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A. Indiana Compensation Act for Patients; A History of the Medical Liability Issue. This "White Paper" by the Indiana State Medical Ass'n contains a summary of Indiana's Malpractice Act, as well as a history of the problems which resulted in passage of malpractice reform.

B. Indiana Code 16-9.5 et seq. Indiana's Medical Malpractice Act.

C. Controlling Large Malpractice Claims: The Unexpected Impact of Damage Caps; William P. Gronfein and Eleanor DeArman Kinney; Journal of Health Politics, Policy and Law, Vol. 16, Fall 1991.

D. Indiana's Malpractice System: No-Fault by Accident?; Gronfein and Kinney; Law and Contemporary Problems; Vol 54, Winter 1991.

E. Lessons for Tort Reform from Indiana; Randall Bovbjerg; Journal of Health Politics, Policy and Law; Vol. 16, Fall 1991.

F. Newspaper clippings; various dates; Indiana's Medical Malpractice Act.

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Indiana Compensation Act for Patients (INCAP)

A History of the
Medical Liability Issue

16-9-5-1 Statutes and administrative rules and regulations

Sec. 1. The term "learning disability" when used in any statute, unless otherwise defined, or any administrative rule or regulation adopted within this state, shall mean a child who exhibits severe specific defects in perceptual, integrative or expressive processes which severely impair learning efficiency. Learning disabilities include conditions which have been referred to as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia and developmental asphasia and may be manifested in disorders of listening, thinking, talking, reading, writing, spelling or arithmetic. They do not include learning problems which are due primarily to visual, hearing, or motor handicaps, to mental retardation, emotional disturbance, or to environmental disadvantages. Children enrolled in programs for the learning disabled shall be those who are chronic failures in the regular classroom setting and are seriously deficient in educational skills. *As added by Acts 1979, P.L.130, SEC.22.*

ARTICLE 9.5. MEDICAL MALPRACTICE

Chapter 1. Definitions, General Applications, Pleadings, and Right of Jury Trial

16-9.5-1-1 Definitions

Sec. 1. As used in this article:

(a) "Health care provider" means:

(1) an 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, health facility, dentist, registered or licensed practical nurse, midwife, optometrist, podiatrist, chiropractor, physical therapist, or psychologist, or as an officer, employee, or agent thereof acting in the course and scope of his employment;

(2) any college, university, or junior college which provides health care to any student, faculty member, or employee, and the governing board or any officer, employee, or agent thereof acting in the course and scope of his employment;

(3) a blood bank, community mental health center, community mental retardation center, community health center, or migrant health center;

(4) a home health agency, as defined under IC 16-10-2.5-1;

(5) a prepaid health care delivery plan, as defined in IC 27-8-7-1(h);

(b) An operator of a bed and breakfast establishment may assume liability in excess of two hundred fifty dollars ($250) for each guest for loss of personal property if the guest and operator:

(1) itemize the personal property and the personal property's value; and

(2) agree in writing to the kind and extent of the liability.

As added by P.L.120-1990, SEC.3.

Chapter 7. Clinical Laboratories

16-9-7-1 State department of health; powers and duties

Sec. 1. (a) The state department of health is the designated state agency to accept delegation from the federal Department of Health and Human Services to carry out the purposes of the Clinical Laboratory Improvement Amendments of 1988 (P.L.100-578).

(b) The state department of health is the designated state agency to adopt rules under IC 4-22-2 to carry out the purposes of the Clinical Laboratory Improvement Amendments of 1988 (P.L.100-578). *As added by P.L.40-1989, SEC.40. Amended by P.L.2-1992, SEC.616.*

ARTICLE 9.5. MEDICAL MALPRACTICE

Chapter 1. Definitions, General Applications, Pleadings, and Right of Jury Trial

16-9.5-1-1 Definitions

Sec. 1. As used in this article:

(a) "Health care provider" means:

(1) an individual, a partnership, a corporation, a professional corporation, a facility, or an institution licensed or legally authorized by this state to provide health care or professional services as a physician, psychiatric hospital, hospital, health facility, emergency ambulance service (IC 16-1-39-2), dentist, registered or licensed practical nurse, midwife, optometrist, podiatrist, chiropractor, physical therapist, respiratory care practitioner, occupational therapist, psychologist, paramedic, emergency medical technician, or advanced emergency medical technician, or a person who is an officer, employee, or agent of the individual, partnership, corporation, professional corporation, facility, or institution acting in the course and scope of the person's employment;

(2) a college, university, or junior college that provides health care to a student, faculty member, or employee, and the governing board or a person who is an officer, employee, or agent of the college, university, or junior college acting in the course and scope of the person's employment;

(3) a blood bank, community mental health center, community mental retardation center, community health center, or migrant health center;

(4) a home health agency (as defined in IC 16-10-2.2-4);

(5) a prepaid health care delivery plan (as defined in IC 27-8-7-1);

(6) a health care organization whose members, shareholders, or partners are health care providers under subdivision (1); and

(7) a corporation, partnership, or professional corporation not otherwise qualified under this subsection that:

(A) as one (1) of its functions, provides health care;

(B) is organized or registered under state law; and

(C) is determined to be eligible for coverage as a health care provider under this chapter for its health care function.

Coverage for a health care provider qualified under this subdivision is limited to its health care functions and does not extend to other causes of action.

(b) "Physician" means an individual with an unlimited license to practice medicine under IC 25-22.5.

(c) "Patient" means an individual who receives or should have received health care from a health care provider, under a contract, express or implied, and includes a person having a claim of any kind, whether derivative or otherwise, as a result of alleged malpractice on the part of a health care provider. Derivative claims include, but are not limited to, the claim of a parent or parents, guardian, trustee, child, relative, attorney, or any other representative of the patient including claims for loss of services, loss of consortium, expenses, and other similar claims.

(d) "Hospital" means a public or private institution licensed under IC 16-10-1.

(e) "Commissioner" means the commissioner of insurance.

(f) "Representative" means the spouse, parent, guardian, trustee, attorney, or other legal agent of the patient.

(g) "Tort" means a legal wrong, breach of duty, or negligent or unlawful act or omission proximately causing injury or damage to another.

(h) "Malpractice" means a tort or breach of contract based on health care or professional services rendered, or which should have been rendered, by a health care provider, to a patient.

(i) "Health care" means an act or treatment performed or furnished, or which should have been performed or furnished, by a health care provider for, to, or on behalf of a patient during the patient's medical care, treatment, or confinement.

(j) "Risk manager" means an insurance company admitted to make insurance and actively engaged in making in this state Class 2 insurance pursuant to IC 27-1-5-1, which company is appointed by the commissioner to manage the authority.

(k) "Risk" means a health care provider that must apply for malpractice liability insurance coverage under IC 16-9.5-8.

(l) "Insurer" means the authority or an insurance company engaged on an admitted or nonadmitted basis in making in this state Class 2(h) malpractice liability insurance pursuant to IC 27-1-5-1.

(m) "Authority" means the residual malpractice insurance authority established under IC 16-9.5-8.

(n) "Psychiatric hospital" means a private institution licensed under IC 12-25 and public institutions under the administrative control of the director of a division as designated by IC 12-24-1-1, IC 12-24-1-2, or IC 12-24-1-3.

(o) "Community mental health center" means a public or private mental health center established pursuant to IC 12-29.

(p) "Community mental retardation center" means a public or private community mental

retardation and other developmental disabilities center established pursuant to IC 12-29.

(q) "Community health center" means a provider of primary health care organized as a nonprofit corporation under IC 23-7-1.1 (before its repeal on August 1, 1991) or IC 23-17 and governed by a board of directors, at least fifty-one percent (51%) of whom are representatives of consumers.

(r) "Migrant health center" means a provider of primary health care organized as a nonprofit corporation under IC 23-7-1.1 (before its repeal on August 1, 1991) or IC 23-17 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.

(s) "College, university, or junior college" means an institution for postsecondary school education accredited by the North Central Association.

(t) "Annual aggregate" means the limitation on a health care provider's liability as provided in IC 16-9.5-2-6.

(u) "Midwife" means a registered nurse who holds a limited license to practice midwifery under IC 25-22.5-5-5.

(v) "Health facility" means a facility licensed under IC 16-10-4.

(w) "Ambulance service" means a person who employs emergency medical technicians, advanced emergency medical technicians, or paramedics.

(x) "Paramedic" has the meaning set forth in IC 16-1-40-1, but does not include such a person while operating an emergency vehicle.

(y) "Emergency medical technician" has the meaning set forth in IC 16-1-39-2 but does not include such a person while operating an emergency vehicle.

(z) "Advanced emergency medical technician" has the meaning set forth in IC 16-1-40-1 but does not include such a person while operating an emergency vehicle. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1976, P.L.65, SEC.1; Acts 1979, P.L.152, SEC.1; Acts 1982, P.L.120, SEC.1; P.L.105-1984, SEC.1; P.L.177-1985, SEC.1; P.L.28-1985, SEC.19; P.L.133-1986, SEC.1; P.L.206-1987, SEC.1; P.L.242-1989, SEC.2; P.L.238-1989, SEC.2; P.L.150-1991, SEC.1; P.L.179-1991, SEC.18; P.L.2-1992, SEC.617.*

16-9.5-1-5 Health care providers; application of law

Sec. 5. A health care provider who fails to qualify under this article is not covered by the provisions of this article and is subject to liability under the law without regard to the provisions of this article. If a health care provider does not so qualify, the patient's remedy will not be affected by the terms and provisions of this article. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by P.L.1-1991, SEC.124.*

Chapter 2. Limitation of Recovery

16-9.5-2-2 Limitations on recovery

Sec. 2. (a) The total amount recoverable for any injury or death of a patient may not exceed five hundred thousand dollars ($500,000) except, that as to an act of malpractice that occurs on or after January 1, 1990, the total amount recovered for any injury or death may not exceed seven hundred fifty thousand dollars ($750,000).

(b) A health care provider qualified under this article is not liable for an amount in excess of one hundred thousand dollars ($100,000) for an occurrence of malpractice.

(c) Any amount due from a judgment or settlement which is in excess of the total liability of all liable health care providers, subject to subsections (a), (b), and (d) shall be paid from

(p) "Community mental retardation center" means any public or private community mental retardation and other developmental disabilities center established pursuant to IC 16-16-1.

(q) "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.

(r) "Migrant health center" means a provider of primary health care organized as a not-for-profit corporation under IC 23-7-1.1 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.

(s) "College, university, or junior college" means any institution for post secondary school education accredited by the North Central Association.

(t) "Annual aggregate" means the limitation on a health care provider's liability as provided in IC 16-9.5-2-6.

(u) "Midwife" means a registered nurse who holds a limited license to practice midwifery under IC 25-22.5-5-5.

(v) "Health facility" means a facility licensed under IC 16-10-4. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1976, P.L.65, SEC.1; Acts 1979, P.L.152, SEC.1; Acts 1982, P.L.120, SEC.1; P.L.105-1984, SEC.1; P.L.177-1985, SEC.1; P.L.28-1985, SEC.19; P.L.133-1986, SEC.1; P.L.206-1987, SEC.1.*

16-9.5-1-2 Terms; gender and number

Sec. 2. Wherever necessary to the context of this article the masculine shall mean and include the feminine and the singular shall mean and include the plural. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-1-3 Construction of certain terms

Sec. 3. Any legal term or word of art used in this article, not otherwise defined, shall have such meaning as is consistent with the common law. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-1-4 Liability based on contract; consent of patient; requirements; withdrawal; exceptions

Sec. 4. (a) No liability shall be imposed on a health care provider on the basis of an alleged breach of contract, express or implied, assuring results to be obtained from any procedure undertaken in the course of health care, unless that contract is in writing and signed by that health care provider or by an authorized agent of that health care provider.

(b) If a patient's written consent is:

(1) signed by the patient or the patient's authorized representative;

(2) witnessed by an individual at least eighteen (18) years of age; and

(3) explained, orally or in the written consent, to the patient or the patient's authorized representative before a treatment, procedure, examination, or test is undertaken;

a rebuttable presumption is created that the consent is an informed consent.

(c) The explanation given in accordance with subsection (b)(3) must include the following information:

(1) The general nature of the patient's condition.

(2) The proposed treatment, procedure, examination, or test.

(3) The expected outcome of the treatment, procedure, examination, or test.

(4) The material risks of the treatment, procedure, examination, or test.

(5) The reasonable alternatives to the treatment, procedure, examination, or test.

(d) This section does not relieve a qualified health care provider of the duty to obtain an informed consent.

(e) This section does not prevent a patient, after having signed a consent, from withdrawing that consent.

(f) This section does not require that a patient's consent or the information described under subsection (c) be in writing in all cases.

(g) Compliance with this section is not required in order to create an informed consent.

(h) A patient may refuse to receive some or all of the information described in subsection (c).

(i) Subsections (b) and (c) do not apply to a person who is mentally incapable of understanding the information required to be provided by subsection (c). This subsection does not require consent to health care in an emergency. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by P.L.207-1987, SEC.1.*

16-9.5-1-5 Health care providers; application of law

Sec. 5. A health care provider who fails to qualify under this article is not covered by the provisions of this article and is subject to liability under the law without regard to the provisions of this article. If a health care provider does not so qualify, the patient's remedy will not be affected by the terms and provisions of this article. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by P.L.1-1991, SEC.124.*

16-9.5-1-6 Pleadings; right of jury trial

Sec. 6. Subject to IC 16-9.5-9, a patient or his representative having a claim under this article for bodily injury or death on account of malpractice may file a complaint in any court of law having requisite jurisdiction and demand right of trial by jury. Except for the declaration called for in IC 16-9.5-9-2.1(a), no dollar amount or figure shall be included in the demand in any malpractice complaint, but the prayer shall be for such damages as are reasonable in the premises. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by P.L.178-1985, SEC.1.*

16-9.5-1-7 Prospective application

Sec. 7. The provisions of this article do not apply to any act of malpractice which occurred before July 1, 1975. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-1-8 Repealed

(Repealed, as added by Acts 1976, P.L.65, SEC.2, and as added by P.L.177-1985, SEC.2, by P.L.19-1986, SEC.31).

16-9.5-1-9 Malpractice claims against governmental entity or its employer; article to govern

Sec. 9. A claim based on an occurrence of malpractice against a governmental entity or an employee of a governmental entity, as those terms are defined in IC 34-4-16.5, shall be governed exclusively by this article if the governmental entity or employee is qualified under this article. *As added by P.L.19-1986, SEC.32.*

16-9.5-1-10 Exemption from IC 4-13.4

Sec. 10. The following are exempt from IC 4-13.4:

(1) Technical contractual personnel and services retained by the commissioner for protecting and administering the fund.

(2) Purchasing of annuities for structuring settlements from the fund or in combination with the fund and the health care provider's insurer.

As added by P.L.19-1986, SEC.33.

Chapter 2. Limitation of Recovery

16-9.5-2-1 Qualification of health care provider or insurance carrier

Sec. 1. (a) To be qualified under the provisions of this article, a health care provider or his insurance carrier shall:

(1) cause to be filed with the commissioner proof of financial responsibility as provided by section 6 of this chapter; and

(2) pay the surcharge assessed on all health care providers under IC 16-9.5-4-1.

(b) The officers, agents or employees of a health care provider, while acting in the course and scope of their employment may be qualified under the provisions of this article if they are individually named, or are members of a named class, in the proof of financial responsibility filed by the health care provider under section 6 of this chapter and if the surcharge assessed under IC 16-9.5-4-1 is paid.

(c) Within five (5) business days of receipt of the information required for qualification of a health care provider, the commissioner shall notify the health care provider:

(1) whether the provider is qualified; and

(2) if the provider is qualified, the date the provider becomes qualified.

(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1976, P.L.65, SEC.3; Acts 1977, P.L.187, SEC.2; P.L.207-1987, SEC.2.

16-9.5-2-2 Limitations on recovery

Sec. 2. (a) The total amount recoverable for any injury or death of a patient may not exceed five hundred thousand dollars ($500,000).

(b) A health care provider qualified under this article is not liable for an amount in excess of one hundred thousand dollars ($100,000) for an occurrence of malpractice.

(c) Any amount due from a judgment or settlement which is in excess of the total liability of all liable health care providers, subject to subsections (a) and (b), and (d) shall be paid from the patient's compensation fund pursuant to the provisions of IC 16-9.5-4-3.

(d) In the event a health care provider qualified under this article admits liability or is adjudicated liable solely by reason of the conduct of another health care provider who is an officer, agent or employee of the health care provider acting in the course and scope of his employment and qualified under this chapter, the total amount which shall be paid to the claimant on behalf of the officer, agent or employee and the health care provider by such health care provider or its insurer shall be one hundred thousand dollars ($100,000) and the balance of any adjudicated sum to which the claimant is entitled, if any, shall be paid by other liable health care providers and/or the patient's compensation fund. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1976, P.L.65, SEC.4; Acts 1977, P.L.187, SEC.9.*

16-9.5-2-2.1 Definitions

Sec. 2.1. (a) As used in this chapter, "periodic payments agreement" means a contract between a health care provider (or its insurer)

retardation and other developmental disabilities center established pursuant to IC 12-29.

(q) "Community health center" means a provider of primary health care organized as a nonprofit corporation under IC 23-7-1.1 (before its repeal on August 1, 1991) or IC 23-17 and governed by a board of directors, at least fifty-one percent (51%) of whom are representatives of consumers.

(r) "Migrant health center" means a provider of primary health care organized as a nonprofit corporation under IC 23-7-1.1 (before its repeal on August 1, 1991) or IC 23-17 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.

(s) "College, university, or junior college" means an institution for postsecondary school education accredited by the North Central Association.

(t) "Annual aggregate" means the limitation on a health care provider's liability as provided in IC 16-9.5-2-6.

(u) "Midwife" means a registered nurse who holds a limited license to practice midwifery under IC 25-22.5-5-5.

(v) "Health facility" means a facility licensed under IC 16-10-4.

(w) "Ambulance service" means a person who employs emergency medical technicians, advanced emergency medical technicians, or paramedics.

(x) "Paramedic" has the meaning set forth in IC 16-1-40-1, but does not include such a person while operating an emergency vehicle.

(y) "Emergency medical technician" has the meaning set forth in IC 16-1-39-2 but does not include such a person while operating an emergency vehicle.

(z) "Advanced emergency medical technician" has the meaning set forth in IC 16-1-40-1 but does not include such a person while operating an emergency vehicle. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1976, P.L.65, SEC.1; Acts 1979, P.L.152, SEC.1; Acts 1982, P.L.120, SEC.1; P.L.105-1984, SEC.1; P.L.177-1985, SEC.1; P.L.28-1985, SEC.19; P.L.133-1986, SEC.1; P.L.206-1987, SEC.1; P.L.242-1989, SEC.2; P.L.238-1989, SEC.2; P.L.150-1991, SEC.1; P.L.179-1991, SEC.18; P.L.2-1992, SEC.617.*

16-9.5-1-5 Health care providers; application of law

Sec. 5. A health care provider who fails to qualify under this article is not covered by the provisions of this article and is subject to liability under the law without regard to the provisions of this article. If a health care provider does not so qualify, the patient's remedy will not be affected by the terms and provisions of this article. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by P.L.1-1991, SEC.124.*

Chapter 2. Limitation of Recovery

16-9.5-2-2 Limitations on recovery

Sec. 2. (a) The total amount recoverable for any injury or death of a patient may not exceed five hundred thousand dollars ($500,000) except, that as to an act of malpractice that occurs on or after January 1, 1990, the total amount recovered for any injury or death may not exceed seven hundred fifty thousand dollars ($750,000).

(b) A health care provider qualified under this article is not liable for an amount in excess of one hundred thousand dollars ($100,000) for an occurrence of malpractice.

(c) Any amount due from a judgment or settlement which is in excess of the total liability of all liable health care providers, subject to subsections (a), (b), and (d) shall be paid from

the patient's compensation fund under IC 16-9.5-4-3.

(d) If a health care provider qualified under this article admits liability or is adjudicated liable solely by reason of the conduct of another health care provider who is an officer, agent, or employee of the health care provider acting in the course and scope of employment and qualified under this chapter, the total amount that shall be paid to the claimant on behalf of the officer, agent, or employee and the health care provider by such health care provider or its insurer shall be one hundred thousand dollars ($100,000). The balance of any adjudicated sum to which the claimant is entitled shall be paid by other liable health care providers or the patient's compensation fund, or both. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1976, P.L.65, SEC.4; Acts 1977, P.L.187, SEC.9; P.L.189-1989, SEC.1.*

16-9.5-2-6 Financial responsibility; establishment

Sec. 6. (a) Financial responsibility of a health care provider and its officers, agents, and employees while acting in the course and scope of their employment with the health care provider under this chapter may be established:

(1) by the health care provider's insurance carrier filing with the commissioner proof that the health care provider is insured by a policy of malpractice liability insurance in the amount of at least one hundred thousand dollars ($100,000) per occurrence and three hundred thousand dollars ($300,000) in the annual aggregate, except that:

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

(i) for hospitals of one hundred (100) beds or less, two million dollars ($2,000,000); and

(ii) for hospitals of more than one hundred (100) beds, three million dollars ($3,000,000);

(B) if the health care provider is a prepaid health care delivery plan as defined in IC 27-8-7-1, the minimum annual aggregate insurance amount is seven hundred thousand dollars ($700,000); and

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

(i) for health facilities with one hundred (100) beds or less, three hundred thousand dollars ($300,000); and

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

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

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

(A) For hospitals of one hundred (100) beds or less, two million dollars ($2,000,000).

(B) For hospitals of more than one hundred (100) beds, three million dollars ($3,000,000).

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.

(b) As used in this chapter, "the cost of the periodic payments agreement" means the amount expended by the health care provider (or its insurer), the commissioner, or the commissioner and the health care provider (or its insurer), at the time the periodic payments agreement is made, to obtain the commitment from a third party to make available money for use as future payment, the total of which may exceed the limits provided in IC 16-9.5-2-2. *As added by P.L.179-1985, SEC.1.*

16-9.5-2-2.2 Discharge of possible liability through immediate payment, periodic payments; contributions by other health care providers

Sec. 2.2. (a) In a case in which the possible liability of the health care provider to the patient is discharged solely through an immediate payment, the limitations on recovery from a health care provider stated in sections 2(b) and 2(d) of this chapter apply without adjustment.

(b) In a case in which the health care provider agrees to discharge its possible liability to the patient through a periodic payments agreement, the amount of the patient's recovery from a health care provider in a case under this subsection is the amount of any immediate payment made by the health care provider or the health care provider's insurer to the patient, plus the cost of the periodic payments agreement to the health care provider or the health care provider's insurer. For the purpose of determining the limitations on recovery stated in sections 2(b) and 2(d) of this chapter and for the purpose of determining the question under IC 16-9.5-4-3 of whether the health care provider or the health care provider's insurer has agreed to settle its liability by payment of its policy limits, the sum of the present payment of money to the patient (or the patient's estate) by the health care provider (or the health care provider's insurer) plus the cost of the periodic payments agreement expended by the health care provider (or the health care provider's insurer) must exceed seventy-five thousand dollars ($75,000).

(c) More than one (1) health care provider may contribute to the cost of a periodic payments agreement, and in such instance the sum of the amounts expended by each such health care provider for immediate payments and for the cost of the periodic payments agreement shall be used to determine whether or not the seventy-five thousand dollar ($75,000) requirement in section 2.2(b) of this chapter has been satisfied; however, one (1) health care provider or its insurer must be liable for at least fifty thousand dollars ($50,000). *As added by P.L.179-1985, SEC.2.*

16-9.5-2-2.3 Patient's compensation fund; discharge through direct payment, periodic payments

Sec. 2.3. (a) In a case in which the possible liability of the fund to the patient is discharged solely through a direct payment made under IC 16-9.5-4-3, the limitations on recovery from the patient's compensation fund established under section 2 of this chapter apply without adjustment.

