fifty percent of the health care provider's insurance premium was deleted from Indiana Code section 16-9.5-4-1(b). As a substitute, Indiana Code section 16-9.5-4-1.1 was added and raised the maximum surcharge to seventy-five percent of the health care provider's insurance premium. In addition, this new section granted authority to the Insurance Commissioner to institute further increases in the surcharge, up to a maximum surcharge equal to one hundred percent of the health care provider's insurance premium, at any time after January 1, 1986, when the balance in the Fund is less than \$15,000,000.<sup>48</sup> Because of a perceived fiscal emergency relating to the solvency of the Fund, authority for a surcharge increase up to the seventy-five percent maximum took effect immediately upon passage.<sup>49</sup>

Prior to the 1985 amendments to the Act, a health care provider could obtain retroactive protection of the Act for a period of up to 180 days prior to the date on which he actually met his proof of financial responsibility<sup>50</sup> and surcharge payment requirements.<sup>51</sup> Under this provision, as long as the proof of financial responsibility was filed not later than 180 days after the effective date of the policy, compliance requirements for protection under the Act were considered to have been met on the effective date of the policy.<sup>52</sup> After 180 days, compliance was deemed to have occurred on the date compliance actually occurred.<sup>53</sup> The 1985 amendments to the Act reduce this time period to ninety days.<sup>54</sup>

Indiana Code section 16-9.5-4-1(h) was amended to grant authority to the Insurance Commissioner to use money from the Fund to purchase services to aid in defending the Fund against claims.<sup>55</sup> Subsection (j) was amended to provide for payments from the Fund twice a year instead of once a year.<sup>56</sup> Under this amendment, claims against the Fund which become final between January 1 and June 30 of each year must be computed on June 30 and paid by the following July 15. Claims which have become final between July 1 and December 31 must be computed on December 31 and paid by the following January 15. If the balance in the Fund is insufficient to pay all claims due in full, all payments are prorated among the remaining unpaid claimants.<sup>57</sup> All unpaid amounts

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<sup>48</sup>Ind. Code § 16-9.5-4-1.1 (Supp. 1985).

<sup>49</sup>Pub. L. No. 178, § 7 (1985). IND. CODE § 16-9.5-4-1(e) (1982), *amended by* IND. CODE § 16-9.5-4-1 (Supp. 1985).

<sup>50</sup>This requirement is generally met by the purchase of a medical malpractice insurance policy. See IND. CODE § 16-9.5-2-1 for the specific requirements.

<sup>51</sup>See IND. CODE § 16-9.5-2-1 (1982) for the requirements.

<sup>52</sup>IND. CODE § 16-9.5-4-1(e) (1982), *amended by* IND. CODE § 16-9.5-4-1 (Supp. 1985).

<sup>53</sup>*Id.*

<sup>54</sup>IND. CODE § 16-9.5-4-1(e) (Supp. 1985).

<sup>55</sup>IND. CODE § 16-9.5-4-1(h) (Supp. 1985).

<sup>56</sup>IND. CODE § 16-9.5-4-1(j) (Supp. 1985).

<sup>57</sup>*Id.*

from one pay period are carried over to the next pay period and are paid before any new final claims are paid.<sup>58</sup> Indiana Code section 16-9.5-4-2 was amended to direct the issuance of warrants by the Indiana State Auditor in the amount of each claim made final by the two computation dates established in Indiana Code 16-9.5-4-1(j).

Indiana Code section 16-9.5-4-4 was added to authorize the Fund to discharge its liability to a patient in one of four ways. The Fund may: (1) make an immediate lump sum payment of the total amount due; (2) enter into an agreement requiring periodic payments from the Fund; (3) purchase an annuity payable to the patient; or (4) any combination of the above.<sup>59</sup> This new section also gives the Insurance Commissioner the authority to contract with approved insurance companies to insure the Fund's ability to meet any periodic payment obligations it assumes. The Insurance Commissioner, unlike the health care provider, thus appears to be able to enter into periodic payments agreements without the obligation to purchase an annuity from a third party. The apparent conflict between this section and Indiana Code section 16-9.5-2-2.1 is unaddressed in the 1985 Amendments.<sup>60</sup>