(b) In a case in which an agreement is made to discharge the fund's possible liability to the patient through a periodic payments agreement, the amount of the patient's recovery from the fund is:

(1) the amount of any immediate payment made directly to the patient from the fund; plus

(2) the cost of the periodic payments agreement paid by the insurance commissioner on behalf of the fund;

for the purposes of the limitations on recovery from the fund established under section 2 of this chapter. *As added by P.L.179-1985, SEC.3.*

16-9.5-2-2.4 Patient's compensation fund; commissioner's authority to discharge possible liability

Sec. 2.4. Notwithstanding IC 16-9.5-4-1 and IC 16-9.5-4-2, the commissioner may:

(1) discharge the possible liability of the patient's compensation fund to a patient through a periodic payments agreement as defined in section 2.1(a) of this chapter; and

(2) combine money from the fund with money of the health care provider (or its insurer) to pay the cost of the periodic payments agreement with the patient (or the patient's estate), but in no event shall the amount provided by the commissioner exceed eighty percent (80%) of the total amount expended for such agreement.

As added by P.L.179-1985, SEC.4.

16-9.5-2-3 Advance payments not admission of liability

Sec. 3. Except as provided in chapter 4, section 3, any advance payment made by the defendant health care provider or his insurer to or for the plaintiff, or any other person, may not be construed as an admission of liability for injuries or damages suffered by the plaintiff or anyone else in an action brought for medical malpractice. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-2-4 Evidence of advance payment inadmissible; reduction of judgment

Sec. 4. Evidence of an advance payment is not admissible until there is a final judgment in favor of the plaintiff, in which event the court shall reduce the judgment to the plaintiff to the extent of the advance payment. The advance payment shall inure to the exclusive benefit of the defendant or his insurer making the payment. In the event the advance payment exceeds the liability of the defendant or the insurer making it, the court shall order any adjustment necessary to equalize the amount which each defendant is obligated to pay, exclusive of costs. In no case shall an advance payment in excess of an award be repayable by the person receiving it. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-2-5 Claims not assignable

Sec. 5. A patient's claim for compensation under this article is not assignable. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-2-6 Financial responsibility; establishment

Sec. 6. (a) Financial responsibility of a health care provider and its officers, agents, and employees while acting in the course and scope of their employment with the health care provider under this chapter may be established:

(1) by the health care provider's insurance carrier filing with the commissioner proof that the health care provider is insured by a policy of malpractice liability insurance in the amount of at least one hundred thousand dollars ($100,000) per occurrence and three hundred thousand dollars ($300,000) in the annual aggregate, except that:

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

the patient's compensation fund under IC 16-9.5-4-3.

(d) If a health care provider qualified under this article admits liability or is adjudicated liable solely by reason of the conduct of another health care provider who is an officer, agent, or employee of the health care provider acting in the course and scope of employment and qualified under this chapter, the total amount that shall be paid to the claimant on behalf of the officer, agent, or employee and the health care provider by such health care provider or its insurer shall be one hundred thousand dollars ($100,000). The balance of any adjudicated sum to which the claimant is entitled shall be paid by other liable health care providers or the patient's compensation fund, or both. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1976, P.L.65, SEC.4; Acts 1977, P.L.187, SEC.9; P.L.189-1989, SEC.1.*

16-9.5-2-6 Financial responsibility; establishment

Sec. 6. (a) Financial responsibility of a health care provider and its officers, agents, and employees while acting in the course and scope of their employment with the health care provider under this chapter may be established:

(1) by the health care provider's insurance carrier filing with the commissioner proof that the health care provider is insured by a policy of malpractice liability insurance in the amount of at least one hundred thousand dollars ($100,000) per occurrence and three hundred thousand dollars ($300,000) in the annual aggregate, except that:

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

(i) for hospitals of one hundred (100) beds or less, two million dollars ($2,000,000); and

(ii) for hospitals of more than one hundred (100) beds, three million dollars ($3,000,000);

(B) if the health care provider is a prepaid health care delivery plan as defined in IC 27-8-7-1, the minimum annual aggregate insurance amount is seven hundred thousand dollars ($700,000); and

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

(i) for health facilities with one hundred (100) beds or less, three hundred thousand dollars ($300,000); and

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

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

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

(A) For hospitals of one hundred (100) beds or less, two million dollars ($2,000,000).

(B) For hospitals of more than one hundred (100) beds, three million dollars ($3,000,000).

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

(b) Security provided pursuant to subsection (a)(2) may be held in any manner mutually agreeable to the commissioner and the health care provider. The agreement shall provide that the principal may not be withdrawn prior to receiving the written permission of the commissioner of insurance. However, any interest earned may be withdrawn at any time by the health care provider.

(c) The bed size of a hospital for the purposes of this section shall be deemed to be the bed size published annually by the state department of health.

(d) In order to establish financial responsibility under this section, each individual who is a member of a partnership or professional corporation must establish financial responsibility separate from that partnership or professional corporation, as well as pay the surcharge required under IC 16-9.5-4-1, but this provision shall not be construed to require any health care provider to qualify under this article. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1976, P.L.65, SEC.5; Acts 1977, P.L.187, SEC.3; Acts 1979, P.L.152, SEC.2; P.L.177-1985, SEC.3; P.L.208-1987, SEC.1; P.L.206-1987, SEC.2; P.L.2-1992, SEC.618.*

Chapter 4. Patient's Compensation Fund

16-9.5-4-1 Creation; levy of annual surcharge; disposition of fund

Sec. 1. (a) There is created a patient's compensation fund to be collected and received by the commissioner for exclusive use for the purposes stated in this article. The fund and any income from it shall be held in trust, deposited in a segregated account, invested, and reinvested by the commissioner pursuant to IC 27-1-13 and shall not become a part of the general fund of the state.

(b) To create the fund, an annual surcharge shall be levied on all health care providers in Indiana. The surcharge shall be determined by the commissioner based upon actuarial principles.

(c) Notwithstanding subsection (b), there is imposed a minimum surcharge of twenty-five dollars ($25).

(d) The surcharge shall be collected on the same basis as premiums by each insurer, the risk manager, or the surplus lines agents. Such surcharge shall be due and payable within thirty (30) days after the premium for malpractice liability insurance has been received by the insurer, risk manager, or surplus lines agent from the health care provider in Indiana. If the surcharge is not paid as provided under this subsection, then the insurer, risk manager, or surplus lines agent responsible for the delinquency shall be liable for the surcharge plus a ten percent (10%) penalty.

(e) Receipt of proof of financial responsibility and the surcharge constitutes compliance with IC 16-9.5-2-1 as of the date of receipt thereof, or as of the effective date of the policy, provided this proof is filed with and the surcharge paid to the department not later than ninety (90) days after the effective date of the insurance policy. If proof of financial responsibility and the payment of the surcharge is not made within ninety (90) days after the policy effective date, compliance occurs on the date when proof is filed and the surcharge is paid.

(f) The commissioner may adopt rules providing for the manner in which the surcharge for health care providers establishing financial responsibility other than by a policy of malpractice liability insurance shall be determined and the manner of payment. The surcharge calculation must provide comparability in rates for insured and self-insured hospitals. In no

(i) for hospitals of one hundred (100) beds or less, two million dollars ($2,000,000); and

(ii) for hospitals of more than one hundred (100) beds, three million dollars ($3,000,000);

(B) if the health care provider is a prepaid health care delivery plan as defined in IC 27-8-7-1(h), the minimum annual aggregate insurance amount is seven hundred thousand dollars ($700,000); and

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

(i) for health facilities with one hundred (100) beds or less, three hundred thousand dollars ($300,000); and

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

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

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

(A) For hospitals of one hundred (100) beds or less, two million dollars ($2,000,000).

(B) For hospitals of more than one hundred (100) beds, three million dollars ($3,000,000).

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

(b) Security provided pursuant to subsection (a)(2) may be held in any manner mutually agreeable to the commissioner and the health care provider. The agreement shall provide that the principal may not be withdrawn prior to receiving the written permission of the commissioner of insurance. However, any interest earned may be withdrawn at any time by the health care provider.

(c) The bed size of a hospital for the purposes of this section shall be deemed to be the bed size published annually by the state board of health.

(d) In order to establish financial responsibility under this section, each individual who is a member of a partnership or professional corporation must establish financial responsibility separate from that partnership or professional corporation, as well as pay the surcharge required under IC 16-9.5-4-1, but this provision shall not be construed to require any health care provider to qualify under this article. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1976, P.L.65, SEC.5; Acts 1977, P.L.187, SEC.3; Acts 1979, P.L.152, SEC.2; P.L.177-1985, SEC.3; P.L.208-1987, SEC.1; P.L.206-1987, SEC.2.*

16-9.5-2-7 Payments from patient's compensation fund; terms and conditions

Sec. 7. In the event an annual aggregate for a health care provider qualified under this article has been paid by or on behalf of any such health care provider, all such sums which may thereafter become due and payable to a claimant arising out of an act of malpractice of such health care provider occurring during the year in which the annual aggregate was exhausted

shall be paid from the patient's compensation fund under the following terms and conditions:

(a) The health care provider whose annual aggregate has been exhausted shall have no right to object to or refuse permission to settle any such claim.

(b) If the health care provider or the insurance commissioner and claimant agree on a settlement the following procedure must be followed:

(1) A petition shall be filed by the claimant with the court in which the action is pending against the health care provider or, if none is pending, in the circuit or superior court of Marion County, seeking approval of the agreed settlement.

(2) A copy of the petition shall be served on the commissioner and the health care provider at least ten (10) days before filing and shall contain sufficient information to inform the other parties about the nature of the claim and the amount of the proposed settlement.

(3) The commissioner may agree to the settlement, or the commissioner may file written objections thereto. The agreement or objections shall be filed within twenty (20) days after the petition is filed.

(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 and the commissioner.

(5) At the hearing the commissioner, the claimant and the health care provider may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if it is submitted on agreement without objections. If the commissioner and the claimant cannot agree on the amount, if any, to be paid out of the patient's compensation fund, then the court shall determine the amount for which the fund is liable and render 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) Any settlement approved by the court shall not be appealed. Any judgment of the court fixing damages recoverable in any such contested proceeding shall be appealable pursuant to the rules governing appeals in any other civil case tried by the court.

The commissioner may promulgate rules and regulations implementing the provisions of this section. *As added by Acts 1976, P.L.65, SEC.6. Amended by Acts 1982, P.L.120, SEC.2.*

16-9.5-2-8 Rules for corporations or partnerships qualifying under 16-9.5-1-1(a)(7); information

Sec. 8. (a) The commissioner shall adopt rules under IC 4-22-2 to establish:

(1) criteria for determining eligibility upon application of a corporation, partnership, or professional corporation for coverage of its health care function under IC 16-9.5-1-1(a)(7), including identification of the corporation, partnership, or professional corporation's health care purpose and function; and

(2) the minimum annual aggregate insurance amount for the corporation, partnership, or professional corporation qualified under IC 16-9.5-1-1(a)(7), not to exceed five hundred thousand dollars ($500,000).

(b) The commissioner may require a corporation, partnership, or professional corporation seeking to qualify under IC 16-9.5-1-1(a)(7) to provide information as necessary to determine eligibility and to establish the minimum annual aggregate amount applicable to the corporation, partnership, or professional corporation. *As added by P.L.206-1987, SEC.3.*

Chapter 3. Statute of Limitations

16-9.5-3-1 Two years; special limitations for minors, claims under 16-9.5-9-2.1(c)

Sec. 1. (a) No claim, whether in contract or tort, may be brought against a health care provider based upon professional services or health care rendered or that should have been rendered unless filed within two (2) years from the date of the alleged act, omission, or neglect, except that a minor under the full age of six (6) years shall have until his eighth birthday in which to file. This section applies to all persons regardless of minority or other legal disability, except as provided in subsection (b).

(b) In the case of a patient who meets the criteria stated in IC 16-9.5-9-2.1(c), the applicable limitations period is equal to the period that would otherwise apply to the patient under subsection (a) plus one hundred eighty (180) days. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by P.L.178-1985, SEC.2.*

16-9.5-3-2 Additional provisions

Sec. 2. Notwithstanding the provisions of IC 1971, 16-9.5-1-7, any claim by a minor or other person under legal disability against a health care provider stemming from professional services or health care rendered, whether in contract or tort, based on an alleged act, omission or neglect which occurred prior to the effective date of this article, shall be brought only within the longer of:

(a) Two (2) years of the effective date of this article; or

(b) The period described in section 1 of this chapter. *(Formerly: Acts 1975, P.L.146, SEC.1).*

Chapter 4. Patient's Compensation Fund

16-9.5-4-1 Creation; levy of annual surcharge; disposition of fund

Sec. 1. (a) There is created a patient's compensation fund to be collected and received by the commissioner for exclusive use for the purposes stated in this article. The fund and any income from it shall be held in trust, deposited in a segregated account, invested, and reinvested by the commissioner pursuant to IC 27-1-13 and shall not become a part of the general fund of the state.

(b) To create the fund, an annual surcharge shall be levied on all health care providers in Indiana. The surcharge shall be determined by the commissioner based upon actuarial principles.

(c) Notwithstanding subsection (b), there is imposed a minimum surcharge of twenty-five dollars ($25).

(d) The surcharge shall be collected on the same basis as premiums by each insurer, the risk manager, or the surplus lines agents. Such surcharge shall be due and payable within thirty (30) days after the premium for malpractice liability insurance has been received by the insurer, risk manager, or surplus lines agent from the health care provider in Indiana. If the surcharge is not paid as provided under this subsection, then the insurer, risk manager, or surplus lines agent responsible for the delinquency shall be liable for the surcharge plus a ten percent (10%) penalty.

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

(b) Security provided pursuant to subsection (a)(2) may be held in any manner mutually agreeable to the commissioner and the health care provider. The agreement shall provide that the principal may not be withdrawn prior to receiving the written permission of the commissioner of insurance. However, any interest earned may be withdrawn at any time by the health care provider.

(c) The bed size of a hospital for the purposes of this section shall be deemed to be the bed size published annually by the state department of health.

(d) In order to establish financial responsibility under this section, each individual who is a member of a partnership or professional corporation must establish financial responsibility separate from that partnership or professional corporation, as well as pay the surcharge required under IC 16-9.5-4-1, but this provision shall not be construed to require any health care provider to qualify under this article. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1976, P.L.65, SEC.5; Acts 1977, P.L.187, SEC.3; Acts 1979, P.L.152, SEC.2; P.L.177-1985, SEC.3; P.L.208-1987, SEC.1; P.L.206-1987, SEC.2; P.L.2-1992, SEC.618.*

Chapter 4. Patient's Compensation Fund

16-9.5-4-1 Creation; levy of annual surcharge; disposition of fund

Sec. 1. (a) There is created a patient's compensation fund to be collected and received by the commissioner for exclusive use for the purposes stated in this article. The fund and any income from it shall be held in trust, deposited in a segregated account, invested, and reinvested by the commissioner pursuant to IC 27-1-13 and shall not become a part of the general fund of the state.

(b) To create the fund, an annual surcharge shall be levied on all health care providers in Indiana. The surcharge shall be determined by the commissioner based upon actuarial principles.

(c) Notwithstanding subsection (b), there is imposed a minimum surcharge of twenty-five dollars ($25).

(d) The surcharge shall be collected on the same basis as premiums by each insurer, the risk manager, or the surplus lines agents. Such surcharge shall be due and payable within thirty (30) days after the premium for malpractice liability insurance has been received by the insurer, risk manager, or surplus lines agent from the health care provider in Indiana. If the surcharge is not paid as provided under this subsection, then the insurer, risk manager, or surplus lines agent responsible for the delinquency shall be liable for the surcharge plus a ten percent (10%) penalty.

(e) Receipt of proof of financial responsibility and the surcharge constitutes compliance with IC 16-9.5-2-1 as of the date of receipt thereof, or as of the effective date of the policy, provided this proof is filed with and the surcharge paid to the department not later than ninety (90) days after the effective date of the insurance policy. If proof of financial responsibility and the payment of the surcharge is not made within ninety (90) days after the policy effective date, compliance occurs on the date when proof is filed and the surcharge is paid.

(f) The commissioner may adopt rules providing for the manner in which the surcharge for health care providers establishing financial responsibility other than by a policy of malpractice liability insurance shall be determined and the manner of payment. The surcharge calculation must provide comparability in rates for insured and self-insured hospitals. In no

event may this surcharge exceed the surcharge that would be charged by the residual authority if the health care provider electing to establish financial responsibility in this manner had applied to the residual authority for insurance.

(g) If the annual premium surcharge is not paid within the time limit specified in subsection (d), the certificate of authority of the insurer, risk manager, and surplus lines agents shall be suspended until the annual premium surcharge is paid.

(h) The commissioner, using money from the fund as deemed necessary, appropriate, or desirable, may purchase the services of persons, firms, and corporations to aid in protecting the fund against claims. All expenses of collecting, protecting, and administering the fund shall be paid from the fund.

(i) If the fund exceeds the sum of one hundred twenty-five million dollars ($125,000,000) at the end of each of two (2) consecutive six (6) month periods described in subsection (j) after the payment of all claims and expenses, the commissioner shall reduce the surcharge provided in this section in order to maintain the fund at an approximate level of one hundred twenty-five million dollars ($125,000,000).

(j) Claims for payment from the patient's compensation fund that become final during the first six (6) months of the calendar year must be computed on June 30 and must be paid no later than the following July 15. Claims for payment from the fund that become final during the last six (6) months of the calendar year must be computed on December 31 and must be paid no later than the following January 15. If the balance in the fund is insufficient to pay in full all claims that have become final during a six (6) month period, the amount paid to each claimant must be prorated. Any amount left unpaid as a result of the proration must be paid before the payment of claims that become final during the following six (6) month period. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1976, P.L.65, SEC.7; Acts 1979, P.L.152, SEC.3; Acts 1982, P.L.121, SEC.1; P.L.105-1984, SEC.2; P.L.177-1985, SEC.4; P.L.178-1985, SEC.3; P.L.208-1987, SEC.2; P.L.130-1988, SEC.1; P.L.121-1990, SEC.1.*

ARTICLE 10. HOSPITALS AND OTHER HEALTH FACILITIES

Chapter 1. Hospital Licensing and Regulation

(e) Receipt of proof of financial responsibility and the surcharge constitutes compliance with IC 16-9.5-2-1 as of the date of receipt thereof, or as of the effective date of the policy, provided this proof is filed with and the surcharge paid to the department not later than ninety (90) days after the effective date of the insurance policy. If proof of financial responsibility and the payment of the surcharge is not made within ninety (90) days after the policy effective date, compliance occurs on the date when proof is filed and the surcharge is paid.

(f) The commissioner may adopt rules providing for the manner in which the surcharge for health care providers establishing financial responsibility other than by a policy of malpractice liability insurance shall be determined and the manner of payment. The surcharge calculation must provide comparability in rates for insured and self-insured hospitals. In no event may this surcharge exceed the surcharge that would be charged by the residual authority if the health care provider electing to establish financial responsibility in this manner had applied to the residual authority for insurance.

(g) If the annual premium surcharge is not paid within the time limit specified in subsection (d), the certificate of authority of the insurer, risk manager, and surplus lines agents shall be suspended until the annual premium surcharge is paid.

(h) The commissioner, using money from the fund as deemed necessary, appropriate, or desirable, may purchase the services of persons, firms, and corporations to aid in protecting the fund against claims. All expenses of collecting, protecting, and administering the fund shall be paid from the fund.

(i) If the fund exceeds the sum of thirty million dollars ($30,000,000) at the end of each of two (2) consecutive six (6) month periods described in subsection (j) after the payment of all claims and expenses, the commissioner shall reduce the surcharge provided in this section in order to maintain the fund at an approximate level of thirty million dollars ($30,000,000).

(j) Claims for payment from the patient's compensation fund that become final during the first six (6) months of the calendar year must be computed on June 30 and must be paid no later than the following July 15. Claims for payment from the fund that become final during the last six (6) months of the calendar year must be computed on December 31 and must be paid no later than the following January 15. If the balance in the fund is insufficient to pay in full all claims that have become final during a six (6) month period, the amount paid to each claimant must be prorated. Any amount left unpaid as a result of the proration must be paid before the payment of claims that become final during the following six (6) month period. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1976, P.L.65, SEC.7; Acts 1979, P.L.152, SEC.3; Acts 1982, P.L.121, SEC.1; P.L.105-1984, SEC.2; P.L.177-1985, SEC.4; P.L.178-1985, SEC.3; P.L.208-1987, SEC.2; P.L.130-1988, SEC.1.*

16-9.5-4-1.1 Annual surcharge; limitation

Sec. 1.1. The annual surcharge levied on all health care providers in Indiana by the commissioner may not exceed two hundred percent (200%) of the cost to each health care provider for maintenance of financial responsibility. The surcharge shall be set by a rule adopted by the commissioner under IC 4-22-2. The surcharge shall be based on actuarial studies and must be adequate for the payment of claims and expenses from the patient's compensation fund. *As added by P.L.178-1985, SEC.4. Amended by P.L.208-1987, SEC.3.*

16-9.5-4-2 Warrant for claims

Sec. 2. The auditor of Indiana shall issue a warrant in the amount of each claim submitted to him against the fund on June 30 and December 31 of each year. The only claim against the fund shall be a voucher or other appropriate request by the commissioner after he receives:

(1) a certified copy of a final judgment against a health care provider; or

(2) a certified copy of a court approved settlement against a health care provider.

(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1976, P.L.65, SEC.8; P.L.177-1985, SEC.5.

16-9.5-4-2.5 Failure of insurance carrier or surety to pay agreed settlement or judgment; payment from patient's compensation fund

Sec. 2.5. If a health care provider, his surety or liability insurance carrier fails to pay any agreed settlement or final judgment within ninety (90) days, the same shall be paid from the patient's compensation fund, and said fund shall be subrogated to any and all of claimant's rights against said health care provider, his surety and/or liability insurance carrier with interest, reasonable costs and attorney fees. *As added by Acts 1976, P.L.65, SEC.9.*

16-9.5-4-3 Settlement in excess of policy limits; procedure

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 hundred thousand dollars ($100,000), and claimant is demanding an amount in excess thereof, then 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 his insurer, and shall 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 thereto.

(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 it 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, then the court, after hearing any relevant evidence on the issue of claimant's damage, submitted by any of the parties described in this section, shall determine the amount of claimant's damages, if any, in excess of the one hundred thousand dollars ($100,000) already paid by the insurer of the health care provider. The court shall determine the amount for which the fund is liable and render 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) Any settlement approved by the court shall not be appealed. Any judgment of the court fixing damages recoverable in any such contested proceeding shall be appealable pursuant to the rules governing appeals in any other civil case tried by the court.

(7) A release executed between the parties shall not bar access to the patient's compensation fund unless the release specifically provides otherwise. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1979, P.L.152, SEC.4.*

16-9.5-4-4 Discharge of obligations; contracts with insurers

Sec. 4. The obligation to pay an amount from the patient's compensation fund under IC 16-9.5-2-2(c), IC 16-9.5-2-7, or section 3 of this chapter may be discharged through:

(1) payment in one (1) lump sum;

(2) an agreement requiring periodic payments from the fund over a period of years;

(3) the purchase of an annuity payable to the patient; or

(4) any combination of subdivisions (1), (2), and (3).

The commissioner may contract with approved insurers to insure the ability of the fund to make periodic payments under subdivision (2). *As added by P.L.177-1985, SEC.6.*

Chapter 5. Attorney Fees

16-9.5-5-1 Limitation on award; election to pay on per diem basis

Sec. 1. (a) When a plaintiff is represented by an attorney in the prosecution of his claim, the plaintiff's attorney fees from any award made from the patient's compensation fund may not exceed fifteen percent (15%) of any recovery from the fund.

(b) A patient has the right to elect to pay for the attorney's services on a mutually satisfactory per diem basis. The election, however, must be exercised in written form at the time of employment. *(Formerly: Acts 1975, P.L.146, SEC.1).*

Chapter 6. Reporting and Review of Claims

16-9.5-6-1 Notice of placing reserve; confidentiality; time limit; required information

Sec. 1. (a) A health care provider's insurer shall notify the commissioner of any malpractice case upon which it has placed a reserve of fifty thousand dollars ($50,000) or more. The insurer shall give notice to the commissioner under this subsection immediately after placing the reserve. The notice and all communications and correspondence relating to it are confidential and may not be made available to any person or any public or private agency.

(b) All malpractice claims settled or adjudicated to final judgment against a health care provider shall be reported to the commissioner by the plaintiff's attorney and by the health care provider or his insurer or risk manager within sixty (60) days following final disposition of the claim. The report to the commissioner shall state the following:

(1) Nature of the claim.

(2) Damages asserted and alleged injury.

(3) Attorney's fees and expenses incurred in connection with the claim or defense.

(4) The amount of any settlement or judgment.

(Formerly: Acts 1975, P.L.146, SEC.1). As amended by P.L.177-1985, SEC.7.

16-9.5-6-2 Fitness reviews of health care providers; disciplinary actions

Sec. 2. (a) The commissioner shall forward the name of every health care provider, except a hospital, against whom a settlement is made or judgment is rendered under this article to the appropriate board of professional registration and examination for review of the fitness of the health care provider to practice his profession. In each case involving review of a health care provider's fitness to practice under this article, the board shall have the power, in appropriate cases, to take the following disciplinary action:

(1) censure;

(2) imposition of probation for a determinate period;

(3) suspension of the health care provider's license for a determinate period; or

(4) revocation of the license.

(b) Review of the health care provider's fitness to practice shall be conducted in accordance with IC 4-21.5.

(c) The board shall report to the commissioner its findings, the action taken, and the final disposition of each case involving review of a health care provider's fitness to practice under this article. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1977, P.L.187, SEC.1; P.L.7-1987, SEC.82.*

Chapter 7. Malpractice Coverage

16-9.5-7-1 Liability contingent upon insurance remaining in force

Sec. 1. Only while malpractice liability insurance remains in force are the health care provider and his insurer liable to a patient, or his representative, for malpractice to the extent and in the manner specified in this article. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-7-2 Filing of proof of financial responsibility constitutes acceptance of article

Sec. 2. The filing of proof of financial responsibility with the commissioner shall constitute, on the part of the insurer, a conclusive and unqualified acceptance of the provisions of this article. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-7-3 Void policy provisions

Sec. 3. Any provision in a policy attempting to limit or modify the liability of the insurer contrary to the provisions of this article is void. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-7-4 Impliedly included policy provisions

Sec. 4. Every policy issued under this article is deemed to include the following provisions, and any change which may be occasioned by legislation adopted by the general assembly of the state of Indiana as fully as if it were written therein:

(1) The insurer assumes all obligations to pay an award imposed against its insured under the provisions of this article.

(2) Any termination of this policy by cancellation initiated by the insurance company is not effective as to patients claiming against the insured covered hereby, unless at least thirty (30) days before the taking effect of the cancellation, a written notice giving the

date upon which termination becomes effective has been received by the insured and the commissioner at their offices.

(3) Any termination of this policy by cancellation initiated by the insured is not effective as to patients claiming against the insured covered by the policy, unless at least thirty (30) days before the taking effect of the cancellation, a written notice giving the date upon which termination becomes effective has been received by the commissioner at the commissioner's office.

(Formerly: Acts 1975, P.L.146, SEC.1). As amended by P.L.208-1987, SEC.4.

16-9.5-7-5 Failure to pay judgment; violations; revocation of approval of policy form

Sec. 5. If an insurer fails or refuses to pay a final judgment, except during the pendency of an appeal, or fails, or refuses to comply with any provisions of this article, in addition to any other legal remedy, the commissioner may also revoke the approval of its policy form until the insurer pays the award or judgment or has complied with the violated provisions of this article and has resubmitted its policy form and received the approval of the commissioner. *(Formerly: Acts 1975, P.L.146, SEC.1).*

Chapter 8. Residual Malpractice Insurance Authority

16-9.5-8-1 Purpose

Sec. 1. The purpose of this chapter is to make malpractice liability insurance available to risks as defined in this article. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-8-2 Residual malpractice insurance authority created

Sec. 2. There is created the Residual Malpractice Insurance Authority. The department of insurance is designated as the authority for the purposes of this article. The authority is empowered to engage in making Class II(h) malpractice liability insurance in this state pursuant to IC 1971, 27-1-5-1. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-8-3 Risk manager; appointment; limited liability

Sec. 3. The commissioner shall appoint a risk manager for the authority. The separate, personal or independent assets of the risk manager shall not be liable for or subject to use or expenditure for the purpose of providing insurance by the authority. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-8-4 Risk manager; powers and duties

Sec. 4. In the administration and provision for malpractice liability insurance by the authority, the risk manager shall:

(a) be subject to all laws and regulations of this state which apply to Class II (h) insurance as provided in IC 1971, 27-1-5-1;

(b) prepare and file appropriate forms with the department of insurance;

(c) prepare and file premium rates with the department of insurance;

(d) perform the underwriting function;

(e) dispose of all claims and litigations arising out of insurance policies;

(f) maintain adequate books and records;

(g) file an annual financial statement regarding its operations under this chapter with the department of insurance on forms prescribed by the commissioner;

(h) obtain private reinsurance for the authority, if necessary;

(i) prepare and file for approval of the commissioner a schedule of agent's compensation; and

(j) prepare and file a plan of operations with the commissioner for approval. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-8-5 Risk manager; compensation

Sec. 5. The risk manager shall receive as compensation for its services, a percentage of all premiums received by it under the terms of this chapter, as determined by the commissioner. The compensation may be adjusted by the commissioner. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-8-6 Uninsured risk; forwarding application to risk manager

Sec. 6. If a risk after diligent effort has been declined by at least two (2) insurers the risk may, together with evidence of the two (2) declinations, forward his application to the risk manager. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-8-7 Refusal to accept risk; appeal

Sec. 7. If the risk manager declines to accept the risk, notice of declination, together with the reasons, shall be sent to the applicant and the commissioner. The applicant shall have ten (10) days from the date of notice to file an appeal for review by the commissioner. On appeal, the commissioner shall review the decision of the risk manager and enter an appropriate order. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-8-8 Appropriations; investments

Sec. 8. All sums appropriated by the state of Indiana, and any surplus of premiums over losses and expenses received by the authority shall be placed in a segregated fund and shall be invested and reinvested by the commissioner pursuant to IC 1971, 27-1-13, and investment income generated shall remain in the fund. *(Formerly: Acts 1975, P.L.146, SEC.1).*

Chapter 9. Medical Review Panel

16-9.5-9-1 Establishment; proposed complaints, filing, limitations, tolling; request for review

Sec. 1. (a) Provision is made for the establishment of medical review panels to review all proposed malpractice complaints against health care providers covered by this article.

(b) The filing of a proposed complaint tolls the applicable statute of limitations to and including a period of ninety (90) days following the receipt of the opinion of the medical review panel by the claimant.

(c) A proposed complaint under this chapter shall be deemed filed when a copy of the proposed complaint is delivered or mailed by registered or certified mail to the commissioner.

The following fees must accompany each proposed complaint filed:

(1) A filing fee of five dollars ($5).

(2) A processing fee of two dollars ($2) for each additional defendant after the first defendant.

(d) The commissioner shall, within ten (10) days after receipt of a proposed complaint, forward by registered or certified mail a copy to each health care provider named as a defendant at his last and usual place of residence or his office.

(e) Not earlier than twenty (20) days after the filing of a proposed complaint either party may request the formation of a medical review panel by serving a request by registered or certified mail upon all parties and the commissioner. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1977, P.L.187, SEC.4; P.L.208-1987, SEC.5.*

16-9.5-9-2 Review as prerequisite to commencement of action; agreements

Sec. 2. (a) Except as provided in subsection (b) and in section 3.5 of this chapter, no action against a health care provider may be commenced in any court of this state before the claimant's proposed complaint has been presented to a medical review panel established pursuant to this chapter and an opinion is rendered by the panel.

(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. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by P.L.177-1985, SEC.8; P.L.31-1988, SEC.4.*

16-9.5-9-2.1 Actions for no more than $15,000

Sec. 2.1. (a) Notwithstanding section 2 of this chapter, a patient may commence an action against a health care provider for malpractice without submitting a proposed complaint to a medical review panel if the patient's pleadings include a declaration that the patient seeks damages from the health care provider in an amount no greater than fifteen thousand dollars ($15,000). In an action commenced under this subsection, the patient is barred from recovering any amount greater than fifteen thousand dollars ($15,000), except as provided in subsection (b).

(b) A patient who:

(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 the pendency of the action, that the bodily injury is more serious than previously believed and that fifteen thousand dollars ($15,000) is insufficient compensation for the bodily injury;

may move that the action be dismissed without prejudice and, upon dismissal of the action, may file a proposed complaint under section 1 of this chapter based upon the same allegations of malpractice as were asserted in the action dismissed under this subsection. In a second action commenced in court following the medical review panel's proceeding on the proposed complaint, the patient may recover an amount greater than fifteen thousand dollars ($15,000). However, a patient may move for dismissal without prejudice and, if dismissal without prejudice is granted, may commence a second action under this subsection only if the

patient's motion for dismissal is filed within two (2) years after commencement of the original action under subsection (a).

(c) In the case of a patient who:

(1) commences an action under subsection (a);

(2) moves for dismissal of the action under subsection (b);

(3) files a proposed complaint under section 1 of this chapter based upon the same allegations of malpractice as were asserted in the action dismissed under subsection (b); and

(4) commences a second action in court following the medical review panel proceeding on the proposed complaint;

the timeliness of the second action is governed by IC 16-9.5-3-1(b).

(d) A medical liability insurer of a health care provider against whom an action has been filed under subsection (a) shall provide written notice to the commissioner within thirty (30) days after:

(1) filing of the action; and

(2) final disposition of the action.

As added by P.L.178-1985, SEC.5. Amended by P.L.208-1987, SEC.6.

16-9.5-9-3 Members; chairman, powers and duties; selection procedures; limitations service requisite

Sec. 3. The medical review panel shall consist of one (1) attorney and three (3) health care providers. The attorney shall act as chairman of the panel and in an advisory capacity but shall have no vote. It is the duty of the chairman to expedite the selection of the other panel members, to convene the panel, and to expedite the panel's review of the proposed complaint. The chairman may establish a reasonable schedule for submission of evidence to the medical review panel but must allow sufficient time for the parties to make full and adequate presentation of related facts and authorities. The medical review panel shall be selected in the following manner:

(a) Within fifteen (15) days after filing the request for formation of a medical review panel under section 1 of this chapter, the parties shall select a panel chairman by agreement, or if no agreement can be reached, either party may request the clerk of the supreme court to draw at random a list of five (5) names of attorneys qualified to practice and presently on the rolls of the supreme court and maintaining offices in the county of venue designated in the proposed complaint or in a contiguous county. Prior to selecting the random list, the clerk shall collect a twenty-five dollar ($25) medical review panel selection fee from the party making the request for the formation of the random list. The clerk shall notify the parties and the parties shall then strike names alternately with the plaintiff striking first until one (1) name remains, and that remaining attorney shall be the chairman of the panel. After the striking, the plaintiff shall notify the chairman and all other parties of the name of the chairman. If a party does not strike a name within five (5) days after receiving notice from the clerk:

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

(2) the clerk shall strike for that party.

When one (1) name remains, the clerk shall within five (5) days notify the chairman and all other parties of the name of the chairman. The chairman shall, within fifteen (15) days after being notified by the clerk of his selection, send a written acknowledgment of his appointment to the clerk or shall show good cause for relief from serving as provided in subdivision (c).

(b)(1) Except for health care providers who are health facility administrators, all health care providers in this state, whether in the teaching profession or otherwise, who hold a license to practice in their profession, shall be available for selection as members of the medical review panel. Health facility administrators may not be members of the medical review panel. Each party to the action shall have the right to select one (1) health care provider and upon selection, the two (2) health care providers thus selected shall select the third panelist. When there are multiple plaintiffs or defendants, there shall be only one (1) health care provider selected per side. The plaintiff, whether single or multiple, shall have the right to select one (1) health care provider and the defendant, whether single or multiple, shall have the right to select one (1) health care provider. 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.

(2) Within fifteen (15) days after the chairman is selected, both parties shall select a health care provider and they shall notify the other party and the chairman of their selection. If a party fails to make a selection within the time provided, the chairman shall make the selection and notify both parties. Within fifteen (15) days after their selection, the health care provider members shall select the third member within the time provided and notify the chairman and the parties. If they fail to make a selection, the chairman shall make the selection and notify both parties.

(3) Within ten (10) days after any selection, written challenge without cause may be made to the panel member. Upon challenge or excuse, the party whose appointee was challenged or dismissed shall select another panelist. If the challenged or dismissed panel member was selected by the other two (2) panel members, they shall make a new selection. If two (2) such challenges are made and submitted, the chairman shall within ten (10) days appoint a panel consisting of three (3) qualified panelists and each side shall within ten (10) days after the appointment strike one (1) with the party whose appointment was challenged striking last, and the remaining member shall serve.

(4) When the medical review panel is formed, the chairman shall within five (5) days notify the commissioner and the parties by registered or certified mail of the names and addresses of the panel members and the date on which the last member was selected.

(c) A panelist selected as provided in subdivision (a) or (b) shall serve unless the parties by agreement excuse him or, for good cause shown, he may be excused as provided in this subsection. To show good cause for relief from serving, the attorney selected as chairman must serve an affidavit upon the clerk of the supreme court. The affidavit shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. The clerk may excuse the attorney from serving and the attorney shall notify all parties who shall then select a new chairman as provided in subdivision (a). To show good cause for relief from serving, a health care provider member must serve an affidavit upon the panel chairman. The affidavit shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. The chairman may excuse the member from serving and notify all parties.

(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1976, P.L.65, SEC.10; Acts 1977, P.L.187, SEC.5; Acts 1982, P.L.122,

SEC.1; P.L.177-1985, SEC.9; P.L.206-1987, SEC.4.

16-9.5-9-3.5 Time limit for panel opinion; exceptions; failure to act as required by chapter, sanctions; removal of chairman or member of panel

Sec. 3.5. (a) The panel shall render its expert opinion within one hundred eighty (180) days of the selection of the last member of the initial panel selected under section 3 of this chapter. However, if:

(1) the chairman of the panel is removed under subsection (c), another member of the panel is removed under subsection (d), or any member of the panel, including the chairman, is removed by a court order; and

(2) a new member is selected to replace the removed member more than ninety (90) days after the last member of the initial panel is selected;

the panel has ninety (90) days after the selection of the new member to render its expert opinion. If the panel has not rendered its opinion within the time allowed under this subsection, the panel shall submit a report to the commissioner, stating the reasons for the delay.

(b) A party, attorney, or panelist who fails to act as required by this chapter without good cause shown is subject to mandate or appropriate sanctions upon application to the court designated in the proposed complaint as having jurisdiction.

(c) The commissioner may remove the chairman of the panel if the commissioner determines that the chairman is not fulfilling the duties imposed upon the chairman by section 3 of this chapter. If the chairman is removed under this subsection, a new chairman shall be selected under section 3 of this chapter.

(d) The chairman may remove a member of the panel if the chairman determines that the member is not fulfilling the duties imposed upon the panel members by this chapter. If a member is removed under this subsection, a new member shall be selected under section 3 of this chapter. *As added by Acts 1976, P.L.65, SEC.11. Amended by Acts 1977, P.L.187, SEC.6; P.L.31-1988, SEC.5.*

16-9.5-9-4 Evidence; oath of panel; communication with panel

Sec. 4. (a) The evidence in written form to be considered by the medical review panel shall be promptly submitted by the respective parties. The evidence may consist of medical charts, x-rays, lab tests, excerpts of treatises, depositions of witnesses including parties, and any other form of evidence allowable by the medical review panel. Depositions of parties and witnesses may be taken prior to the convening of the panel. The chairman shall ensure that before the panel renders its expert opinion under section 7 of this chapter each panel member has the opportunity to review every item of evidence submitted by the parties.

(b) Before considering any evidence or deliberating with other panel members, each member of the medical review panel shall take an oath in writing on a form provided by the panel chairman, which must read as follows:

"I (swear) (affirm) under penalties of perjury that I will well and truly consider the evidence submitted by the parties and that I will render my opinion without bias thereon; that I have not and will not communicate with any party or representative of a party before rendering my opinion, except as authorized by law."

Neither a party, a party's agent, a party's attorney, nor a party's insurance carrier may communicate with any member of the panel, except as authorized by law, before the rendering of the panel's expert opinion under section 7 of this chapter.

(c) The chairman of the panel shall advise the panel relative to any legal question involved in the review proceeding and shall prepare the

opinion of the panel as provided in section 7 of this chapter. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by P.L.177-1985, SEC.10.*

16-9.5-9-5 Right to convene and question panel

Sec. 5. Either party, after submission of all evidence and upon ten (10) days notice to the other side, shall have the right to convene the panel at a time and place agreeable to the members of the panel. Either party may question the panel concerning any matters relevant to issues to be decided by the panel before the issuance of their report. The chairman of the panel shall preside at all meetings. Meetings shall be informal. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-9-6 Access to information and consultation

Sec. 6. The panel shall have the right and duty to request all necessary information. The panel may consult with medical authorities. The panel may examine reports of such other health care providers necessary to fully inform itself regarding the issue to be decided. Both parties shall have full access to any material submitted to the panel. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-9-7 Expert opinions

Sec. 7. The panel shall have the sole duty to express its expert opinion as to whether or not the evidence supports the conclusion that the defendant or defendants acted or failed to act within the appropriate standards of care as charged in the complaint. After reviewing all evidence and after any examination of the panel by counsel representing either party, the panel shall, within thirty (30) days, render one or more of the following expert opinions which shall be in writing and signed by the panelists:

(a) The evidence supports the conclusion that the defendant or defendants failed to comply with the appropriate standard of care as charged in the complaint.

(b) The evidence does not support the conclusion that the defendant or defendants failed to meet the applicable standard of care as charged in the complaint.

(c) That there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury.

(d) The conduct complained of was or was not a factor of the resultant damages. If so, whether the plaintiff suffered: (1) any disability and the extent and duration of the disability, and (2) any permanent impairment and the percentage of the impairment. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-9-8 Repealed

(Repealed by Acts 1977, P.L.187, SEC.7).

16-9.5-9-9 Expert opinion, evidentiary value; panel members as witnesses; immunity

Sec. 9. Any report of the expert opinion reached by the medical review panel shall be admissible as evidence in any action subsequently brought by the claimant in a court of law, but such expert opinion shall not be conclusive and either party shall have the right to call, at his cost, any member of the medical review panel as a witness. If called, the witness shall be required to appear and testify. A panelist shall have absolute immunity from civil liability for all communications, findings, opinions and conclusions made in the course and scope of duties prescribed by this article. *(Formerly: Acts 1975, P.L.146, SEC.1).*

16-9.5-9-10 Compensation; records; submittal of report

Sec. 10. (a) Each health care provider member of the medical review panel shall be paid up to three hundred fifty dollars ($350) for all work performed as a member of the panel exclusive of time involved if called as a witness to testify in court, and in addition thereto, reasonable travel expense.

(b) The chairman of the panel shall be paid at the rate of two hundred fifty dollars ($250) per diem, not to exceed one thousand two hundred fifty dollars ($1,250), plus reasonable travel expenses. The chairman shall keep an accurate record of the time and expenses of all the members of the panel, and the record shall be submitted to the parties for payment with the panel's report.

(c) Fees of the panel including travel expenses and other expenses of the review shall be paid by the side in whose favor the majority opinion is written. If there is no majority opinion, then each side shall pay one-half (1/2) of the cost.

(d) The chairman shall submit a copy of the panel's report to the commissioner and all parties and attorneys by registered or certified mail within five (5) days after the panel renders its opinion. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by Acts 1977, P.L.187, SEC.8; P.L.180-1985, SEC.1; P.L.31-1988, SEC.6.*

Chapter 10. Preliminary Determination of Affirmative Defense or Issue of Law or Fact; Discovery

16-9.5-10-1 Affirmative defenses or issues of law or fact; compelling discovery; motion; jurisdiction; limitations

Sec. 1. A court having jurisdiction over the subject matter and the parties to a proposed complaint filed with the commissioner under this article may, upon the filing of a copy of the proposed complaint and a written motion under this chapter, (1) preliminarily determine any affirmative defense or issue of law or fact that may be preliminarily determined under the Indiana Rules of Procedure; or (2) compel discovery in accordance with the Indiana Rules of Procedure; or (3) both. The court has no jurisdiction to rule preliminarily upon any affirmative defense or issue of law or fact reserved for written opinion by the medical review panel under IC 16-9.5-9-7(a), (b) and (d). The court has jurisdiction to entertain a motion filed under this chapter only during that period of time after a proposed complaint is filed with the commissioner under this article but before the medical review panel renders its written opinion under IC 16-9.5-9-7. The failure of any party to move for a preliminary determination or to compel discovery under this chapter before the medical review panel renders its written opinion under IC 16-9.5-9-7 shall not constitute the waiver of any affirmative defense or issue of law or fact. *As added by Acts 1979, P.L.152, SEC.5.*

16-9.5-10-2 Moving parties to proceedings; limited jurisdiction; procedures

Sec. 2. Any party to a proceeding commenced under this article, the commissioner or the chairman of any medical review panel, if any, 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, including the taxation and assessment of costs or the allowance of expenses, including reasonable attorney fees, or both. 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 nonmoving party to the proceedings and the chairman of the medical review panel, if any, unless the commissioner or the chairman

is the moving party, together with a copy of the proposed complaint and a copy of the motion pursuant to Rules 4 through 4.17 of the Indiana Rules of Trial Procedure, IC 34-5-1-1. *As added by Acts 1979, P.L.152, SEC.5.*

16-9.5-10-3 Nonmoving parties; appearance and response to motion; ruling; time limits

Sec. 3. Each nonmoving party to the proceeding, including the commissioner and the chairman of the medical review panel, if any, shall have a period of twenty (20) days after service, or a period of twenty-three (23) days after service if service is by mail, to appear and file and serve his written response to the motion, unless the court, for cause shown, orders the period enlarged. The court shall enter its ruling on the motion within thirty (30) days after it is heard, or if no hearing is requested, granted or ordered, within thirty (30) days after the date on which the last written response to the motion is filed, and shall order the clerk to serve a copy of its ruling on the motion by ordinary mail on the commissioner, each party to the proceeding and the chairman of the medical review panel, if any. *As added by Acts 1979, P.L.152, SEC.5.*

16-9.5-10-4 Stay of medical review panel proceedings

Sec. 4. Upon the filing of a copy of the proposed complaint and motion with the clerk of the court, all further proceedings before the medical review panel shall be stayed automatically until the court has entered its ruling on the motion. *As added by Acts 1979, P.L.152, SEC.5.*

16-9.5-10-5 Enforcement of court's rulings

Sec. 5. The court may enforce its ruling on any motion filed under this chapter in accordance with the Indiana Rules of Procedure, subject to the right of appeal. *As added by Acts 1979, P.L.152, SEC.5.*

ARTICLE 10. HOSPITALS AND OTHER HEALTH FACILITIES

Chapter 1. Hospital Licensing and Regulation

Controlling Large Malpractice Claims: The Unexpected Impact of Damage Caps

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Controlling Large Malpractice Claims: The Unexpected Impact of Damage Caps

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Abstract. Indiana's comprehensive malpractice reforms, inaugurated in 1975, include a cap on damages, a mandated medical review before trial, and a state insurance fund to pay claims equal to or greater than $100,000. We have found that the amount of compensation going to claimants with such large malpractice claims in Indiana is, on average, substantially higher than in Michigan and Ohio. Indiana's mean claim severity between 1977 and 1988 was $404,832, while the means for Michigan and Ohio were $290,022 and $303,220, respectively, with the difference between these three means being highly significant. Although data on claim and claimant characteristics reveal considerable interstate variation, the results of regression analyses show that Indiana claim payment amounts are higher than Michigan or Ohio payments, independent of the effect of factors such as sex, age, severity of injury, allegations of negligence, and year of settlement.