#### VI. CHAPTER 6 - REPORTING AND REVIEW OF CLAIMS

Indiana Code section 16-9.5-6-1 was amended to add a reserve notification requirement to the pre-existing requirement that the plaintiff's attorney notify the Insurance Commissioner of all claim settlements or judgments within sixty (60) days following final disposition of the claim.<sup>61</sup> Under the new reporting requirement, the health care provider's insurer must immediately notify the Insurance Commissioner whenever the insurer establishes a claim reserve of \$50,000 or more on any malpractice case.<sup>62</sup> The "notice" and contents of these reports are confidential.<sup>63</sup>

#### VII. CHAPTER 9 - MEDICAL REVIEW PANEL

Perhaps the most significant legislative changes in the Act are those relating to the medical review panel. Several changes affect panel composition and procedures. Two separate sections provide, for the first time, procedural mechanisms for bypassing panel review in claims against qualified health care providers.

A new subsection has been added to Indiana Code section 16-9.5-9-2, which previously required that any claim against qualified health

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<sup>58</sup>*Id.*

<sup>59</sup>IND. CODE § 16-9.5-4-4 (Supp. 1985).

<sup>60</sup>*See supra* note 21 and accompanying text.

<sup>61</sup>IND. CODE § 16-9.5-6-1(b) (Supp. 1985).

<sup>62</sup>IND. CODE § 16-9.5-6-1(a) (Supp. 1985).

<sup>63</sup>*Id.*

care provides be presented to a medical review panel, and that an opinion be rendered by that panel before the claim could be filed in any court. The new subsection further provides that

(b) [a] claimant may commence an action in court for malpractice without the presentation of the claim to a medical review panel if the claimant and all parties named as defendants in the action agree that the claim is not to be presented to a medical review panel. The agreement must be in writing and must be signed by each party or an authorized agent of the party. The claimant must attach a copy of the agreement to the complaint filed with the court in which the action is commenced.<sup>64</sup>

A second avenue allowing commencement of court action against a health care provider without obtaining prior panel review has been created by new section 2.1, which allows for direct court filing against a qualified health care provider without prior panel review if the patient seeks damages of no more than \$15,000 and so states in the complaint. A patient who files directly in a court under this provision is barred from recovering any more than \$15,000 unless the patient

(1) commences an action under subsection (a) in the reasonable belief that damages in an amount equal to or less than fifteen thousand dollars (\$15,000) are adequate compensation for the bodily injury allegedly caused by the health care provider's malpractice; and

(2) later learns, during pendency of the action, that the bodily injury is more serious than previously believed and that the fifteen thousand dollars (\$15,000) is insufficient compensation for the bodily injury . . . .<sup>65</sup>

The use of the term "bodily injury" in this escape clause creates a significant ambiguity. Does subsection (b)(1) mean that the threshold damages amount in the escape clause or, perhaps, even the entire section, refers only to "bodily injury," as distinguished from economic injury such as lost wages, or does it refer more generally to all recognized consequences of a bodily injury? Does subsection (b)(2) mean that the consequences of bodily injury itself must be more serious than previously believed, or that the consequences of bodily injury, of whatever nature, must be more serious than previously believed?<sup>66</sup>

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<sup>64</sup>IND. CODE § 16-9.5-9-2(b) (Supp. 1985). The author's discussions of this provision with numerous attorneys familiar with medical malpractice litigation have revealed the nearly universally held opinion that it is highly unlikely that an Indiana health care provider (or its insurer) would ever agree to waive the medical panel review.

<sup>65</sup>IND. CODE § 16-9.5-9-2.1(b) (Supp. 1985).