Medical malpractice is a persistent irritant in the American health care system (Posner 1986; Robinson 1986). Patients fear bad care, and physicians are concerned about the fairness of the medical liability system and the cost of medical malpractice insurance. Following two crises in the availability and affordability of malpractice insurance in the early 1970s and in the mid-1980s, many states enacted legislation to "reform" the common law tort system for malpractice claims (Bovbjerg 1989; DHHS 1987a; Robinson 1986; Posner 1986).

In 1975, Indiana adopted a comprehensive set of malpractice insurance and tort reforms, including a cap on all damages, a state-operated insurance fund

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for claims over $100,000, and mandated pretrial medical review before trial.[1] These reforms focused on improving the common law tort system from the perspective of physicians and insurers on the theory that controlling claim severity and frequency would result in lower malpractice premiums, thereby assuring continued availability of health care services in the state (Bovbjerg 1989). Not surprisingly, Indiana's reforms, developed and promoted by Indiana's medical profession, continue to enjoy great support from the profession and from malpractice insurers (Benjamin 1976; Bowen 1984; GAO 1986c; Slomski 1991; Kinney and Gronfein forthcoming).

This article compares the experience of Indiana with its neighbors, Michigan and Ohio, with respect to the severity of large malpractice claims (that is, equal to or greater than $100,000). Indiana is the only state in the nation that has had a cap on all damages, including economic loss as well as pain and suffering, in place consistently since 1975. Michigan and Ohio have adopted insurance and tort reforms only sporadically and have never implemented a damage cap.

Indiana has enjoyed some of the lowest malpractice insurance premiums in the nation, particularly when compared to states of comparable size, including Michigan and Ohio (GAO 1986a; Mullen 1989). Further, Indiana's tort reforms have served as a model nationally. Such states as Nebraska and Louisiana have substantially adopted Indiana's reforms and the Department of Health and Human Services has urged other states to do so (DHHS 1987a, 1987b). Finally, Indiana's reforms, including the damage cap, have survived a definitive constitutional challenge before the Indiana Supreme Court.[2]

Our chief interest in this article is the effect of Indiana's damage cap on the size of recoveries in large claims. We focused on large claims, since they are most likely to be affected by a damage cap. Previous research has demonstrated repeatedly that damage caps are effective in reducing the severity of malpractice claims. Danzon (1986) found that caps on damages reduce average claim severity by 23 percent. More recently, Sloan, Mergenhagen, and Bovbjerg (1989) found that damage caps on total payments achieved savings in claim payment from 38 to 39 percent. Research demonstrates that caps affect malpractice insurance premium levels as well (Sloan 1985; Zuckerman, Bovbjerg, and Sloan 1990). Nevertheless, comprehensive damage caps seem intuitively unfair to plaintiffs with large claims; they impose a limit on compensation which bears no relation to the damages the plaintiff actually sustained.

Indiana's major reform is a comprehensive cap on damage awards. For claims occurring before 1 January 1990, the cap was $500,000; for claims

1. Ind. Code §§ 16-9.5 (1988).
2. *Johnson v. St. Vincent Hospital, Inc.*, 404 N.E.2d 585 (Ind. 1980).

thereafter, the cap is $750,000. Unless parties otherwise agree, all cases over $15,000 must go through mandated pretrial medical review before proceeding to a jury trial in state court. To obtain the protection of reforms, medical providers must insure themselves for $100,000 and so demonstrate to the Indiana Department of Insurance. They must also pay a surcharge, assessed on all participating providers to finance the Patient Compensation Fund.

The state-operated insurance fund, the Patient Compensation Fund (PCF), pays claims over $100,000. The provider's malpractice insurer pays the first $100,000 of any claim. Empirical evidence suggests that, in practice, private malpractice insurers are apt to settle claims at PCF thresholds to make claims eligible for PCF payment. At that point, their exposure as well as their obligation to provide a legal defense terminates and the state assumes the defense of the claim (Kinney and Gronfein forthcoming). For PCF claims, the only question at issue is the extent of damage, and not liability. There is also a 15 percent limit on attorneys' fees on PCF payments.

Ohio and Michigan have attempted to institute malpractice tort reform with little success. In 1975, the Michigan legislature authorized voluntary but binding arbitration in lieu of a court trial, but this arbitration alternative has not been used to any significant extent (Michigan Commissioner of Insurance 1989). In 1975, the Ohio legislature enacted a $200,000 limit on noneconomic damage except for wrongful death, as well as compulsory arbitration of malpractice claims. However, the Ohio Supreme Court immediately ruled that these reforms were unconstitutional and thus they were never implemented.[3]

Indiana, Michigan, and Ohio tightened their statutes of limitation for malpractice in the mid-1970s. All three states modified the common law collateral source rule to require some offset of collateral payments from damage awards in the late 1980s, although Ohio's rule does not apply to malpractice cases. These two reforms have been found effective in reducing claim frequency and severity (Danzon 1982, 1985, 1986).

Indiana has had lower malpractice insurance premiums than Michigan and Ohio as well as other states (GAO 1986a, 1986b, 1986c). For example, the Medical Protective Company, a major malpractice insurer in Indiana, Michigan, and Ohio during the relevant period, charged lower premiums in Indiana compared to Michigan and Ohio. Medical Protective reports the following annual premiums for malpractice insurance of $100,000 per occurrence and $300,000 total for nonsurgeons in January 1989: Indianapolis, Indiana—$988; Cincinnati, Ohio—$2,291; Cleveland, Ohio—$2,579; Kalamazoo, Michigan—$4,881; and Detroit, Michigan—$7,953 (Mullen 1989). For Med-

3. Simon v. St. Elizabeth Medical Center, 355 N.E.2d 903 (Ohio 1976).

Table 1. Selected Characteristics of Indiana, Michigan, and Ohio

	Indiana	Michigan	Ohio
Percentage urban, 1986[a]	64.2	70.7	73.3
Per capita income, 1986[a]	$13,136	$14,775	$13,933
Doctors per 100,000, 1985[a]	146	158	186
Lawyers per 100,000, 1985[a]	172	200	253
Ratio of surgical specialties to all physicians[b]	.221	.240	.243

Sources:
a. U.S. Bureau of the Census 1989.
b. American Medical Association 1987.

ical Protective's highest premium category (obstetricians or gynecologists and neurosurgeons), annual malpractice premiums in January 1989 were: Indianapolis—$8,398, Cincinnati—$19,474, Cleveland—$21,922, Kalamazoo—$43,929, and Detroit—$71,577 (Mullen 1989).

Not surprisingly, Medical Protective's defense costs were lower in Indiana than in either Ohio or Michigan. Specifically, between 1984 and 1988, it cost Medical Protective 46 percent more in allocated loss adjustment expenses to close claims in Ohio and over 100 percent more in such expenses to close claims in Michigan (Robert Miller, Medical Protective Company, letter to authors, June 1990). These sharply lower defense costs may be explained in part by the fact that private insurers like Medical Protective do not pay the cost of defending claims before the PCF.

Indiana, Michigan, and Ohio are reasonably similar in terms of aggregate variables identified as having an important influence on claim severity. Danzon (1986) found that both level of urbanization and number of physicians per 100,000 population were positively associated with claim severity. Sloan (1985) reported a direct association between number of lawyers per 100,000 population and claim severity, while Feldman (1979) reported that both per capita income and the ratio of surgeons to total physicians were directly associated with claim severity.

As Table 1 demonstrates, Indiana is slightly lower than Michigan and Ohio in percentage urbanization and in per capita income. Indiana has fewer physicians and attorneys per 100,000 population and also a lower ratio of surgeons to physicians. Since all of these variables have been reported to be directly associated with increases in claim severity in previous research and since Indiana has a damage cap, one would expect that claim severity in Indiana would be lower than claim severity in either Michigan or Ohio.

Data sources and variables

Our analysis of claim severity in Indiana, Michigan, and Ohio uses data from each of the states to explore the differences among them. With the exception of Sloan, Mergenhagen, and Bovbjerg (1989), little empirical work examines the differences in types of claimant or claim characteristics across states or the relationships which tie these characteristics to particular claims. Most previous research on medical malpractice has focused on the effects of tort reforms on claims and premiums, accounting for interstate differences in claim frequency, claim severity, or insurance premiums and has used ecological variables, for example, per capita income, urbanization, and unemployment rates, as well as specific tort reforms, as their independent variables (Zuckerman, Bovbjerg, and Sloan 1990; Danzon 1985, 1986; Sloan 1985; Feldman 1979).

We studied a sample of large medical malpractice claims filed after July 1975 and closed from 1977 to 1988 in Indiana, Michigan, and Ohio.[4] Our sample includes a total of 1,282 claims of $100,000 or more, with 420 from Indiana (32.8 percent), 521 (40.6 percent) from Michigan, and 341 (26.6 percent) from Ohio. For Indiana, the study includes all large medical malpractice claims, that is, those in which $100,000 or more was paid out.[5]

For Michigan and Ohio, we obtained data on all large claims filed with the Medical Protective Company of Fort Wayne, Indiana, between July 1975 and 1988 and closed during this period. "Large" is defined as "payments by all insurers to claimants of $100,000 or more."[6] In both Michigan and Ohio, Medical Protective had a market share of just over one-third in terms of the proportion of insured physicians during the relevant period, even though they began withdrawing from the Michigan market at the end of the 1980s (Robert Miller, Medical Protective Company, letter to authors, June 1990).

For claimant and claim characteristics on Indiana claims, we used the data collection instrument developed by the U.S. General Accounting Office (GAO 1987) for its study of closed claims. Data came from information in the claim file at the Indiana Department of Insurance and often contained relevant in-

4. No claim filed after July 1975 closed before 1977.

5. Data on these claims came from a database of all claims filed with the Indiana Department of Insurance (1989) from 1975 through 1988 and include data on about 2,100 closed and 3,000 open claims. PCF cases constituted 20% of all closed claims in Indiana for this period.

6. Medical Protective advises that additional amounts not reflected in these data may have been paid in some claims by other insurers. They estimate that 5–15% of the cases may have had such additional payments. Therefore, to some extent, we will have undercounted dollars paid out in Ohio and Michigan relative to Indiana. In any tort claim with multiple defendants, a defendant may typically be dismissed before the claim's final disposition, making it possible that the defendant's insurer might not be informed of the final settlement amount. Consequently, data from any insurer on any type of litigated tort claim may be similarly affected.

formation from the claimant's medical record for the episode involving the malpractice injury. A registered nurse coded all data. For coding allegations of negligence, we used the categories developed by the Risk Management Foundation of the Harvard Medical Institutions, while severity of injury was coded using the nine-level system employed in earlier analyses of closed claims (Risk Management Foundation 1987; National Association of Insurance Commissioners 1980).[7]

Data on Michigan and Ohio claims came from claim files of the Medical Protective Company and included (1) age of claimant at time of injury, (2) sex of claimant, (3) total payment of the claim, including contribution of other insurers, (4) allegation of negligence, (5) severity of injury, (6) date of claim filing, and (7) date of final payment. A registered nurse coded allegations of negligence and severity of injury according to the same categories used for the Indiana claims.

Indiana claims data include all claims of $100,000 or more paid between 1977 and 1988. Ohio and Michigan data, however, include only a subset of such large claims (i.e., those in which Medical Protective was involved). Therefore, we compared Indiana claims in which Medical Protective was an insurer (49.0 percent) with those Indiana claims not involving Medical Protective (51.0 percent). The two groups did not differ significantly in terms of age and sex of claimant, allegations of negligence, or severity of injury. Nor was the average payment for claims involving Medical Protective ($412,147) significantly larger than the mean payment for claims in which Medical Protective was not involved ($397,792).

Results

Interstate variations in claim severity. The principal finding of this study was a considerable and unexpected difference among Indiana, Michigan, and Ohio in mean claim severity for large claims. Overall, claims averaged $331,146 in the 1,282 large malpractice claims examined, as indicated in Table

7. The RMF protocols provide for 77 individual allegations of negligence, which may be grouped into 12 larger categories: (1) diagnosis, (2) anesthesia, (3) surgery, (4) medication, (5) medication administration, (6) intravenous procedures, (7) obstetrics, (8) treatment, (9) patient monitoring, (10) biomedical equipment, (11) blood products, and (12) other allegations not elsewhere classified (Risk Management Foundation 1987).

The nine codes for severity of injury in this system are (1) emotional only (e.g., fright), (2) insignificant (e.g., lacerations, contusions, rash), (3) minor temporary disability (e.g., infections, incorrectly set fracture leading to delayed recovery), (4) major temporary disability (burns, surgical material left in patient, recovery delayed), (5) minor permanent partial disability (e.g., loss of fingers), (6) major permanent partial disability (e.g., deafness, loss of limb, loss of one kidney), (7) major permanent total disability (e.g., paraplegia, brain damage), (8) grave permanent total disability (e.g., quadriplegia, severe brain damage), and (9) death (National Association of Insurance Commissioners 1980).

Table 2. Severity of Large Malpractice Claims in Indiana, Michigan, and Ohio, 1977–1988

	All Cases	Indiana	Michigan	Ohio
Mean payment ≥ $100,000, in dollars	331,146	404,832	290,022	303,220
(Standard deviation)	(329,931)	(102,399)	(440,814)	(299,884)
N	1,282	420	521	341
Median payment ≥ $100,000, in dollars	251,847	435,283	180,000	200,000
Claims paid at $100,000 as a percentage of total claims	9.6	1.2	16.1	10.0
Claims paid between $100,000 and $200,000 as a percentage of total claims	41.7	6.2	62.8	53.4
Claims paid at ≥ $500,000 as a percentage of total claims	17.9	27.9	12.3	14.1
Million-dollar claims as a percentage of total claims[a]	2.0	—	3.1	2.6
Amount paid on million-dollar claims as a percentage of total payments[a]	10.9	—	21.1	14.0

a. Indiana claims limited to award at $500,000 or less.

2. Indiana's mean was $404,832, while the means for Michigan and Ohio were $290,022 and $303,220, respectively, expressed in current dollars. Thus, the average Indiana claim was $114,810 (or 39.6 percent) greater than the average Michigan claim, and $101,612 (33.5 percent) greater than the average Ohio claim. Analysis of variance indicates that the difference between these three means is highly significant ($F = 16.11$, $p < .001$). Pairwise comparisons show that Indiana settlements are significantly larger than settlements in both Michigan ($t = 5.22$, $p < .001$) and Ohio ($t = 6.49$, $p < .001$), while Michigan and Ohio settlements did not differ significantly.

Maximum claims in Michigan ($7,500,000) and Ohio ($2,668,000) were, as expected, far higher than Indiana's $500,000 cap. These larger claims in Michigan and Ohio notwithstanding, payments to Indiana's PCF claimants tended to be considerably more generous than payments to claimants in Michigan and Ohio. The median payment was $435,283 for large Indiana claims, compared to $180,000 for large Michigan claims and $200,000 for large Ohio claims. Also, a much higher percentage of Indiana claims (27.9 percent) were

paid at the $500,000 cap than in either Michigan or Ohio, where the percentage of claims settled at or above $500,000 was only 12.3 percent and 14.1 percent, respectively. Payments at the low end of the payment distribution followed a reverse pattern. Only 1.2 percent of Indiana's large claims were paid at the $100,000 level, while 16.1 percent of large Michigan claims and 10.0 percent of large Ohio claims were paid at this level. Further, while only 6.2 percent of the large Indiana claims fell between $100,000 and $200,000, 62.8 percent of large Michigan claims and 53.4 percent of large Ohio claims were in this range.

Indeed, in some respects, the higher maximum awards in Michigan and Ohio act to distort measures of central tendency such as the mean, biasing it upward. Claims paid at $1,000,000 or more constitute only 3.1 percent of all claims in Michigan and 2.6 percent of all claims in Ohio, yet they represent 21.1 percent of all claim payments in Michigan and 14.0 percent of all claim payments in Ohio. Had these cases not been brought, there would be an even greater difference in mean claim payment size between Indiana and Michigan ($168,730 compared to $114,810) and between Indiana and Ohio ($136,962 compared to $101,612) than was actually the case.

Claimant characteristics. Table 3 presents data on sex and age of claimant for the entire sample and the three comparison states. While states did not differ significantly from each other in terms of sex, there were significant differences among the states in terms of age.[8]

Claim characteristics. The major variables related to claims, as opposed to claimants, were severity of injury, allegations of negligence, and the time of filing and closing a claim. Because we studied large claims, lower levels of injury severity (e.g., emotional damage or temporary injury) were rare. The two most serious types of injury, that is, grave disability or death, ac-

8. Exact ages of claimants were available for Michigan and Ohio claims, while the Indiana age data were grouped into eight intervals, which we collapsed as follows to produce acceptable cell sizes: (1) newborn/infant (2) 1–17, (3) 18–39, (4) 40–59, (5) 60+. For 225 cases (17.6% of cases), we had no information on age. Missing age data was concentrated mainly in Michigan (31.5%) and Ohio (15.0%).

To take advantage of the exact ages contained in the Michigan and Ohio data, we assigned all Indiana cases an age value equal to the midpoint of the age category employed, assigning cases involving newborns an age value of zero. When age was expressed as an interval level variable, analysis of variance indicated a statistically significant difference among the three states. Further, Indiana's mean age of 32.3 years was significantly higher than Michigan's mean of 26.1 but did not differ from Ohio's mean of 30.8.

When the age categories described above were cross-classified by state, a statistically significant difference was found (chi-square = 31.61, degrees of freedom = 8, $p < .001$). When Indiana is compared to Michigan or Ohio, the results indicate a significant association between age and jurisdiction.

Table 3. Characteristics of Malpractice Claimants with Large Claims in Indiana, Michigan, and Ohio, 1977–1988

	All Cases		Indiana		Michigan		Ohio	
Sex[a]								
Female	646	50.4%	229	54.5%	258	49.5%	159	46.6%
Male	630	49.1%	190	45.2%	260	49.9%	180	52.8%
Don't know/not available	6	0.5%	1	0.2%	3	0.6%	2	0.6%
Total	1,282		420		521		341	
Age: categories[a]								
Newborn/infant	207	16.1%	58	13.8%	90	17.3%	59	17.3%
1–17	129	10.1%	38	9.0%	58	11.1%	33	9.7%
18–39	333	26.0%	155	36.9%	92	17.7%	86	25.2%
40–59	273	21.3%	112	26.7%	84	16.1%	77	22.6%
60 and over	115	9.0%	47	11.2%	33	6.3%	35	10.3%
Don't know/not available	225	17.6%	10	2.4%	164	31.5%	51	15.0%
Total	1,282		420		521		341	
Age: interval								
Mean	29.8		32.3		26.1		30.8	
(Standard deviation)	(22.5)		(20.6)		(23.3)		(23.4)	
N	1,058		410		358		290	

a. Percentages may not sum to 100 due to rounding.

counted for just over half of the cases in all three states. We limit presentation of results to the five most serious categories (Table 4). The distribution of severity of injury across all three states showed a statistically significant association between level of injury severity and jurisdiction (chi-square = 31.50, degrees of freedom = 8, $p < .001$). Pairwise comparisons showed that Indiana differed significantly from both Michigan and Ohio, with Indiana having a lower percentage of deaths.

Four types of allegations of negligence, that is, "diagnostic error," "surgical error," "obstetrical error," and "treatment error" accounted for nearly 80 percent of our sample, as indicated in Table 4. We collapsed the remaining eight categories into a residual category called "other errors." Indiana had a lower percentage of cases involving allegations related to "obstetrical errors" and "treatment errors" and a higher percentage of cases involving "other errors." The distributions of allegations of negligence among the three states indicated a significant association between state and type of allegation (chi-square = 49.17, $df = 8$, $p < .001$). Indiana differed significantly from both Michigan and Ohio in the distribution of allegations of negligence, while Michigan and Ohio did not differ significantly from each other.

Data on the years in which claims were filed and the years in which they were paid are presented in Table 5. Because relatively few claims were filed in both early years and late years, we collapsed data on year of filing into four groups to produce a more even distribution. Indiana differed significantly from Michigan but not from Ohio in the distribution of claim filing dates.

Given the upward trend in payments (Danzon 1986; Sloan and Bovbjerg 1989), the year in which claims are paid has a potential effect on the size of the payment. Since our data contained very few payments per year in the period from 1977 to 1983, we combined payments for this period. As Table 5 indicates, Michigan and Ohio have larger percentages of claims paid in the early years, while Indiana has relatively few in the early years.[9]

While more than 65 percent of the Indiana cases were settled in 1986, 1987, or 1988, less than 50 percent of Michigan or Ohio cases were settled during those three years. Cross-classifying year of settlement with the three states produces a statistically significant association (chi-square = 55.71, $df = 10$, $p < .001$). Pairwise comparisons between Indiana and Michigan and Indiana and Ohio also show statistically significant differences.

Even though Indiana has insurance and tort reforms expressly designed to expedite the disposition of claims, large claims in Indiana were not disposed of any more quickly than in either Michigan or Ohio. Specifically, the mean time period between claim filing and closing of Indiana large claims was 57.8

9. This may be due to the fact that Indiana claims occurring before July 1975 but paid thereafter were handled under the old common law tort system and are not in our database.

Table 4. Characteristics of Large Malpractice Claims in Indiana, Michigan, and Ohio, 1977–1988

	All Cases		Indiana		Michigan		Ohio	
Allegations of negligence[a]								
Diagnosis	329	25.7%	110	26.2%	148	28.4%	71	20.8%
Surgery	323	25.2%	112	26.7%	123	23.6%	88	25.8%
Obstetrics	220	17.2%	62	14.8%	96	18.4%	62	18.2%
Treatment	195	15.2%	40	9.5%	87	16.7%	68	19.9%
Other	188	14.7%	95	22.6%	60	11.5%	33	9.7%
Don't know/not available	27	2.1%	1	0.2%	7	1.3%	19	5.6%
Total	1,282		420		521		341	
Severity of injury[a]								
Permanent disability—minor (e.g., loss of finger)	292	22.8%	98	23.3%	114	21.9%	80	23.5%
Permanent disability—major (e.g., loss of eye)	153	11.9%	73	17.4%	49	9.4%	31	9.1%
Major total disability (e.g., brain damage)	55	4.3%	29	6.9%	14	2.7%	12	3.5%
Grave disability (e.g., quadriplegia)	284	22.2%	92	21.9%	119	22.8%	73	21.4%
Death	457	35.6%	126	30.0%	207	39.7%	124	36.4%
Don't know/not available	41	3.2%	2	0.4%	18	3.4%	21	6.2%
Total	1,282		420		521		341	

a. Percentages may not sum to 100 due to rounding.

Table 5. Year of Payment for Large Malpractice Claims in Indiana, Michigan, and Ohio, 1977–1988

	All Cases		Indiana		Michigan		Ohio	
Year of filing[a]								
1975–1978	310	24.2%	89	21.2%	142	27.3%	79	23.2%
1979–1980	317	24.7%	85	20.2%	154	29.6%	78	22.9%
1981–1982	358	27.9%	121	28.8%	132	25.3%	105	30.8%
1983–1987	295	23.0%	123	29.3%	93	17.9%	79	23.2%
[Missing]	2	0.2%	2	0.5%	—	--	—	--
Total	1,282		420		521		341	
Year of payment[a]								
1977–83	264	20.6%	54	12.9%	123	23.6%	87	25.5%
1984	143	11.2%	35	8.3%	64	12.3%	44	12.9%
1985	204	15.9%	56	13.3%	97	18.6%	51	15.0%
1986	234	18.3%	80	19.0%	92	17.7%	62	18.2%
1987	206	16.1%	93	22.1%	69	13.2%	44	12.9%
1988	231	18.0%	102	24.3%	76	14.6%	53	15.5%
Total	1,282		420		521		341	

a. Percentages may not sum to 100 due to rounding.

months; the mean time period was shorter for Ohio (52.4 months) and longer for Michigan (60.9 months). Ohio claims were settled significantly more quickly than claims in either Indiana or Michigan, but there was no significant difference in time of resolution between Indiana and Michigan.

Changes over time in claim severity. Table 6 presents data on annual mean malpractice payments computed over the entire sample and includes data on payments in both current and constant dollars. We used the Consumer Price Index to compute constant 1977 dollars. In current dollars, claim payments increased 82.4 percent from 1978 to 1988, while the average year-to-year change was 8.0 percent.[10] While these figures indicate an appreciable rise in the average payment for large malpractice claims from 1978 to 1988, this increase is by no means consistent nor was it consistently large from year to year. Mean payments were lower in three years (1981, 1982, and 1987) than they had been in the prior year. When claim payments are expressed in constant rather than current dollars, the total increase from 1978 to 1988 is greatly reduced—from 82.0 percent to 0.6 percent. Similar reductions appear when year-by-year changes are examined: the mean change from one year to the next is 1.6 percent, and mean claim severity was lower than the previous year in four out of ten cases. In sum, when malpractice payments for claims of $100,000 and above in the three states are adjusted for inflation, there is a modest and uneven increase in claim severity over time.

Table 6. Mean Severity of Large Malpractice Claims in Indiana, Michigan, and Ohio, in Current and Constant Dollars, 1978–1988

			Percentage Change from Previous Year	
Year	Current Dollars	Constant Dollars[a]	Current Dollars	Constant Dollars[a]
1978	209,523 (119,247) $n = 7$	194,618 (110,674)	—	—
1979	242,929 (165,672) $n = 7$	204,315 (137,960)	15.9	5.0

Table continues following page

10. Because only one claim was settled in 1977, we used the 1978–1988 period to measure changes in claim severity.

Table 6. Continued

Year	Current Dollars	Constant Dollars[a]	Percentage Change from Previous Year: Current Dollars	Percentage Change from Previous Year: Constant Dollars[a]
1980	367,574 (497,161) $n = 27$	270,318 (365,619)	51.3	32.3
1981	271,180 (178,325) $n = 54$	180,687 (118,818)	− 26.2	− 33.2
1982	243,683 (171,646) $n = 61$	152,959 (107,765)	− 10.1	− 15.3
1983	262,040 (155,582) $n = 107$	159,384 (94,632)	7.5	4.2
1984	320,297 (299,543) $n = 143$	186,865 (174,757)	22.2	17.2
1985	326,057 (243,381) $n = 204$	183,672 (137,100)	1.8	− 1.7
1986	354,621 (317,674) $n = 234$	195,992 (175,571)	8.8	6.7
1987	340,514 (247,267) $n = 206$	181,561 (131,842)	− 4.0	− 7.4
1988	382,232 (526,528) $n = 231$	195,809 (269,728)	12.3	7.8

Note: Standard deviation given in parentheses.

a. Constant 1977 dollars. Consumer price index data for 1977–86 from U.S. Bureau of the Census 1989: Table 738; 1987–88 data come from U.S. Department of Labor (USDL 1990: Table 1A).

Regression analyses. We used multiple regression to see if Indiana's claim severity differed from Ohio's and Michigan's, independent of the effects of age, sex, year of settlement, severity of injury, and allegations of negligence. The most striking finding is that location in Indiana has a marked

positive effect on claim severity even after the impact of these other variables is accounted for. The variables used in the regression are described in the appendix.

Because the distribution of claim payment amounts was highly skewed, claim severity was expressed as a logarithm to the base 10. Two regressions that we report used logarithm of payment as the dependent variable, while the third used the untransformed payment amount. The results of the regressions are presented in Table 7. In the first regression (Table 7, column 1), the logarithm of claim severity was regressed on dummy variables for state

Table 7. Regression Coefficients for Severity of Large Malpractice Claims in Indiana, Michigan, and Ohio, 1977–1988

Variable	Unstandardized Regression Coefficients[a] (Standard Error)	Unstandardized Regression Coefficients[a] (Standard Error)	Unstandardized Regression Coefficients[b] (Standard Error)
AGE	− .001**	− .001**	− 1,566**
	(.0004)	(.0004)	(611)
INDIANA	.268***	.269***	73,019*
	(.018)	(.021)	(29,326)
OHIO	.065***	.066***	21,792
	(.019)	(.019)	(27,084)
SEX	− .003	− .003	668
	(.015)	(.015)	(21,192)
DIAGNOSE	.054	.054	105,681**
	(.029)	(.029)	(40,475)
SURGERY	.049	.049	104,592*
	(.031)	(.031)	(43,288)
TRTMNT	.017	.017	45,802
	(.031)	(.031)	(43,200)
OTHER	.070*	.070*	101,212*
	(.031)	(.032)	(43,814)
SEV1	− .194***	− .194***	− 235,211***
	(.027)	(.027)	(37,241)
SEV2	− .136***	− .136***	− 192,386***
	(.030)	(.030)	(41,918)
SEV3	− .122**	− .122**	− 170,666**
	(.041)	(.041)	(56,581)

Table continues following page

Table 7. Continued

Variable	Unstandardized Regression Coefficients[a] (Standard Error)	Unstandardized Regression Coefficients[a] (Standard Error)	Unstandardized Regression Coefficients[b] (Standard Error)
SEV5	− .133***	− .133***	− 181,329***
	(.023)	(.023)	(32,187)
DUM84	.033	.034	51,627
	(.029)	(.029)	(40,921)
DUM85	.074**	.074**	64,689
	(.026)	(.026)	(36,080)
DUM86	.073**	.073**	76,290**
	(.025)	(.025)	(34,700)
DUM87	.061*	.061*	62,467
	(.025)	(.025)	(34,890)
DUM88	.075**	.075**	89,167**
	(.024)	(.024)	(33,661)
MEDDUM		.003	− 55,577
		(.022)	(31,052)
CONSTANT	5.383***	5.379***	421,060
	(.026)	(.035)	(48,605)
N	1,028	1,028	1,028
Adjusted R^2	.261	.260	.079

a. Dependent variable = log of malpractice payment (current dollars).
b. Dependent variable = malpractice payment (current dollars).
* $p < .05$.
** $p < .01$.
*** $p < .001$.

of occurrence, sex of claimant, allegations of negligence, severity of injury, year of settlement, and an interval-level variable for age.[11]

Taken together, the seventeen independent variables accounted for over one-quarter of the variance in the logarithm of claim severity. The variable INDIANA is by far the most important single variable in terms of accounting for explained variance. When INDIANA is omitted from the first equation, the R^2 drops from .261 to .141, but when INDIANA is retained and all the other significant variables (e.g., age, severity of injury, etc.) are dropped, the

11. To take advantage of the exact ages contained in the Michigan and Ohio data, we assigned all Indiana cases an age value equal to the midpoint of the age category employed. Indiana newborns were coded as having an age of zero, as were newborns in Michigan and Ohio.

R^2 only drops to .183.[12] Thus, nearly 50 percent of the explained variance is associated with the variable INDIANA. Coefficients for age, the two variables for state, the four variables for severity of injury, and the variables for settling a case in 1985 through 1988 were all statistically significant at the .05 level or below, as was the variable for "other allegations of negligence."

As discussed above, one important difference between the Indiana cases and the Michigan and Ohio cases was that the Michigan and Ohio samples contained only cases in which the Medical Protective Company was involved. While Medical Protective cases in Indiana appeared to be roughly comparable to non–Medical Protective cases, it is possible that our results were due to some unmeasured difference between Medical Protective cases and the cases handled by other insurance carriers.

To check for this possibility, in a second regression (Table 7, column 2), we regressed the logarithm of claim severity on the same set of variables used in Equation 1 plus a dummy variable (MEDDUM) to measure whether or not the case was one in which Medical Protective was involved. The new variable did not have a statistically significant effect. The results of the two regressions are nearly identical, although the R^2 is marginally lower in Equation 2 (.260) than in Equation 1 (.261) and for several other variables the regression coefficients are slightly different. Thus, whatever differences may exist between Medical Protective cases and non–Medical Protective cases, they do not seem to contribute either directly or indirectly to the differences in claim severity we have found.

To present a more complete picture of the impact of the various independent variables on claim severity, we used the independent variables from the second regression (Table 7, column 2) to predict actual payment rather than the logarithm of claim severity (Table 7, column 3). The value of R^2 falls quite sharply to .079, as a result of the several very large payments in Michigan and Ohio mentioned earlier. More importantly, this equation shows that Indiana cases receive a payment nearly $75,000 higher than Michigan cases, and more than $50,000 higher than Ohio cases—even when the effects of the other independent variables are controlled.

The two possible internal threats to the validity of our findings, that is, the differential distribution of Medical Protective claims and the large number of cases with missing values for age, did not have a significant impact on our results. The role of Medical Protective in a claim would have been significant only if non–Medical Protective cases had systematically received higher awards than comparable Medical Protective cases. However, when we compared cases in Indiana that did involve Medical Protective with those in the

12. Results of the regression without the variable INDIANA and the regressions in which INDIANA was the sole predictor are available from the authors.

state that did not, there was no statistically significant difference in mean claim severity. Similarly, the addition of the dummy variable for the involvement of Medical Protective left the regression analyses virtually unchanged.

Regarding age data, when cases missing data for age were compared in terms of claim severity to cases with valid age information, no statistically significant differences were found within either the Michigan or Ohio groups, which contained over 90 percent of the missing age cases. Further, when the regressions were rerun without age, neither the coefficients nor the R^2 changed appreciably.[13]

Discussion

The most important finding in this analysis is that, between 1977 and 1988, Indiana's mean payment for large malpractice claims was substantially higher than the mean payment for similar claims in Michigan and Ohio, independent of sex, age, severity of injury, allegations of negligence, and year of resolution. Our results are strikingly counterintuitive. We expected Indiana's cap on damages to depress average claim severity, especially since other Indiana characteristics, for example, fewer physicians and surgeons per capita and lower urbanization (see Table 1), should also work to lower claim size. As noted above, previously published work based on both aggregate and individual level data indicates that a cap on damages is the tort reform with the strongest and most direct limiting effect on claim severity (Danzon 1982, 1985, 1986; Sloan, Mergenhagen, and Bovbjerg 1989; Zuckerman, Bovbjerg, and Sloan 1990).

Moreover, the mean Indiana payment for large claims is nearly 40 percent higher than the mean claim payment in Michigan and more than 33 percent higher than the mean Ohio claim payment. Clearly, payments for large claims in Indiana tend to "bump up" against Indiana's cap. Of all large Indiana claims, 27.9 percent received the maximum of $500,000, while only 13 percent of Michigan and Ohio claims were paid at this level or above. In other words, large Indiana claims are more than twice as likely to be paid at the $500,000 level. Further, Indiana's large claims have only one tenth the chance of being paid for $100,000 as large claims in either Michigan or Ohio. It appears that Indiana's cap has actually become a "floor," as some have speculated happens with caps on malpractice damages (Sloan and Bovbjerg 1989).

Claimants may actually be getting more in Indiana than these differences in average claim payments suggest, since Indiana has a 15 percent cap on attorney's fees for payments from the PCF and neither Michigan nor Ohio impose a similar limit. Further, the PCF has the authority to make periodic payments which could have the effect of stretching PCF dollars even more.

13. The results of these regressions are available from the authors.

Why then are payments on large claims so high in Indiana—a state with stiff malpractice reforms, including a comprehensive damage cap—compared to Michigan and Ohio, which have no reforms?

The most reasonable explanation is the way in which the PCF operates. Recall that the PCF pays any portion of a claim above $100,000 and bases decisions on the appropriate level of payment only on the amount of damage and not liability. Consequently, the factors that influence and ordinarily depress final settlement amounts in common law jurisdictions—for example, what a jury would find on liability at trial, or what the future legal expenses might be, for both the plaintiff and defendant, of pressing a claim to judgment, are not considered in determining payment of a PCF claim.

Also, some evidence suggests that the PCF has not been vigorously defended by its counsel in the adjudication of PCF claim payments. Lawyers from the Indiana attorney general's office have customarily defended PCF claims. The performance of these attorneys has been questioned by Indiana's commissioner of insurance, who stated in a recent newspaper story, "We feel like the fund [PCF] has not been adequately defended" (Hallinan 1991). The state's lawyers are supposedly young and inexperienced and thus no match for the more experienced plaintiffs' attorneys. The executive director of the Indiana State Medical Association characterized the matchup of counsel in PCF claims as "the NBA versus Bedford High" (Hallinan 1991). With concerns within the Department of Insurance about the adequacy of defense of PCF claims as well as the solvency of the PCF, one should expect payments in large claims to be less generous in the future.

An important question is how Indiana can have such a comparatively high mean claim severity and still enjoy comparatively low malpractice insurance premiums. The financial history of the PCF is noteworthy, given that, under Indiana's system, the PCF absorbs all of the risk of large malpractice claims and private insurers' risk is capped at $100,000. From 1975 through 1982, the surcharge on providers to support the PCF was 10 percent of their malpractice premiums; but by 1988 this surcharge had increased to 125 percent to assure continued solvency of the PCF (Indiana Department of Insurance 1988). The PCF is basically financed on a "pay-as-you-go" basis and the surcharge has not been set according to actuarial principles designed to ensure sufficient accumulation to meet future losses (Kinney and Gronfein forthcoming). It should be noted that, with the PCF surcharge, total cost of malpractice insurance increases significantly. For example, in Indianapolis, in January 1989, malpractice insurance costs (primary insurance premium plus PCF surcharge) were $2,223 for nonsurgeons and $18,896 for obstetricians or gynecologists and neurosurgeons (Mullen 1989).

A remaining concern, despite the comparative generosity of the payment of Indiana's large claims in the aggregate, is the fairness of Indiana's system for individual claimants. While it is true that the mean Indiana claim payment

for large claims is much higher than the mean claim payment in Michigan and Ohio and proportionately more claims are paid at the $500,000 level than in these states, a few individual Michigan and Ohio awards far exceed the $500,000 or even $750,000 cap now in place in Indiana. An appropriate question is whether some claimants in Indiana would or should have received comparable recoveries in an uncapped system. Given that malpractice claimants in Indiana with catastrophic damage from malpractice injury, for example, premature death of a young spouse and father or permanent and totally disabling injuries, are limited to recovering $500,000 or, more recently, $750,000, while claimants in neighboring states can receive recoveries ten times as high, it is possible to conclude that the system is unfair to these individuals, whatever its aggregate results may be. We recognize that policymakers are often faced with implementing policy choices (for cost or other reasons) where superior aggregate performance rests on the possibility of individual losses. Nonetheless, it is sobering to consider that while our study indicates quite clearly that malpractice claimants with large claims in Indiana do better in the aggregate than similar claimants in Michigan or Ohio, their comparative advantage may be the result of limiting compensation for a few who suffer the terribly catastrophic consequences of negligent medical care.

The fact remains, however, that Indiana claimants with large claims, on average, get substantially more than their counterparts in either Michigan or Ohio. These findings suggest that relatively subtle administrative arrangements for the management of large claims at the state level may influence whether claimants can be fairly treated in a system that is tightly structured to control claim severity and thus stabilize the price and availability of malpractice insurance for providers. Our study results demonstrate that, under Indiana's system, all major parties are better off in the aggregate. Malpractice insurers, which still compensate most tort claimants in our society, have a more favorable actuarial environment because claim severity is controlled and therefore more predictable. Providers are better off because they are assured the availability of coverage and comparatively low malpractice insurance costs. Most importantly, most claimants with large claims are better off because they receive more for their injuries and their attorneys' fees are capped, although some catastrophically injured claimants may be disadvantaged.

Appendix. *Continued*

Variable	Mean	Standard Deviation	Description and Coding
SEV3[d]	.046	.209	Dummy variable for severity (1 if major total disability; 0 else)
SEV5[d]	.361	.480	Dummy variable for severity (1 if death; 0 else)
DUM8[e]	.099	.299	Dummy variable for year of settlement (1 if 1984; 0 else)
DUM85[e]	.153	.360	Dummy variable for year of settlement (1 if 1985; 0 else)
DUM86[e]	.180	.384	Dummy variable for year of settlement (1 if 1986; 0 else)
DUM87[e]	.179	.384	Dummy variable for year of settlement (1 if 1987; 0 else)
DUM88[e]	.202	.402	Dummy variable for year of settlement (1 if 1988; 0 else)
MEDDUM[f]	.780	.414	Dummy variable for Medical Protective case (1 if Med. Prot. case; 0 else)

Note: N = 1,028 with listwise deletion.
a. Michigan is the reference category.
b. Male is the reference category.
c. Obstetrical negligence is the reference category.
d. Grave total disability is the reference category.
e. 1977–83 is the reference category.
f. Non–Medical Protective is the reference category.

Appendix. Descriptive Statistics for Regression Variables

Variable	Mean	Standard Deviation	Description and Coding
AGE	29.8	22.4	Age at time of alleged malpractice, in years; Indiana cases assigned at midpoint of interval
PAYMENT	350,539	345,977	Amount of malpractice claim payment, in current dollars
LOGPAYMENT	5.45	.277	Log_{10} of claim payment, in current dollars
INDIANA[a]	.396	.489	Dummy variable for state (1 if Indiana; 0 else)
OHIO[a]	.268	.443	Dummy variable for state (1 if Ohio; 0 else)
SEX[b]	.510	.500	Dummy variable for sex (1 if female; 0 else)
DIAGNOSE[c]	.260	.439	Dummy variable for allegation (1 if diagnostic negligence; 0 else)
SURGERY[c]	.246	.431	Dummy variable for allegation (1 if surgical negligence; 0 else)
TRTMNT[c]	.150	.357	Dummy variable for allegation (1 if treatment related negligence; 0 else)
OTHER[c]	.145	.352	Dummy variable for allegation (1 if other negligence; 0 else)
SEV1[d]	.217	.412	Dummy variable for severity (1 if minor permanent disability; 0 else)
SEV2[d]	.125	.330	Dummy variable for severity (1 if major permanent disability; 0 else)

Appendix continues following page

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MEDICAL MALPRACTICE: LESSONS FOR REFORM

RANDALL R. BOVBJERG AND THOMAS B. METZLOFF
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Winter Issue

THE MEDICAL MALPRACTICE SYSTEM AND EXISTING REFORMS

Spring Issue

THE MEDICAL MALPRACTICE SYSTEM AND EMERGING REFORMS

INDIANA'S MALPRACTICE SYSTEM: NO-FAULT BY ACCIDENT?

ELEANOR D. KINNEY* AND WILLIAM P. GRONFEIN**

I

INTRODUCTION

This article reviews Indiana's ten years of experience with medical malpractice tort and insurance reforms. Indiana's malpractice reforms were among the first comprehensive malpractice reforms in the nation, have withstood several constitutional challenges, and have undergone few major changes since 1975.[1] A model for other states[2] and the federal government,[3] these reforms have helped Indiana health care providers continue to enjoy low malpractice premiums compared to other states.[4] Both health care providers and insurers are highly satisfied with the system.[5] Recently, however, press reports have galvanized consumer concerns about whether the reforms promote the interests of providers and insurers over those of claimants.[6]

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1. See *Cha v Warnick*, 476 NE2d 109, 114 (Ind 1985); *Rohrabaugh v Wagoner*, 274 Ind 661, 664-68, 413 NE2d 891, 894-95 (1980); *Johnson v St. Vincent Hosp., Inc.*, 273 Ind 374, 386-408, 404 NE2d 585, 591-606 (1980); *Whitaker v St. Joseph's Hosp.*, 415 NE2d 737, 745-46 (Ind App 1981); *Lee v Lafayette Home Hosp., Inc.*, 410 NE2d 1319, 1320-21 (Ind App 1980). Contrast *Hines v Elkhart General Hosp.*, 465 F Supp 421, 431-34 (ND Ind 1979), aff'd, 603 F2d 646 (7th Cir 1979).

2. See, for example, Kan Stat Ann §§ 60.3407, 65.4901 (Kan Dep't Admin, 1985 & 1989 Supp); La Rev Stat Ann § 40.1299.49 (West, 1977 & 1990 Supp); Neb Rev Stat §§ 2801-2855 (West, 1988); Randall R. Bovbjerg, *Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card*, 22 UC Davis L Rev 499, 521-31 (1989).

3. See generally Dept of Health & Human Services, Description of Model Health Care Provider Liability Reform Act (December 1987); Dept of Health & Human Services, Report of the Task Force on Medical Liability and Malpractice (August 1987).

4. See notes 143-47 and accompanying text.

5. See US Gen Acct'g Office, *Medical Malpractice: Case Study on Indiana* 2 (December 1986) ("GAO, *Case Study on Indiana*").

6. See Joseph T. Hallinan & Susan M. Headden, *A Case of Neglect: Medical Malpractice in Indiana*, Indianapolis Star 1 (June 24, 1990); Joseph T. Hallinan & Susan M. Headden, *State Failing to Crack Down on Malpractice*, Indianapolis Star 1 (June 25, 1990); Joseph T. Hallinan & Susan M. Headden, *Malpractice Laws Stacked Against Victims: Doctors, Insurance Companies Reap Biggest Benefits*, Indianapolis

This article analyzes the history and operation of the reforms, focusing on Indiana's Patient Compensation Fund ("PCF") and the comprehensive cap on all damages. The PCF and its cap on damages are among the most substantial legal changes of any state's,[7] and have the greatest impact on the most seriously injured claimants. Part II describes Indiana's Medical Malpractice Act ("the Act"),[8] and analyzes its practical application. Part III compares Indiana's experiences under the Act with neighboring states' experiences and with national data on malpractice claims, claimants, and defendants. As shown by the data, the unique characteristics of the Act and its implementation have led to quite generous payment of large claims with surprisingly little consideration of the defendants' fault. These results suggest that Indiana may have implemented, quite accidentally, a compensation system for large medical malpractice claims containing many key characteristics of no-fault compensation systems.[9]

II

THE INDIANA MEDICAL MALPRACTICE ACT

A. Background

Indiana is a conservative jurisdiction whose statutory and case law in the tort law field favors defendants.[10] The state has a modified comparative fault statute (although medical malpractice claims are exempted) that, unlike pure comparative fault statutes, adopts the more conservative approach allowing recovery only when the defendant's fault exceeds the plaintiff's.[11] Additionally, in 1986, Indiana modified the common law collateral source rule, making evidence of other sources of compensation for the plaintiff's injury admissible at trial.[12] Finally, Indiana's wrongful death statute, unlike the more generous statutes of some other states, precludes recovery for emotional loss even for the death of children.[13] It is not surprising then that

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Star 1 (June 26, 1990). See also Isabel Wilkerson, *As Indiana Debates its Malpractice Law, So Does the Country*, NY Times (National) A11 (August 20, 1990).