<sup>66</sup>The minutes of the hearings before the Interim Committee on Medical Malpractice

If a patient files a "small claims" action under Indiana Code section 16-9.5-9-2.1(a) and then wishes to "escape" under subsection (b), the patient may file a motion to dismiss without prejudice and, if granted, may file a proposed complaint under Indiana Code section 16-9.5-9-1 and proceed through the panel review process.<sup>67</sup> After the panel opinion is rendered, the patient may proceed with an action in court without being subject to the \$15,000 limitation.<sup>68</sup> If a patient moves for a dismissal without prejudice, obtains it, and later wishes to refile under subsection (a) of this "small claims" section, the patient may do so only if the motion for dismissal was filed within two years after the original filing under subsection (a).<sup>69</sup> For a patient who files in court under this "small claims" provision, then "escapes" under subsection (b), proceeds through medical review panel review, and eventually refiles his action in court, the statute of limitations determining timeliness of the second court filing is two years and 180 days from the date of the alleged act, omission, or neglect.<sup>70</sup>

Indiana Code section 16-9.5-9-3(b)(1), which partially controls the selection of the health care provider panel members, has also been significantly revised. Previously, if there was only one party defendant, *other than a hospital*, two of the three panel members had to be of the same class of health care provider as the defendant.<sup>71</sup> In apparent recognition of the fact that the Act covers types of non-individual health care providers other than hospitals, the legislature deleted the "other than a hospital" language and provided that where there is only one party defendant "*who is an individual*," then two of the panelists must be of the same class of health care provider as the defendant.<sup>72</sup> However, aware of ambiguities in the concept of "class" of health care provider, the legislature virtually rewrote the part of this provision setting forth the classification requirements of panel members.<sup>73</sup> Unfortunately, the legislature may have substituted one ambiguity for another. This provision now reads:

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contain no indication that this provision was intended to embody the narrower interpretation. However, the ambiguity remains as a potential procedural trap for the patient who files directly in court under IND. CODE § 16-9.5-9-2.1(a) and then attempts to exercise the escape clause of IND. CODE § 16-9.5-9-2.1(b).

<sup>67</sup>IND. CODE § 16-9.5-9-2.1(b) (Supp. 1985).

<sup>68</sup>*Id.*

<sup>69</sup>*Id.*

<sup>70</sup>IND. CODE § 16-9.5-9-2.1(c) (Supp. 1985) (citing IND. CODE § 16-9.5-3-1(b), the two-year limitations statute).

<sup>71</sup>IND. CODE § 16-9.5-9-3(b)(1) (1982), *amended by* IND. CODE § 16-9.5-9-3-3 (Supp. 1985).

<sup>72</sup>IND. CODE § 16-9.5-9-3(b)(1) (Supp. 1985) (emphasis added).

<sup>73</sup>*See* IND. CODE § 16-9.5-9-3(b)(1) (Supp. 1985). The earlier version of this statute stated only that "two [2] of the panelists selected shall be from *the same class of health care provider as the defendant.*" IND. CODE § 16-9.5-9-3, *amended by* IND. CODE § 16-9.5-9-3 (Supp. 1985) (emphasis added).

If there is only one (1) party defendant who is an individual, two (2) of the panelists selected must be members of the profession identified in IC 16-9.5-1-1(a)(1) of which the defendant is a member, and if the individual defendant is a health care professional who specializes in a limited area, two (2) of the panelists selected must be health care professionals who specialize in the same area as the defendant.<sup>74</sup>

Left unanswered is who or what determines whether a health care professional specializes in a limited area. Must the health care professional be board certified, board eligible, or merely concentrate his practice in a given area? Is the health care provider's "specialization" in a given area to be judged by an objective standard and, if so, by whom, or is holding oneself out to the public as a "specialist" sufficient? This new language therefore appears to hold the same potential for controversy as did the previous language.

Amended section four contains several additions that address panel procedural issues. The panel chairman must now "ensure" that each panel member has had the opportunity to review every item of evidence before the panel renders its opinion.<sup>75</sup> Each panel member must take an oath in writing before considering any evidence or deliberating with other panel members.<sup>76</sup> Neither a party, nor a party's agent, attorney or insurer, may communicate "except as authorized by law," with a panel member before the panel has rendered its opinion.<sup>77</sup>

Indiana Code section 16-9.5-9-10, which controls compensation and fees of the panel members, was amended to change the compensation of health care provider panel members from twenty-five dollars per day to "up to \$250" for all work performed as a panel member, exclusive of witness fees if called to testify.<sup>78</sup> Compensation of the panel chairman was raised from \$100 per day to \$200 per day, not to exceed a total of \$1,000, increased from a previous total of \$500.<sup>79</sup>

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<sup>74</sup>IND. CODE § 16-9.5-9-3(b)(1) (Supp. 1985).