7. See Bovbjerg, 22 UC Davis L Rev at 525 (cited in note 2).

8. Ind Code Ann § 16-9.5 (Burns, 1990).

9. See notes 157-71 and accompanying text.

10. See John F. Vargo, *1983 Survey of Recent Developments in Indiana Law: Torts*, 17 Ind L Rev 341, 385 (1984); Robert G. Ziegler, *1984 Survey of Recent Developments in Indiana Law: Torts*, 18 Ind L Rev 417, 425-27 (1985).

11. Ind Code Ann § 34-4-33-4 (1986); L. Larson, 1 *Comparative Negligence: Law and Practice* § 2.30 (Matthew Bender, 1990); see Lawrence P. Wilkins, *The Indiana Comparative Fault Act at First (Lingering) Glance*, 17 Ind L Rev 687 (1984); Victor E. Schwartz, *Comparative Negligence in Indiana: A Unique Statute that Will Reshape the Law*, 17 Ind L Rev 957, 963-64 (1984).

12. Act of March 11, 1986, Pub L No 201-1986, 1986 Ind Acts 1969, codified at Ind Code Ann §§ 34-4-36-1 to 3 (Burns, 1988). See generally Lawrence P. Wilkins, *A Multi-Perspective Critique of Indiana's Legislative Abrogation of the Collateral Source Rule*, 20 Ind L Rev 399 (1987).

13. Ind Code Ann §§ 34-1-1-1 to 2 (1990); see Stuart M. Speiser, 1 *Recovery for Wrongful Death* § 1:12-14 at 32-38 (Lawyers Co-Op, 2d ed 1975).

Indiana has adopted, and its courts have upheld, what are arguably the nation's strictest set of tort and insurance reforms for medical malpractice.[14]

In the early 1970s, Indiana, along with the rest of the nation, experienced a crisis in the cost and availability of medical malpractice insurance for its health care providers.[15] Indiana, like other states, experienced sharp increases in the size and frequency of medical malpractice claims.[16] Consequently, the availability of medical malpractice insurance for physicians and hospitals decreased sharply in the mid-1970s.[17] In January 1975, Governor Otis R. Bowen, himself a physician, called in his State of the State address for reform of the common law tort system for medical malpractice.[18]

On February 4, 1975, House Bill 1460 ("H 1460"), drafted by attorneys for the Indiana State Medical Association, was introduced into the Indiana House of Representatives.[19] H 1460 called for an independent administrative tribunal, composed of physicians, lawyers, and consumers, to adjudicate malpractice claims and award damages and attorneys' fees according to fixed schedules and formulas.[20] When it became clear that most Indiana senators opposed the bill as too radical a departure from the common law jury system, the Indiana Senate considered a flurry of amendments that introduced elements of the current Act. Throughout, the legislature deliberated in an atmosphere of crisis. Physicians packed the galleries as the legislators debated. As one attorney recalls, "The entire House chamber was full of doctors—yelling, screaming . . . . [I]t was the damnedest thing you've ever seen."[21]

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14. See Frank A. Sloan & Randall R. Bovbjerg, *Medical Malpractice: Crisis, Response and Effects*, Health Ins Ass'n Am Res Bull 13 (May 1989).

15. See generally Otis R. Bowen, *Medical Malpractice Law in Indiana*, 11 J Legis 15 (1984). See also Adam Benjamin, Jr., *Indiana's Medical Malpractice Crisis*, in David Warren & Richard Merritt, eds, *A Legislator's Guide to the Medical Malpractice Issue* 38 (Health Policy Center, Graduate School, Georgetown University, and National Conference of State Legislatures, 1976).

16. The frequency of claims filed against physicians between 1970 and 1975 increased 42%, and the average damage award increased from $12,993 in 1970 to $34,297 in 1975, with medical malpractice insurance premiums for physicians rising 410% during the same period. Indiana Medical Malpractice Study Commission, Final Report 5-6 (1976) ("IMMSC Final Report").

17. See *Mansur v Carpenter*, No 37281, slip op 4 (Hancock County Cir Ct, April 6, 1978); IMMSC Final Report at 5-6 (cited in note 16).

In the summer of 1974, St. Paul Fire and Marine Insurance Company advised nearly 1,000 Indiana physicians that it would not renew their malpractice insurance. The Medical Protective Company, Indiana's major malpractice insurer for physicians, sharply limited the amount of insurance it would write for individual physicians. Similarly, in 1974 and early 1975, the seven major malpractice insurers for hospitals discontinued or limited writing liability insurance for hospitals. In response, many Indiana hospitals curtailed emergency and surgery services because of the high cost of liability insurance or lack of insured physicians to staff these services. *Mansur*, No 37281 at 4.

18. Message of Governor Otis R. Bowen to the 99th General Assembly, First Session, *Journal of the House* 31-36 (January 9, 1975). See also Benjamin, *Indiana's Medical Malpractice Crisis* at 38 (cited in note 15); Bowen, 11 J Legis at 15 (cited in note 15).

19. See Benjamin, *Indiana's Medical Malpractice Crisis* at 39 (cited in note 15).

20. Id at 39-40.

21. Hallinan & Headden, June 26, 1990 Indianapolis Star at 8 (cited in note 6).

This activity culminated on April 17, 1975, when the Indiana General Assembly enacted the Act.[22] The Act's purpose was to provide health care professionals and institutions with affordable medical malpractice insurance and thus assure the continued availability of health care services in the state.[23] Shortly after the Act was passed, medical malpractice premiums in Indiana dropped, and insurance became readily obtainable again.[24]

B. The Act's Provisions

The Act contains three major reforms: (1) a comprehensive cap on damages, (2) mandated medical review before trial, and (3) a state-run insurance fund to pay large claims (the PCF). Through 1989, the cap on medical malpractice recoveries was $500,000.[25] The legislature raised the cap to $750,000 for claims occurring after January 1, 1990, presumably in recognition of a need to address inequities in the system for persons with large claims.[26]

Eligible health care providers, exhaustively defined in the statute,[27] participate voluntarily by proving "financial responsibility." In this context, financial responsibility means a specified level of primary malpractice insurance coverage. Health care providers also participate by paying a surcharge on their primary insurance coverage to finance the PCF.[28] The level of primary insurance coverage for physicians and other health care providers is $100,000 per occurrence and $300,000 total.[29] Nearly all Indiana physicians and about 90 percent of Indiana hospitals participate.[30] Nonparticipants are protected neither by the damage cap nor by the PCF.[31]

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22. Act of April 17, 1975, Pub L No 146-1975, 1975 Ind Acts 854, codified as amended at Ind Code § 16-9.5 (1990).

23. Report of the Committee on Labor and the Economy to the 99th General Assembly, First Session, *Journal of the House* 577-78 (March 5, 1975). See Bowen, 11 J Legis at 15 (cited in note 15); Benjamin, *Indiana's Medical Malpractice Crisis* at 39-40 (cited in note 15); *Johnson*, 273 Ind at 379-80, 404 NE2d at 589-90; *Mansur*, No 37281 at 6-7.

24. GAO, *Case Study on Indiana* at 2 (cited in note 5); Michael S. Mullen, *Update on the Indiana Law of Medical Malpractice*, in *Indiana Medical Malpractice* S-13 to S-14 (Medical Protective Co., Fort Wayne, 1984) (materials prepared for Indiana Continuing Legal Education Forum) ("*Update*").

25. Ind Code Ann § 16-9.5-2-2(b)-(c).

26. Act of May 2, 1989, Pub L No 189-1989 § 1, 1989 Ind Acts 1538, codified as amended at Ind Code Ann § 16-9.5-2-2. The Indiana State Medical Association, the Indiana Hospital Association, and the Indiana Trial Lawyers Association entered an agreement, subsequently communicated to the legislative leadership by memorandum on March 1, 1989, to support this increase in the cap and not to support a legislatively mandated study of the Act until after January 1, 1993. Memorandum to Michael K. Phillips, Paul S. Mannweiler, Robert D. Garton, and Dennis P. Neary.

27. Ind Code Ann § 16-9.5-1-1.

28. Id at § 16-9.5-2-1(a).

29. Id at § 16-9.5-2-6(a). As of 1985, small hospitals (fewer than 100 beds) must carry $2 million in annual aggregate insurance, larger hospitals must carry $3 million, and prepaid health care delivery plans must carry $700,000. Act of April 14, 1985, Pub L No 177-1985, § 3, 1985 Ind Acts 1391, codified at Ind Code Ann § 16-9.5-2-6.

30. Telephone interview between Julie Ann Randolph, assistant director, Center for Law and Health, and Dianna J. Pitcher, manager, Medical Malpractice Division, Indiana Department of Insurance (September 18, 1990).

31. Ind Code Ann § 16-9.5-1-5.

1. *The Medical Review Panel.* The Act specifies that malpractice claimants must file their claims with the Indiana Department of Insurance and go through a medical review panel before proceeding to trial.[32] As of 1985, however, claimants can opt out and proceed directly to court if all parties agree to forgo panel review.[33] Also as of 1985, claimants with claims under $15,000 can unilaterally opt out.[34] At any point, the parties may settle the claim. Further, the PCF may consider and pay the claim without a medical review panel opinion.[35]

For the remaining claimants, the medical review panel provides an informal process to encourage an early decision on liability and can thereby facilitate quick resolution of the claim.[36] The panel consists of one attorney, who serves as nonvoting chair, and three health care providers.[37] The parties select the attorney who will serve as chair.[38] Each party selects one provider panelist, and those two provider panelists select the third.[39] Each party may challenge the third panelist without the need to show cause.[40] When requested, providers must serve on medical review panels except in cases of serious hardship.[41] The panel review process is designed to take less than nine months.[42]

The panel is authorized solely to give expert opinion on the cause of the injury and on the defendant's liability, or to determine that a material issue of fact bears on liability.[43] The panel has no role in determining damages, unlike its counterpart in some other states.[44] The panel receives evidence and reviews the discovery made by the parties, and can also consult independent medical authorities.[45] The panel's opinion is admissible at trial, but is not conclusive evidence of causation or liability; either party can compel any panel member to testify at trial at that party's expense.[46]

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32. Id at §§ 16-9.5-1-6, 16-9.5-9-1, 16-9.5-9-2, 16-9.5-9-2.1. Any party may request a medical review panel by filing a request with the Indiana Commissioner of Insurance. Id at § 16-9.5-9-1.

33. Act of April 14, 1985, Pub L No 177-1985, § 8, codified as amended at Ind Code Ann § 16-9.5-9-2(b).

34. Act of April 18, 1985, Pub L No 178-1985, § 5, 1985 Ind Acts 1402, codified as amended at Ind Code Ann § 16-9.5-9-2.1.

35. Ind Code Ann § 16-9.5-4-3.

36. Note, *Constitutionality of the Indiana Medical Malpractice Act: Re-Evaluated*, 19 Valp U L Rev 493, 494 (1985) (authored by Catherine Schick Hurlbut); James D. Kemper, Myra C. Selby & Bonnie K. Simmons, *Reform Revisited: A Review of the Indiana Medical Malpractice Act Ten Years Later*, 19 Ind L Rev 1129, 1131 (1986).

37. Ind Code Ann § 16-9.5-9-3.

38. Id at § 16-9.5-9-3(a).

39. Id at § 16-9.5-9-3(b).

40. Id at § 16-9.5-9-3(b)(3).

41. Id at § 16-9.5-9-3(b)(4).

42. According to statutory deadlines found in Ind Code Ann § 16-9.5-9-3, convening the panel should take less than two months. Once selected, the panel must meet and make its decision within 180 days. Id at § 16-9.5-9-3.5. See Kemper, Selby & Simmons, 19 Ind L Rev at 1133 (cited in note 36).

43. Ind Code Ann § 16-9.5-9-7.

44. See Sloan & Bovbjerg, Health Ins Ass'n Am Res Bull at 13 (cited in note 14).

45. Ind Code Ann §§ 16-9.5-9-4(a), 16-9.5-9-6.

46. Id at § 16-9.5-9-9.

2. *The Patient Compensation Fund.* The PCF, administered by the Indiana Department of Insurance and financed by a surcharge on a provider's primary malpractice insurance,[47] pays large claims to the extent they exceed $100,000—that is, when the primary insurer of one or more defendants agrees to settle a claim for at least $100,000, or (more rarely) when a court renders a verdict in excess of $100,000.[48] As of 1985, primary insurers and the PCF can make periodic payments to claimants,[49] with no limit on the actual value of the total payment that ultimately comes to the claimant.[50] There is a 15 percent limit on attorneys' fees that are based on recoveries from the PCF.[51]

The primary insurer (or the uninsured health care provider) generally pays claims up to $100,000.[52] These claims are resolved privately through settlements, the customary way in which claims have been resolved under the common law tort system since the widespread advent of liability insurance.[53]

To be eligible for PCF payment, the primary insurer of one or more defendants must settle a claim for $100,000, or a court must enter a judgment for more than $100,000.[54] Until 1985, one defendant had to contribute $100,000, part of which could be paid in the future, toward the claimant's recovery before a case was eligible for the PCF.[55] However, since 1985, at least $75,000 must be paid at settlement; such a payment, coupled with a commitment to a future payment of $25,000, qualifies for PCF payment.[56] Most importantly, more than one insurer can contribute to the requisite amount of primary insurance (although one insurer must pay at least $50,000 at the time of settlement).[57] The cost of an annuity or similar form of security for a structured settlement is counted in the requisite amount of primary insurance to be paid at settlement.[58]

To obtain funds from the PCF, a claimant must petition the court for approval of a settlement or payment of a judgment.[59] The other parties and/or the Commissioner of Insurance may contest the petition, and the

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47. Id at § 16-9.5-4-1 (1990 & 1990 Supp).

48. Id at § 16-9.5-2-7.

49. Act of April 14, 1985, Pub L No 179-1985 § 1, 1985 Ind Acts 1403, codified as amended at Ind Code Ann §§ 16-9.5-2-2.1 to 2.4. See Robin B. Stickney, *1985 Amendments to the Indiana Medical Malpractice Act*, 19 Ind L Rev 403, 405 (1986).

50. Ind Code Ann § 16-9.5-2-1(a).

51. Id at § 16-9.5-5-1(a).

52. Id at § 16-9.5-2-2(d).

53. See generally H. Laurence Ross, *Settled Out of Court: The Social Process of Insurance Claims Adjustment* (Aldene, 2d ed 1980); Fleming James, Jr. & John V. Thornton, *The Impact of Insurance on the Law of Torts*, 15 L & Contemp Probs 430 (Summer 1950).

54. Ind Code Ann § 16-9.5-2-2(d). If a provider's aggregate insurance ($300,000) has been exhausted, the entire claim can be paid from the PCF according to a procedure that is substantially similar to that for claims above $100,000 according to § 16-9.5-2-7.

55. Id at § 16-9.5-4-3.

56. Id at § 16-9.5-2-2.2(b).

57. Id at § 16-9.5-2-2.2(c).

58. Id at § 16-9.5-2-2.2(b).

59. Id at § 16-9.5-4-3(1).

court may even convene an evidentiary hearing on damages.[60] No judicial review of a court-approved settlement is available.[61] In the PCF and associated court proceedings, the liability of the health care provider is admitted and established.[62]

3. *Other Key Provisions.* The Act contains several other important provisions, including a shortened statute of limitations[63] and the establishment of the Residual Malpractice Insurance Authority, which offers primary insurance for physicians unable to obtain private insurance.[64] The Act also requires that the disposition of any malpractice claim be reported to the Indiana Department of Insurance by counsel and insurers.[65]

Finally, the Act establishes some linkages with Indiana's formal medical discipline system. Specifically, the Act requires that the Commissioner of Insurance report to the appropriate licensure or registration boards the settlements and judgments against each health care professional for review of his or her continued fitness to practice.[66] The board may then, if deemed appropriate, proceed with various disciplinary actions against the health care provider, including censure, or the probation, suspension, or revocation of the provider's license.[67]

III

INDIANA'S EXPERIENCE UNDER REFORMS

This section reviews data on the operation of Indiana's malpractice reforms as well as data collected on all malpractice claims filed with the Indiana Department of Insurance from 1975 through 1988.[68] This analysis also relies on claims data from the Medical Protective Company of Fort Wayne, Indiana—the largest insurer of physicians in the state.

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60. Id at §§ 16-9.5-4-3(3), 16-9.5-4-3(5).
61. Id.
62. Id at § 16-9.5-4-3(5).
63. Id at § 16-9.5-3-1. The statute of limitations has been amended to require a claimant to file a malpractice claim within two years of the alleged malpractice, although minors under age six have until age eight to file a claim. Id.
64. Id at §§ 16-9.5-8-2, 16-9.5-8-6.
65. Id at § 16-9.5-6-1(b).
66. Id at § 16-9.5-6-2(a).
67. Id. In practice, the various professional disciplinary authorities have taken little or no action on reported malpractice settlements and judgments, generating considerable public concern recently. See Hallinan & Headden, June 25, 1990 Indianapolis Star at 1 (cited in note 6).
68. From 1987 through 1990, the Center for Law and Health at Indiana University School of Law—Indianapolis conducted an evaluation of Indiana's Medical Malpractice Act. The evaluation collected data on all opened and closed claims filed with the Indiana Department of Insurance from 1975 through 1988. These materials are on file at the Center.

A. General Trends

From 1975 through 1988, 6,225 malpractice claims were filed with the Indiana Department of Insurance.[69] Of these claims, only 2,074 were closed.[70] It is remarkable that under Indiana's model malpractice reforms, less than one-third of filed claims were closed over a twelve-year period.

1. *Claim Frequency and Severity.* The key characteristics of claims affecting the availability and affordability of medical malpractice insurance are their frequency and their severity (that is, their size in dollar terms).[71] Increases in claim frequency and severity helped trigger the two malpractice crises of the 1970s and 1980s.[72] Most legislated tort and insurance reforms are aimed at controlling the frequency and severity of claims.[73]

Despite the reforms adopted, Indiana, like other states, experienced increases in claim frequency in the 1980s. Table I presents data on the number of new claims opened per physician from 1977 through 1988. While actual annual frequency in Indiana is lower than in other states, the rate of increase in the frequency of Indiana's malpractice claims is comparable to national trends,[74] with claim frequency in the state increasing by 70 percent between 1980 and 1985.

Between 1975 and 1988, the mean claim severity in current dollars for paid Indiana claims was $130,855 ($89,350 for all claims; $12,231 for paid, non-PCF claims). The median was $14,000. The mean paid claim in 1977 constant dollars was $73,566, and the median was $7,684. A study combining data collected by the National Association of Insurance Commissioners ("NAIC") [75] and United States General Accounting Office ("GAO")[76]

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69. Indiana Department of Insurance, Indiana Patient's Compensation Fund as of December 31, 1988, 3 (1988).

70. Id. A claim file is considered "closed" when (1) a claim for damages is not made, (2) the plaintiff drops the claim, (3) the insurer and plaintiff agree to a financial settlement, (4) a court renders a verdict, or (5) a settlement is reached through arbitration. US Gen Acct'g Office, *Medical Malpractice: Characteristics of Claims Closed in 1984*, 14 (April 1987) ("GAO, *Characteristics of Claims Closed*"). In this study, the determination that a claim was closed was made by the Indiana Department of Insurance, based on these criteria but also often requiring the reporting of information on settlement from the parties and involved insurers.

71. See Sloan & Bovbjerg, Health Ins Ass'n Am Res Bull at 7 (cited in note 14).

72. See id at 2-7; Glen O. Robinson, *The Medical Malpractice Crisis of the 1970s: A Retrospective*, 49 L & Contemp Probs 5 (Spring 1986); Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 L & Contemp Probs 57 (Spring 1986); Frank A. Sloan, *State Responses to the Malpractice Insurance "Crisis" of the 1970s: An Empirical Assessment*, 9 J Health Pol, Pol'y & L 629 (Winter 1985).

73. See Sloan & Bovbjerg, Health Ins Ass'n Am Res Bull at 13-14 (cited in note 14).

74. Id at 7, Figure 2. See also US Gen Acct'g Office, *Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms* 17-18 (December 1986) ("GAO, *Six Case Studies*"); GAO, *Case Study on Indiana* at 14-15 (cited in note 5).

75. Nat'l Ass'n Insurance Commissioners, *Medical Malpractice Closed Claims, 1975-1978* (1980) ("NAIC, *Medical Malpractice Closed Claims*").

76. GAO, *Characteristics of Claims Closed* (cited in note 70).

TABLE 1

FREQUENCY AND SEVERITY OF INDIANA MALPRACTICE CLAIMS, 1977-1988

Year	Mean Paid Claim[a] Current $	Mean Paid Claim[b] Constant 1977 $	Claims Per 100 Physicians[c]
1977	$ 4,166	$ 4,166	2.2
1978	53,760	49,935	4.1
1979	79,531	66,398	4.7
1980	74,264	54,615	5.7
1981	26,625	17,740	6.1
1982	85,674	53,731	7.6
1983	111,719	67,952	8.3
1984	128,511	74,975	9.0[d]
1985	135,925	76,569	9.7
1986	186,387	103,012	8.5
1987	220,697	117,674	8.0
1988	37,988	19,460	—[e]

SOURCE: Indiana Malpractice Claims Database, The Center for Law and Health, Indiana University School of Law—Indianapolis, 1988; Indiana Department of Insurance, 1988.

[a] Indiana Malpractice Claims Data Base, The Center for Law and Health, Indiana University School of Law—Indianapolis, 1990.

[b] Id.

[c] Indiana Department of Insurance, American Medical Association 1988.

[d] AMA physician data unavailable for 1984—figure obtained by taking average of 1983 and 1985.

[e] AMA physician data not yet available for 1988.

reported a national mean severity for paid claims at $102,313, using 1984 constant dollars.[77]

Claim severity in Indiana also increased substantially over time. Table I presents data on mean paid claim severity from 1977 through 1988.[78] Between 1978 and 1987, the mean paid claim severity in constant 1977 dollars rose from $49,935 to $117,674, an increase of more than 135 percent. Nationally, the severity of paid claims doubled in real dollars between 1980 and 1986.[79] Basically, then, Indiana's experience with claim severity has been similar to national trends despite its malpractice reforms.

2. *Unique Patterns in Indiana Claim Severity.* About 32 percent of Indiana's closed claims settled without payment; this figure is considerably smaller than the 57 percent found by GAO in its study of claims closed in 1984.[80] This difference is interesting because it suggests either (1) that the operation of Indiana's malpractice reforms negatively influences the initial decisions of

77. Frank A. Sloan, Paula M. Mergenhagen & Randall R. Bovbjerg, *Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis*, 14 J Health Pol, Pol'y & L 663, 688, Appendix 2 (Winter 1989).

78. Although data on closed claims included claims filed as early as 1975, none of these earlier claims were settled before 1977. Also, the table "endpoints" (1977 and 1988) are excluded from consideration because the number of claims settled in those years was much lower than the number of claims settled from 1978 through 1987.

79. Sloan & Bovbjerg, Health Ins Ass'n Am Res Bull at 7 (cited in note 14).

80. GAO, *Characteristics of Claims Closed* at 19 (cited in note 70).

plaintiffs' attorneys to bring a claim or (2) that malpractice insurers have a more expansive view toward settlement.

The distribution of Indiana's mean paid claim severity is especially interesting. Specifically, very few claims settled between $25,000 and $100,000 (12 percent) compared with the national data in GAO's study of 1984 closed claims (28.5 percent).[81] Large Indiana claims ($100,000 or more) constituted 30.2 percent of the total, compared with 18.3 percent in the GAO study.[82] However, the proportion of small claims (less than $25,000) in Indiana, 57.9 percent, and in the GAO study, 53.2 percent, were similar.[83] Moreover, only 14 out of 2,074 claims (0.5 percent) closed under Indiana's reforms from 1975 through 1988 were paid at levels between $75,000 and $100,000. The unique patterns of Indiana's mean claim severity are quite important and, as will be discussed below, suggest that Indiana's system may be working in a highly unusual fashion.[84]

3. *Claim Disposition Time.* An average of 23.7 months elapsed between the time a claim was filed and when it was closed, with virtually no difference between paid and nonpaid claims. Interestingly, Indiana's average was almost two months shorter than the GAO study of 1984 claims.[85] Like other national studies,[86] larger claims in Indiana took longer than smaller claims.

4. *Characteristics of Indiana Malpractice Claimants.* Of Indiana's malpractice claimants, 59.5 percent were female and 40.5 percent were male. While this disparity represents a statistically significant difference from Indiana's population generally, it is quite similar to the percentages of 56.9 and 43.1, respectively, found in the 1984 GAO study of closed claims.[87] It is well documented that women seek more health care services on average than men, due in part to childbearing needs.[88] This may explain the large representation of women among malpractice claimants.

Men, however, tended to receive larger claim payments than women, receiving $105,909 on average compared to $78,887 for women. The mean paid claim payment for men was $157,709 and $114,188 for women, a highly significant difference.[89] This disparity can perhaps be explained in part by the fact that men continue to command higher salaries than women, which

81. Id at 20.
82. Id.
83. Id.
84. See notes 157-60 and accompanying text.
85. GAO, *Characteristics of Claims Closed* at 35 (cited in note 70) (indicating an average elapsed time of 25.1 months between the filing and closing of a claim). See also Sloan, Mergenhagen & Bovbjerg, 14 J Health Pol, Pol'y & L at 688, Appendix 2 (cited in note 77) (indicating an average elapsed time of 1.97 years).
86. GAO, *Characteristics of Claims Closed* at 35 (cited in note 70).
87. Id at 28.
88. Lu Ann Aday, Ronald Andersen & Gretchen V. Fleming, *Health Care in the United States: Equitable for Whom?* 104 Table 3.4 (Sage Publications, 1980).
89. The difference is significant at $p < .001$. This indicates that the probability of such a finding occurring by chance is less than .001.

translates into higher awards for lost wages. But this difference also suggests that, in practice, male lives may be generally valued more highly than female lives.

Data showed that the ages of Indiana claimants were relatively similar in distribution to the age data reported by GAO.[90] Newborns received the highest mean award of any age category ($230,592), although as a group they constituted only 6.4 percent of the total number of claimants. These awards are almost certainly higher because injuries suffered at birth are likely to require expensive, often lifelong, care. Other differences between age groups were not significant.

5. *Characteristics of Indiana Malpractice Claims.* Most malpractice injuries in Indiana from 1975 through 1988 occurred in hospitals (68.3 percent, versus 22.2 percent in physicians' offices or clinics). GAO found that 80 percent of injuries occurred in hospitals, compared to 13 percent in physicians' offices nationally.[91]

The predominant allegation of negligence among Indiana's closed claims was surgical error, followed by errors in diagnosis and treatment.[92] These were the same top three categories in GAO's study of claims closed in 1984.[93] Further, the distribution of severity of injury[94] closely parallels the distribution reported by the GAO study. Finally, as in the GAO study, award size varied directly with severity.[95]

6. *Characteristics of Indiana Malpractice Defendants.* Physicians and hospitals accounted for about 80 percent of the 4,230 malpractice defendants in the closed claims under Indiana's malpractice reforms through 1988. Of all reported defendants, nearly 60 percent were individual physicians, roughly 7 percent were physician professional corporations, 8 percent were other health professionals, and approximately 25 percent were hospitals and other health care institutions. More than 75 percent of claims involved just one or two

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90. GAO, *Characteristics of Claims Closed* at 28 (cited in note 70).

91. Id at 24. See also Sloan, Mergenhagen & Bovbjerg, 14 J Health Pol, Pol'y & L at 688, Appendix 2 (cited in note 77).

92. Allegations of negligence were classified according to the categories developed by the Risk Management Foundation of the Harvard Medical Institutions. Harvard Risk Management Foundation, *Risk Management Foundation Information System* (1987).

93. GAO, *Characteristics of Claims Closed* at 23 (cited in note 70).

94. Severity of injury was classified according to the nine-level system used in other studies: (1) emotional only (for example, fright); (2) insignificant (for example, lacerations, contusions, rash); (3) minor temporary disability (for example, infections, improperly set fractures leading to delayed recovery); (4) major temporary disability (for example, burns, surgical material left in patient, recovery delayed); (5) minor permanent partial disability (for example, loss of fingers); (6) major permanent partial disability (for example, deafness, loss of limb, loss of one kidney); (7) major permanent total disability (for example, paraplegia, brain damage); (8) grave permanent total disability (for example, quadriplegia, severe brain damage); and (9) death. NAIC, *Medical Malpractice Closed Claims* at 8 (cited in note 75). See GAO, *Characteristics of Claims Closed* at 41 (cited in note 70).

95. GAO, *Characteristics of Claims Closed* at 41 (cited in note 70). See also Randall R. Bovbjerg, et al, *Juries and Justice: Are Malpractice and Other Personal Injuries Created Equal?*, 54 L & Contemp Probs 5 (Winter 1991); Frank A. Sloan & Chee Ruey Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?*, 24 L & Soc'y Rev 601 (Fall 1990).

defendants. This is not surprising given that one defendant must pay a substantial portion of the requisite $100,000 to get a claim to the PCF.[96] In claims with a physician as defendant, no settlement or judgment was made or reached in almost 54 percent of the cases. About one third of physician defendants were either obstetricians, general surgeons, or orthopedic surgeons. This is also consistent with the distribution nationally.[97]

Of all specialties, obstetricians represented the largest single group of malpractice defendants (14.5 percent), with general surgeons a close second (14.2 percent). These specialty groups, along with anesthesiologists, orthopedic surgeons, and radiologists, were overrepresented compared to their respective proportions of Indiana's physician population, while physicians in family practice, internal medicine, and psychiatry were underrepresented.[98]

About 55 percent of Indiana's physician defendants were board certified, compared to 50 percent reported in the GAO study.[99] Also, about 20 percent of the Indiana physician defendants were educated in foreign medical schools, compared to 23 percent nationally.[100] There were no statistically significant differences between board certified physicians and nonboard certified physicians, nor between foreign medical graduates and physicians educated in the United States, in terms of whether a claim was paid on their behalf.

Hospitals constituted about one-fourth of the defendants in all Indiana closed claims between 1975 through 1988. Private, nonprofit hospitals accounted for 69.9 percent of hospital defendants, a proportion substantially higher than their representation among Indiana's general acute care hospitals (48.1 percent). On the other hand, public hospitals made up only 29.4 percent of hospital defendants, and for-profit hospitals comprised 0.2 percent of hospital malpractice defendants. Of Indiana's general acute care hospitals, 45.1 percent are public and 6.8 percent are investor-owned.[101]

B. Performance of the System

1. *Operation of the Cap.* A controversial issue is the fairness of Indiana's comprehensive damage cap. Intuitively, comprehensive damage caps seem unfair to plaintiffs with large claims; they impose a limit on possible compensation that bears no relation to the damages the plaintiff actually sustained. Indeed, several state courts have invalidated damage caps on grounds that they deny plaintiffs their property rights.[102] Only California has

96. See notes 54-58 and accompanying text.

97. GAO, *Characteristics of Claims Closed* at 55 (cited in note 70).

98. These trends are similar to results of a study of Florida physician defendants. Frank A. Sloan, et al, *Medical Malpractice Experience of Physicians: Predictable or Haphazard?*, 262 J Am Med Ass'n 3291, 3292-94 (1989).

99. GAO, *Characteristics of Claims Closed* at 58 (cited in note 70).

100. Id at 59.

101. Am Hosp Ass'n, *Guide to the Health Care Field: 1988 Edition* A119-A124 (Am Hosp Ass'n, 1989).

102. See, for example, *Wright v Central DuPage Hosp. Ass'n.*, 63 Ill 2d 313, 347 NE2d 736 (1976); *Arneson v Olson*, 270 NW2d 125 (ND 1978); *Carson v Maurer*, 120 NH 925, 424 A2d 825 (1980);

a court-sanctioned damage cap, but it applies only to noneconomic losses.[103] Nevertheless, empirical research repeatedly demonstrates that damage caps are one of the few tort reforms that effectively reduce the severity of malpractice claims.[104]

In assessing the operation of Indiana's cap, comparisons with two neighboring states regarding large ($100,000 or more) malpractice claims are instructive.[105] Unlike Indiana, Michigan and Ohio have only sporadically adopted malpractice reforms and have never implemented a damage cap.[106] However, with respect to other, more general tort reforms, all three states are rather similar.[107] Also, in terms of aggregate variables identified by several

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Waggoner v Gibson, 647 F Supp 1102 (ND Tex 1986). But see, for example, *Prendergast v Nelson*, 199 Neb 97, 256 NW2d 657 (1977); *Jones v St. Board of Medicine*, 97 Idaho 879, 55 P2d 399 (1976); *Boyd v Bulula*, 877 F2d 1191 (4th Cir 1989), rev'g 647 F Supp 781 (WD Va 1986); *Etheridge v Medical Center Hosp.*, 237 Va 87, 376 SE2d 525 (1989); *LaMark v NME Hosps.*, 542 S2d 753 (La App 1989), cert denied, 551 S2d 1334 (1989). See Randall R. Bovbjerg, Frank A. Sloan & James F. Blumstein, *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering,"* 83 Nw U L Rev 908, 956-58 (discussing caps generally); 968-74 (discussing their constitutionality) (1989). See also Kathryn L. Vezina, *Constitutional Challenges to Caps on Tort Damages: Is Tort Reform the Dragon Slayer or is it the Dragon?*, 42 Me L Rev 218 (1990); Jill Oliverio, *To Cap or Not to Cap Damage Awards: That is the Constitutional Question*, 91 W Va L Rev 519 (1988); Jesse M. Wagner & Ronald E. Reiter, *Damage Caps in Medical Malpractice: Standards of Constitutional Review*, 1987 Det Coll L Rev 1005 (1987); Paul M. Barrett, *Tort Reform Fight Shifts to State Court*, Wall St J 27 (September 19, 1988).

103. Cal Civ Code § 3333.2 (West, 1970 & Supp 1989). See *Fein v Permanente Medical Group*, 38 Cal3d 137, 695 P2d 665, 211 Cal Rptr 368 (1985), appeal dismissed, 474 US 892 (1985). See Bovbjerg, 22 U C Davis L Rev at 525 & n115 (cited in note 2).

104. Danzon, 49 L & Contemp Probs at 77-78 (cited in note 72); Patricia M. Danzon, *Medical Malpractice: Theory, Evidence, and Public Policy* 82 (Harv U Press, 1985); Patricia M. Danzon & Lee A. Lilliard, *Medical Malpractice* 26 (RAND, 1982). Contrast Sloan, 9 J Health Pol, Pol'y & L at 633-34, 639-43 (cited in note 72); Sloan, Mergenhagen & Bovbjerg, 14 J Health Pol, Pol'y & L at 663 (cited in note 77). See generally Sloan & Bovbjerg, Health Ins Ass'n Am Res Bull (cited in note 14).

Danzon found that caps on damages reduce the average severity of the claim by 23%. Danzon, 49 L & Contemp Probs at 72 (cited in note 72). More recently, Sloan, Mergenhagen & Bovbjerg found that damage caps on total payments in particular achieved savings in claim payments of up to 39%. Sloan, Mergenhagen & Bovbjerg, 14 J Health Pol, Pol'y & L at 678 (cited in note 77).

105. William P. Gronfein & Eleanor D. Kinney, *Controlling Large Medical Malpractice Claims: The Unexpected Impact of Damage Caps* (recently accepted for publication in J Health Pol, Pol'y & L).

106. In 1975, Michigan authorized voluntary, binding arbitration in lieu of a court trial, but this arbitration alternative has not been used to any significant extent. Michigan Commissioner of Insurance, *Claims Experience and Market Conditions for Medical Malpractice Insurance* 26 (1989). See also Rhoda M. Powser & Frances Hamermesh, *Medical Malpractice Crisis the Second Time Around: Why Not Arbitrate?*, 8 J Legal Med 283 (1987); Mary Bedikian, *Medical Malpractice Arbitration Act: Michigan's Experience with Arbitration*, 10 Am J L & Med 287 (1984-85). In 1975, Ohio enacted a $200,000 limit on noneconomic damage except for wrongful death and mandated compulsory arbitration of malpractice claims. The Ohio Supreme Court immediately ruled that these reforms were unconstitutional; thus, they were never implemented. *Simon v St. Elizabeth Medical Center*, 355 NE2d 903 (Ohio 1976). See Mary Ann Willis, *Limitation on Recovery of Damages in Medical Malpractice Cases: A Violation of Equal Protection?*, 54 U Cin L Rev 1329 (1986); Thomas J. O'Connell & Amy Tolnitch, *Ohio's Attempt to Halt the Medical Malpractice Crisis: Effective or Meaningless?*, 9 U Dayton L Rev 361 (1984).

107. Michigan, Ohio, and Indiana all adopted the two tort reforms (that is, shortened statutes of limitations and modified the common law collateral source rule) that Danzon found effective in reducing claim frequency and severity. Danzon, 49 L & Contemp Probs at 71, 72, 77 (cited in note 72); Danzon, *Medical Malpractice* at 166 (cited in note 104). All three states tightened their statutes of limitations for malpractice in the mid-1970s. Ind Code Ann § 16-9.5-3-1; Mich Comp Laws Ann § 600.5805(4) (West, 1987); Ohio Rev Code Ann § 2305.10 (Page, 1981 & 1989 Supp). All three states also modified the common law collateral source rule in the late 1980s to require some offset of collateral payments from damage awards, although Ohio's rule does not apply to medical

experts as having an important influence on claim severity, Indiana, Michigan, and Ohio are again reasonably similar. These variables include: level of urbanization;[108] number of physicians per 10,000 persons;[109] number of lawyers per 10,000 persons;[110] per capita income;[111] and ratio of surgeons to all physicians.[112] With respect to these variables, Indiana's figures are lower than either Michigan's or Ohio's.[113] Thus, one would expect that claim payments in Indiana would be lower than in either Michigan or Ohio.

In fact, however, the amount of compensation going to claimants with large malpractice payments in Indiana is, on average, substantially higher than in either Michigan or Ohio.[114] The mean severity of Indiana's large claims ($100,000 or more) between 1975 and 1988, in current dollars, was $404,832; by contrast, Michigan's was $290,022 and Ohio's was $303,220.[115] The median payment for large claims was $435,283 in Indiana, $180,000 in Michigan, and $200,000 in Ohio.[116] Further, 27.9 percent of Indiana's PCF cases received the maximum allowable payment of $500,000, while only 13 percent of Michigan's and Ohio's claims were paid at this level or above.[117]

2. *Operation of the Medical Review Panel.* Surprisingly, medical review panels were invoked in only 11.7 percent of claims closed before December 31, 1988, although a panel had reviewed 1,452 open claims as of this date.[118] For 52 percent of the PCF defendants for whom the PCF paid claims, no medical review panel was convened.[119] Of the defendants in closed claims whose cases were considered by a medical review panel, only 189 (22.4 percent) were found to have committed malpractice.[120]

One reason for these startling findings regarding the use of the panel in closed claims is that the panel review process has proven to be quite time-consuming. The average time between the filing of a complaint and the issuance of a final panel opinion is thirty-two months.[121] Some anecdotal evidence suggests that slowness in forming and convening medical review

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malpractice. Ind Code Ann §§ 34-4-36-1 to 3; Mich Comp Laws Ann § 600.6301; Ohio Rev Code Ann § 2317.45.

108. Danzon, 49 L & Contemp Probs at 75-76 (cited in note 72).

109. Sloan, 9 J Health Pol, Pol'y & L at 638 (cited in note 72); Danzon, *Medical Malpractice* at 70-72 (cited in note 104).

110. Sloan, 9 J Health Pol, Pol'y & L at 631 (cited in note 72).

111. Roger Feldman, *The Determinants of Medical Malpractice Incidents: Theory of Contingency Fees and Empirical Evidence*, 8 Atlantic Econ J 59, 61-62 (1979).

112. Danzon, 49 L & Contemp Probs at 74, 79 (cited in note 72).

113. Gronfein & Kinney, J Health Pol, Pol'y & L (cited in note 105).

114. Id. The Michigan and Ohio data derive from all large claims ($100,000 or more) filed with the Medical Protective Company, Fort Wayne, Indiana between 1977 and 1988. For the relevant period, the Medical Protective Company had about one-third of the market in Michigan and Ohio.

115. Id. The difference between these three means was highly significant at $p < .001$.

116. Id.

117. Id.

118. Indiana Patient's Compensation Fund at 3 (cited in note 69).

119. Id.

120. Id.

121. Id at 5. See also Kemper, Selby & Simmons, 19 Ind L Rev at 1133-35 (cited in note 36); Lester F. Murphy, *Pitfalls in Medical Malpractice Panel Practice*, 28 Res Gestae 178, 178-79 (1985).

panels ultimately leads to delays in resolving malpractice claims,[122] and perhaps also to the large backlog in open claims described above.[123]

These findings are quite interesting, given the role the medical review panel was designed to play in affording accessible expert review to determine liability early in a claim. However, as the experience with closed claims reveals, the medical review panel in fact plays an unexpectedly reduced role in the adjudication of malpractice claims. It should be noted that Pennsylvania and Florida courts have invalidated screening panels on grounds that they impose unconstitutionally impermissible delays.[124] To the extent that delays in convening medical review panels contribute to the fact that only one-third of filed claims were closed from the start of reforms in 1975 through 1988, the theories advanced in the Pennsylvania and Florida cases could prove persuasive in a future constitutional challenge to Indiana's reforms. It is also noteworthy that one Indiana trial court ruled the Act unconstitutional because of undue delays in the operation of Indiana's medical review panels; however, the Indiana Supreme Court reversed, concluding that the panel review process was not significantly longer than the disposition of lawsuits in the common law tort system.[125]

3. *Impact of the By-Pass Amendment.* As noted above, a 1985 legislative amendment authorized the filing of small claims ($15,000 or less) directly in state court, thus by-passing the medical review panel.[126] Some commentators anticipated that this authority would generate a flood of claims filed in court and effectively undercut Indiana's malpractice reforms.[127] However, the by-pass amendment has rarely, if ever, been used.[128] Apparently, plaintiffs' attorneys are unwilling to acknowledge at the inception of a lawsuit that its value is less than $15,000.

4. *PCF Performance.* Between 1975 and 1988, the PCF paid about 410 claims. The great majority of PCF claims were settled; only twenty-one claims were paid following court judgments, and one claim was settled after trial.[129] Once claims reached the PCF, recoveries were generous. The mean payment was $405,297 in real dollars,[130] and the average severity of injury index was at

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122. Kemper, Selby & Simmons, 19 Ind L Rev at 1133 (cited in note 36); Murphy, 28 Res Gestae at 180-81 (cited in note 121).

123. See notes 69-70 and accompanying text.

124. *Aldana v Holub*, 381 S2d 231 (Fla 1980); *Mattos v Thompson*, 491 Pa 385, 421 A2d 190 (1980). See Bovbjerg, 22 UC Davis L Rev at 524 & n109 (cited in note 2).

125. *Warnick v Cha*, No SC-83-163 (Jasper County Superior Ct 1983), rev'd, *Cha v Warnick*, 476 NE2d 109 (Ind), cert denied, 474 US 920 (1985).

126. See note 34 and accompanying text.

127. See Kevin C. Murray, *"Small Claims" Suits: Legislative Erosion of the Medical Malpractice Act*, Marion County Med Soc'y Bull 10 (February 1986).

128. The Indiana Department of Insurance has no record of this procedure being used in any claim. (The Act requires health care providers and insurers to report the disposition of all malpractice claims. See note 65 and accompanying text.)

129. Indiana Patient's Compensation Fund at 3 (cited in note 69).

130. This figure differs from the mean large claim reported at note 115 and accompanying text because that figure included claims for which no additional payments were made from the PCF.

the level that represents major permanent and total disability. About 14.9 percent of PCF claims involved injuries to infants at birth, while 29.8 percent of PCF claims were wrongful death cases.

The PCF's financial condition over the years has been troublesome. The PCF has always operated on a "pay-as-you-go" basis. Since 1975, the PCF surcharge has generated $150.8 million in revenue, while the PCF has paid $135.3 million in claim payments.[131] In 1988, the PCF collected $41.3 million from the surcharge and paid $21.5 million for claims, leaving a balance of $29.8 million.[132] A transfer of $7.2 million from the reserves of the state's Medical Malpractice Joint Underwriting Commission rescued the PCF from insolvency in 1984.[133] As discussed below, the surcharge on health care providers to finance the PCF has risen substantially since the Act's inception.[134]

5. *Use of Structured Settlements.* Periodic payments and associated structured settlements are ostensibly designed to ensure that damage awards will remain available to claimants for as long as they continue to need compensation.[135] Structured settlements are particularly useful for claimants, especially because some evidence exists that a significant number of them exhaust large damage awards quickly, thus leaving their future needs largely unmet.[136] On the other hand, structured settlements are attractive to insurers because the companies save by avoiding present cash payments and by using annuities and similar products from their other lines of business to help finance such settlements. In many Indiana claims, the use of periodic payments has resulted in creative structured settlements that benefit the claimants by permitting them to receive compensation worth more than the $500,000 cap; nevertheless, a concern exists that, after attorneys' fees are paid, claimants actually receive very little in present compensation.[137] Also, in a very few cases, serious abuses have occurred.[138]

In a judicial challenge brought by the Commissioner of Insurance, the Indiana Court of Appeals upheld two structured settlements entered into before 1985 in which insurers paid only $10,000 at settlement, with the

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131. Indiana Patient's Compensation Fund at 1 (cited in note 69).

132. Id.

133. GAO, *Case Study on Indiana* at 3 (cited in note 5).

134. See notes 146-47 and accompanying text.

135. Comment, *Making a Client Whole: Rhetoric or Reality?*, 12 S U L Rev 281, 286 (1986) (authored by David Ferguson); Note, *Periodic Payment Plans: Are Annuities Adequately Protecting the Personal Injury Plaintiff from Inflation, Providing Accurate Attorney's Fees and Promoting the Compensatory Goal of Our Tort Law System?*, 12 Ohio N U L Rev 271, 272 (1985) (authored by James S. Marello); T. V. Mangelsdorf, *Structured Settlements in Review: The Fundamental Concept*, 4 Am J Trial Advoc 559, 561 (1981).