<sup>75</sup>IND. CODE § 16-9.5-9-4(a) (Supp. 1985). The prior version of the Code section contained no similar requirement.

<sup>76</sup>IND. CODE § 16-9.5-9-4(b) (Supp. 1985). The precise language of the required oath is quoted in the subsection.

<sup>77</sup>IND. CODE § 16-9.5-9-4(b) (Supp. 1985). This subsection does not specify what communication with panel members is "authorized by law," however, other Code sections seem to provide some guidance on this issue. IND. CODE § 16-9.5-9-4(a) (Supp. 1985) provides for submission of written evidence to the panel, including, "any . . . form of evidence allowable by the medical review panel." General panel practice has been to allow submission of a wide range of "evidence," including such items as briefs, letters, and settlement brochures. IND. CODE § 16-9.5-9-5 (1982) authorizes questioning of panel members by the parties at an informal hearing.

<sup>78</sup>IND. CODE § 16-9.5-9-10(a) (Supp. 1985).

<sup>79</sup>IND. CODE § 16-9.5-9-10(b) (Supp. 1985).

### VIII. COMPARATIVE FAULT

Indiana Code section 34-4-33-1, which controls the applicability of the Indiana Comparative Fault Act,<sup>80</sup> was amended to provide that the Comparative Fault Act "does not apply to an action brought against a qualified health care provider under IC 16-9.5 for medical malpractice."<sup>81</sup> Medical malpractice claims thus join the ever increasing list of claims exempted from the new Comparative Fault Act.<sup>82</sup>

### IX. EDITORIAL COMMENTS

The 1985 Amendments to the Indiana Medical Malpractice Act have solved some old problems, created some new ones, and ignored others. If there are prevailing themes to be found in the 1985 Amendments, they are found in efforts to bolster the sagging fiscal fortunes of the Patient's Compensation Fund and to avoid controversial issues. The amendments provide for an increase in both the surcharge levied against the health care providers and the rate at which further increases can occur. The effect is a potential doubling of the surcharge over the second half of 1985. Greater emphasis has been placed on encouraging structured settlements of both the health care provider's primary liability and the liability of the Fund. However, measures to encourage patients to accept structured settlements on the health care provider's liability may expose the Fund to easier and more frequent access by plaintiffs. Once again, the legislature has chosen to leave the maximum liability of both the health care provider and the Fund at the 1975 levels of \$100,000 and \$400,000, respectively, apparently feeling that structuring of settlements provides patients with a reasonable alternative to higher potential recovery. In addition, the legislature has provided the Insurance Commissioner with additional resources with which to defend the Fund.

Provisions addressing the adequacy of the current recovery limit, structured settlements notwithstanding, the problems with procedural delays, and the nature of the relationship between the primary carrier and the Fund are conspicuous by their absence. Even more important, neither the new amendments nor the minutes of the meetings of the Interim Study Committee on Medical Malpractice reflect an attempt to reevaluate either the policy assumptions that led to the passage of the Act in 1975 or the efficacy of the Act in dealing with the increasing problem of medical malpractice.

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<sup>80</sup>IND. CODE §§ 34-4-33-1 to -13 (Supp. 1985).

<sup>81</sup>IND. CODE § 34-4-33-1(a) (Supp. 1985).

<sup>82</sup>IND. CODE § 34-4-33-8 (Supp. 1985), provides that the Comparative Fault Act does not apply to tort claims against governmental entities or public employees. IND. CODE § 34-4-33-13 (Supp. 1985) provides that the Comparative Fault Act does not apply to strict liability actions under IND. CODE § 33-1-1.5 (the Indiana Product Liability Act) or to breach of warranty actions.