136. Note, 12 Ohio N U L Rev at 271 (cited in note 135).

137. Hallinan & Headden, June 26, 1990 Indianapolis Star at 9 (cited in note 6).

138. In one dramatic illustration of such abuses, St. Paul Fire and Marine Insurance Company agreed to settle a case with a claimant by paying $100,000 to get the case to the PCF if the claimant agreed to repay St. Paul $25,000 out of the settlement received. The claimant subsequently reported this arrangement to the Indiana Attorney General, and the Indiana Department of Insurance persuaded St. Paul to repay this $25,000 to the claimant. See Joseph T. Hallinan, *Insurer's Proposal for $25,000 Loan Draws State's Ire*, Indianapolis Star 8 (June 26, 1990).

balance to be paid in future payments, noting that in seventy-five cases claimants gained access to the PCF following a structured settlement.[139] Thus, the 1985 legislative amendments specifically authorizing structured settlements and establishing mandatory contribution amounts for insurers were actually intended to reform the practice regarding structured settlement that had evolved.[140]

Since 1985, periodic payments by primary insurers and the PCF have been used in structured settlements of PCF claims. Of the 264 PCF claims settled between 1985 and 1988, 32.6 percent involved periodic payments. Also, 23.9 percent of PCF claims during this period involved contributions from multiple health care providers or their insurers to activate the PCF. These data suggest that insurers continued to find the periodic payment option attractive in settling claims.

6. *Litigation Costs.* Under Indiana's system, attorneys' fees are limited for claims paid from the PCF,[141] ostensibly in order to maximize payments to claimants. While it appears that Indiana claimants with large claims pay less because of the cap on fees than they otherwise would under a common law system, some reason for concern exists because plaintiffs' attorneys have been able to charge expenses in addition to attorneys' fees, effectively increasing their total payments under the capped system.

Defense costs in Indiana compare favorably with defense costs in other states. The Medical Protective Company reports that its defense costs were markedly lower in Indiana than in either Ohio or Michigan. Specifically, between 1984 and 1988, Medical Protective paid 46 percent more in allocated loss adjustment expenses to close claims in Ohio and over 100 percent more in such expenses to close claims in Michigan.[142]

7. *Malpractice Insurance Premiums.* Given these trends, it is interesting that Indiana's malpractice insurance premiums have remained low compared to other states. According to a GAO study, Indiana health care providers continue to pay among the lowest malpractice insurance premiums in the nation.[143] Specifically, Indiana physicians pay lower premiums than do physicians in the neighboring states of Ohio, Michigan, Illinois, and Kentucky, although with the PCF surcharge, physicians in comparable classes in Indianapolis, Indiana, now pay only slightly less than their counterparts in Cincinnati, Ohio, although they receive coverage for $500,000 in damages compared to $100,000 for their neighboring physicians. They also have total immunity from claims above $500,000, indemnity that physicians in

139. See *Eakin v Mitchell-Leech*, 557 NE2d 1057 (Ind App 1990), transfer to US Supreme Court denied, No 45A02-8807-CV-213 (February 8, 1991).

140. See notes 49-50, 56-58 and accompanying text.

141. See note 51 and accompanying text.

142. Gronfein & Kinney, J Health Pol, Pol'y & L (cited in note 105).

143. US Gen Acct'g Office, *Medical Malpractice: Insurance Costs Increased but Varied among Physicians and Hospitals* 30-34, 60-69 (September 1986); GAO, *Six Case Studies* at 15-16 (cited in note 74). See also Sloan & Bovbjerg, Health Ins Ass'n Am Res Bull at 5-6 (cited in note 14).

neighboring states do not enjoy.[144] It should be noted that physician carriers in Indiana offer occurrence insurance, which covers all claims that occurred during the policy period (whether or not the claim was actually brought within that period), as opposed to claims-made insurance, which covers only claims actually made during the policy period. Claims-made insurance is generally all that is available to physicians in Ohio, Michigan, and most other states. Nevertheless, the experience with imposing the surcharge to finance the PCF should dispel complacency about low insurance premiums in the long term. As discussed above,[145] the PCF's solvency has been a persistent concern since the Act's inception. From 1975 through 1982, the surcharge on providers to support the PCF was 10 percent of malpractice premiums.[146] By 1988, the surcharge increased to 125 percent.[147]

8. *Subrogation, Statutory Liens, and the Collateral Source Rule.* In a capped system, various remedies and rules accord rights to third parties to share in the claimant's tort recovery or require reductions in the claimant's recovery to adjust for compensation from other sources. The operation of these devices raises important concerns. These rights and rules may be analytically appealing in an abstract sense because they appear to prevent possible windfalls to claimants. However, one must question their fairness in a capped system. When a damage cap both sets a categorical limit on what can be awarded and permits attorneys to be paid off the top of awards, claimants may actually receive very little after third parties have received reimbursement of their expenses.

Indiana has adopted several statutory lien provisions to permit hospitals,[148] workers compensation insurers,[149] and the state Medicaid program[150] to obtain reimbursement from plaintiff's tort recoveries. Indiana common law recognizes the right of health insurers, pursuant to contract, to recover reimbursement for medical expenses from tort recoveries gained by their insureds.[151] Also, as noted above,[152] Indiana's legislature abrogated the common law collateral source rule, which prohibits the admission at trial of evidence of other sources of compensation available to the plaintiff.[153] These

144. Mullen, *Update* at S-15, chart F (cited in note 24).

145. See notes 131-34 and accompanying text.

146. Indiana Patient's Compensation Fund at 61 (cited in note 69).

147. Id.

148. Ind Code Ann § 32-8-26-1.

149. Id at §§ 22-3-2-13, 22-3-7-36. See *Dearing v Perry*, 499 NE2d 268 (Ind App 1982); *Hagerman v Mutual Hosp. Ins., Inc.*, 175 Ind App 293, 371 NE2d 394 (Ind App 1978). See generally Robert E. Keeton & Alan I. Widiss, *Insurance Law: A Guide to Fundamental Principles, Legal Doctrines, and Commercial Practices* § 3.10(a)(7), 228-32 (West, 1988).

150. Ind Code Ann § 12-1-7-24.6.

151. See, for example, *Costello v Mutual Hosp. Ins., Inc.*, 441 NE2d 506 (Ind App 1982); *Hagerman*, 175 Ind App 293, 371 NE2d 394. See generally Keeton & Widiss, *Insurance Law* § 3.10(a)(7), at 228-32 (cited in note 149).

152. See note 12 and accompanying text.

153. Ind Code Ann § 34-4-36-1. See generally Wilkins, 20 Ind L Rev 399 (cited in note 12). Under Indiana's rule, the trier of fact calculates reductions in awards for collateral benefits received. Life insurance payments and other death benefits, insurance benefits directly paid for by the plaintiff

authorities have been invoked in many medical malpractice claims, including 8 percent of PCF claims, for a total of $2,256,596. The Indiana Medicaid program has imposed the great majority of these liens, while Blue Cross and Blue Shield of Indiana, Inc., the Medicare program, and hospitals have imposed a few.

The operation of these rights of third parties in a capped system indeed raises fundamental questions of fairness, as Indiana's actual experience demonstrates. There have been instances where claimants have received very little from a large recovery because third parties and the plaintiff's attorney have been paid first.[154] Particularly disturbing is the interaction of the damage cap with these statutory liens. Arguably, the cap is designed to hold down claim severity and thereby make malpractice insurance more affordable for health care providers. Thus, the cap represents a transfer of wealth from a few claimants with very large claims to the health care providers that collectively finance the system for compensating malpractice injury. Such a transfer is appropriate as long as claimants are not harmed substantially.

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or his family, and governmental benefits received by the plaintiff before trial are excluded, but worker's compensation is not. Ind Code Ann § 34-4-36-2.

154. The following letter from a 43-year-old PCF claimant to the Indiana Department of Insurance dramatically illustrates the injustice that can result from imposing such liens in a capped system:

> During April of 1981, I became a victim of medical malpractice. . . . To meet his one hundred thousand dollar ($100,000.00) obligation, Dr. [Defendant] purchased an annuity that will mature in fifteen (15) years. According to my attorney, I will be awarded four hundred thousand dollars ($400,000.00) on the fifteenth of this month (July 15th, 1987). I feel it is necessary to write to you to show you how that amount will be divided up and thus showing the injustice of the state's medical malpractice system.
>
> During the last five and one-half (5.5) years, the Indiana State Department of Public Welfare (through Medicaid) has spent two hundred thirty-nine thousand eighty-two dollars and forty-two cents ($239,082.42) for my care as of mid-June 1987. A lien for this amount has been filed and must be honored accordingly. The attorneys' fees are one hundred thousand dollars ($100,000.00) plus expenses incurred for this case. Those expenses have been set at thirty thousand dollars. The balance is the actual compensation I'll receive until the annuity matures. The following table illustrates the settlement's division.
>
> | | |
> |---|---|
> | $400,000.00 | Amount to be received July 15 |
> | 239,082.42 | To the State Welfare Department |
> | 130,000.00 | Attorney fees and expenses |
> | 30,917.58 | TO THE VICTIM |
>
> By July 15th, Medicaid will probably increase the lien by two thousand dollars ($2000.00). The Malpractice incident resulted in the loss of function in my left arm and both legs. I also lost bladder and bowel control making the possibility of employment almost impossible. I'm living in a nursing home and my part of the settlement will not cover one year's expenses. This means I'll be back on Medicaid and in fifteen (15) years (when the annuity matures) it will be claimed through a lien by Medicaid.
>
> I'm forty-three (43) years old. If financially able to do so I could live on my own with an attendant, but I've lost more than bodily functions. I've also lost independence and my liberty. That loss of independence and liberty was through medical malpractice yet as the victim, I'll not be allowed to regain my liberty and independence through just compensation.

Letter of Malpractice Claimant to Indiana Commissioner of Insurance (July 4, 1987). This letter is available from The Center for Law and Health, Indiana University School of Law—Indianapolis, Indianapolis, Indiana 46202.

However, poor claimants on Medicaid are disproportionately victimized by these liens.

When third parties are placed ahead of the claimant who, to serve other societal goals, already must expect limited compensation, a clear ethical issue emerges: whose interest is more deserving? Medicaid liens raise more complicated issues, because Medicaid eligibility rules require applicants to deplete resources before becoming eligible for benefits. Nevertheless, future medical expenses represent only part of special and general damages, which also include losses due to inability to work, pain and suffering,[155] or, in the case of wrongful death, losses to the survivors.[156] Allowing third parties to receive full payment from claimants' damage awards under a capped system embodies the erroneous assumption that claimants' damages are basically medical expenses rather than these other types of equally important items of damage.

IV

NO-FAULT BY ACCIDENT?

Indiana's claims are adjudicated and paid under the most comprehensive and severe set of insurance and tort reforms in the nation.[157] Yet Indiana's malpractice reforms operate in a way that softens the expected impact of these reforms and results in a comparatively generous compensation system. In Indiana's system, a variety of subtle incentives appear to encourage the insurers of health care providers to settle claims, particularly large claims, with little concern about the defendant's fault.

Insurers are apparently pushing claims involving serious injury to the PCF by agreeing to pay claimants the requisite amount to make cases eligible for PCF payment. If a structured settlement can be arranged with other insurers contributing to the initial settlement, the insurer is in an even better position. In any event, upon settlement, the insurer has exhausted the limits of the insured's primary policy and no longer has any interest or real obligation to provide a defense to the insured. Given that the medical review panel is an optional proceeding, insurers have much to gain and little to lose by forgoing a costly defense before the review panel and instead expeditiously pushing a borderline case to the PCF.

The fact that, compared to the GAO study, fewer Indiana claims are paid between $25,000 and $100,000, more Indiana claims are paid at $100,000 and above, and only fourteen claims fell between $75,000 and $100,000 in a twelve-year period[158] is persuasive evidence that insurers may be pushing substantial claims to the PCF that ordinarily would be settled for under $100,000. Insurers are apparently willing to add a few dollars to get a claim

155. Dan B. Dobbs, *Handbook on the Law of Remedies* § 8.1, 540-51 (West, 1973).
156. Id at § 8.3, 556-57.
157. See Sloan & Bovbjerg, Health Ins Ass'n Am Res Bull at 19 (cited in note 14).
158. See notes 81-82 and accompanying text.

to the PCF in order to terminate their obligation to defend the claim and pay related expenses.

The statutory constraints on what can be considered in a PCF decision to pay a claim also uniquely affect the adjudication and resolution of large malpractice claims. By law, the PCF can consider only the amount of the claimant's damages; it must assume that the defendant's liability is admitted.[159] Consequently, the factors that influence the ultimate payment of claims in the common law tort system, such as the jury's final decision on liability or the expenses involved in pressing a claim through trial,[160] are not considered in establishing the amount of compensation for the claimant.

One crucial result of these incentives in Indiana's system is that a state-run insurance fund is paying large sums of money to most PCF claimants without a formal determination of fault. As a practical matter, the only required indications of a defendant's liability are (1) a private decision by a malpractice insurer—or several insurers in a structured settlement—that its exposure (including likely litigation costs) is such that it will pay a sizable sum to the claimant, and (2) the PCF's subsequent assessment of the value of the claimant's damages.

Is this no-fault by accident? The distinguishing characteristics of no-fault schemes are the imposition of liability for designated injuries regardless of the defendant's fault, limits on damages generally paid according to a fixed schedule, and a broader spectrum of compensable injuries for which payment is not contingent on fault.[161]

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159. See note 62 and accompanying text.

160. Ross, *Settled Out of Court* at 111 (cited in note 53).

161. In the mid-1970s, when sharply increased severity and frequency of medical malpractice claims spawned a "crisis" in the availability and affordability of medical malpractice insurance, tort scholars looked to the no-fault concept as a potential solution. See, for example, Clark C. Havighurst & Laurence R. Tancredi, *"Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance*, 51 Millbank Mem Fund Q 125 (Spring 1973); Robert E. Keeton, *Compensation for Medical Accidents*, 121 U Pa L Rev 590 (1973); Clark C. Havighurst, *Medical Adversity Insurance: Has its Time Come?*, 1975 Duke L J 1233; Jeffrey O'Connell, *An Alternative to Abandoning Tort Liability: Elective No-Fault Insurance for Many Kinds of Injury*, 60 Minn L Rev 501 (1976). See also Albert A. Ehrenzweig, *Compulsory "Hospital Accident" Insurance: A Needed First Step toward the Displacement of Liability for "Medical Malpractice,"* 31 U Chi L Rev 279 (1964). Several scholars concluded that the no-fault concept was not suitable for medical malpractice because of the difficulty and cost involved in distinguishing an injury for which compensation would be paid from an unavoidable bad result due to the claimant's underlying illness. Keeton, 121 U Pa L Rev 590 (cited in this note); Guido Calabresi, *The Problem of Malpractice—Trying to Round Out the Circle*, and Richard A. Epstein, *Medical Malpractice: Its Cause and Cure*, both in Simon Rottenburg, ed, *The Economics of Medical Malpractice* at 233, 239 and 261-62 respectively (Am Enterprise Inst for Pub Pol'y Res, 1978).

But since the 1970s, scholars have maintained that these problems could be ironed out and medical malpractice claims could still be resolved through some type of no-fault scheme. Laurence R. Tancredi, *Designing a No-Fault Alternative*, 49 L & Contemp Probs 277 (Spring 1986); Jeffrey O'Connell, *Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives*, 49 L & Contemp Probs 125 (Spring 1986). See generally Ronald S. Latz, *No-Fault Liability and Medical Malpractice: A Viability Analysis*, 10 J Legal Med 479 (1989). In the late 1970s, the American Bar Association seriously explored the concept and developed proposals. Am Bar Ass'n, *Designated Compensable Event System: A Feasibility Study* 5 (Am Bar Ass'n, 1979). At least two states, Virginia in 1987 and Florida in 1988, adopted a no-fault-like system for adjudication and compensation of birth injuries. Va Code §§ 38.2-5000 to -5021 (1989); Fla Stat Ann §§ 766.301 to .316 (West, 1990). See Richard A. Epstein, *Market and Regulatory Approaches to Medical Malpractice: The Virginia Obstetrical No-*

Indiana's system does contain some of the central features of a no-fault compensation system. Perhaps most importantly, Indiana's system weakens the requirement that the plaintiff prove fault on the part of the defendant before recovery, as evidenced by the fact that relatively few medical review panels have been convened to adjudicate liability. As noted above, a medical review panel was convened in only 11.7 percent of claims closed from 1975 through 1988.[162] Furthermore, for over half (52 percent) of the defendants for whom the PCF paid claims during this period, no medical review panel was ever convened.[163]

The adjudication process is somewhat more streamlined in Indiana, particularly for large PCF claims. Adjudication costs are lower in Indiana compared to neighboring states,[164] and claimant attorneys' fees for large claims are statutorily fixed.[165] In addition, Indiana claims overall are adjudicated in a somewhat shorter time frame (nearly two months shorter) than claims nationally.[166]

Finally, Indiana's system pays more claims at more generous levels (which is not necessarily characteristic of a no-fault system), but is constrained by the upper limit imposed by the cap. As discussed above, Indiana's mean large-claim severity between 1975 and 1988 was more than $100,000 greater than either Michigan's or Ohio's, and nearly twice the number of Indiana claims over $100,000 were paid at the $500,000 level.[167] Further, Indiana had comparatively more large claims, with proportionately fewer claims settling for under $100,000 than the national sample.[168] Also, of claims brought, more claims are paid in Indiana compared to other states—a trend more typical of no-fault systems.[169]

Fault Statute, 74 Va L Rev 1451 (1988); Jeffrey O'Connell, *Pragmatic Constraints on Market Approaches: A Response to Professor Epstein*, 74 Va L Rev 1475 (1988). One group of the various no-fault proposals and enacted plans is characterized as neo-no-fault early compensation schemes. See, for example, Jeffrey O'Connell, *Offers That Can't Be Refused: Foreclosure of Personal Injury Claims by Defendants' Prompt Tender of Claimants' Net Economic Losses*, 77 Nw U L Rev 589 (1982); O'Connell, 49 L & Contemp Probs 125 (cited in this note); W. Henson Moore & John S. Hoff, *H.R. 3084: A More Rational Compensation System for Medical Malpractice*, 49 L & Contemp Probs 117 (Spring 1986). A second category is limited-no-fault, such as specified events schemes. Am Bar Ass'n, *Designated Compensable Event System* (cited in this note); Tancredi, 49 L & Contemp Probs 277 (cited in this note); Havighurst & Tancredi, 51 Millbank Mem Fund Q 125 (cited in this note). See also James A. Henderson, Jr., *The Virginia Birth-Related Injury Compensation Act: Limited No-Fault Statutes as Solutions to the "Medical Malpractice Crisis,"* in Victoria P. Rostow & Roger J. Bulger, eds, 2 *Medical Professional Liability and the Delivery of Obstetrical Care* 194, 196 (Nat'l Acad Press, 1989). A third group is pure no-fault. See Latz, 10 J Legal Med at 488-92 (cited in this note); Ehrenzweig, 31 U Chi L Rev 270 (cited in this note); William H. L. Dornette, *Medical Injury Insurance—A Possible Remedy for the Malpractice Problem*, in Nicholas N. Kittrie, Harold L. Hirsh & Glen Wegner, eds, *Medicine, Law and Public Policy* 26 (AMS Press, 1975).

162. See note 118 and accompanying text.
163. See note 119 and accompanying text.
164. See note 142 and accompanying text.
165. See note 151 and accompanying text.
166. See note 85 and accompanying text.
167. See notes 116-17 and accompanying text.
168. See notes 81-82 and accompanying text.
169. See note 80 and accompanying text.

Admittedly, the disposition of claims in Indiana, including large claims, is similar to the process for settling claims in a common law tort system, with Indiana's PCF playing the role of a private secondary insurer. Nevertheless, the unique incentives in Indiana's system that encourage insurers to push claims to the PCF without medical review, and the PCF's mandate to consider only damages in determining compensation levels, represent crucial departures from the common law tort system and encourage insurers to behave more as if operating under a no-fault system. The unique distribution of claim severity and the comparative generosity in payment levels for medium and large claims,[170] coupled with the infrequent use of the panel review process (at least for closed claims),[171] confirm the impression that such incentives are operating in Indiana's system, and that the settlement process under Indiana's system differs from that under a common law, fault-based system.

In sum, by adjudicating and resolving claims, although not particularly expeditiously, through an informal process supervised by an administrative agency, Indiana's system reduces the need to prove fault. The interesting feature of Indiana's system is that the design and operation of the PCF and the rules governing eligibility for payment of claims by the PCF create incentives for insurers to behave as if Indiana had a no-fault system without an explicit legal mandate to do so.

Indiana's system also offers intriguing opportunities to implement a new generation of reforms, such as a designated compensable events scheme proposed by leading torts scholars.[172] Specifically, Indiana could easily incorporate a designated events scheme into its system expressly for PCF claims, since the PCF process already identifies large claims that would be the most likely candidates for the application of such a scheme. Upon selecting and installing a particular designated events scheme, the Department of Insurance staff could review cases for conformity with the criteria for the compensable events and decide whether compensation was warranted. These cases could then be referred to a panel of experts retained by the PCF to review each case and decide on compensation under the designated events scheme and an associated schedule of damages.

The centralized nature of Indiana's system simplifies legislative or regulatory changes that would be needed to implement no-fault reforms,

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170. See notes 81-84, 114-17 and accompanying text.

171. See notes 118-20 and accompanying text.

172. A designated compensable events system would identify a limited set of adverse outcomes occurring with some frequency during medical treatment, fix an amount of damages specific to each outcome, and award that amount to a patient whenever he or she suffers the particular outcome. Such a system would eliminate inquiry regarding whether the physician was at fault for the injury. See Laurence R. Tancredi, Randall R. Bovbjerg & Dan S. Gaylin, *Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System* (submitted for publication); Laurence R. Tancredi & Randall R. Bovbjerg, *Rethinking Responsibility for Patient Injury: Accelerated-Compensation Events, A Malpractice and Quality Reform Ripe for a Test*, 54 L & Contemp Probs 147 (Spring 1991); Tancredi, 49 L & Contemp Probs 277 (cited in note 161); Am Bar Ass'n, *Designated Compensable Event System* (cited in note 161); Havighurst & Tancredi, 51 Millbank Mem Fund Q 125 (cited in note 161).

which have heretofore been relegated to theory because of the practical difficulties posed by implementation. The supervision of the system by the Department of Insurance ensures the accountability and performance to which the public is entitled. By making compensation faster and more predictable, such reforms might more directly address the need for adequate and expeditious compensation of medical accident victims than does Indiana's existing system currently.

V

CONCLUSION

Indiana's experience, particularly with large claims, suggests that relatively subtle administrative arrangements for the management of claims at the state level may influence whether claimants are treated fairly by a system that is tightly structured to control claim severity and thus the price and availability of malpractice insurance for providers. The operation of the Indiana system provides exciting opportunities for further experimentation with no-fault reforms. Nevertheless, Indiana's experience should caution reformers, critics, and other observers to look closely at the more mundane, detailed aspects of how the supposedly strict, insurer- and provider-oriented reforms exemplified in Indiana's current malpractice system operate in practice before reaching intuitively appealing conclusions about the fairness of the reforms or the need for additional reforms.

APPENDIX

Data from this study is from the Indiana Malpractice Claims Data Base ("IMDB") obtained from all Indiana malpractice claims filed with the Indiana Department of Insurance from 1975 through 1988. Collected data fall in three categories: claims, claimants, and defendants. Data on claims include: (1) filing date; (2) date of final disposition; (3) allegations of negligence; (4) medical review panel decision, if any; (5) results of court proceedings, if any; (6) amount of award, if any; and (7) nature of final disposition. On claimants, the data include: (1) demographic characteristics of claimants, for example, age, sex, marital status, residential county, and zip code; (2) the medical condition giving rise to the malpractice, including initial diagnosis and any misdiagnosis; (3) any operations or procedures performed on the claimant; (4) injuries sustained during the incident of alleged malpractice, including initial and ultimate injuries; and (5) severity of injury. On physician defendants, the data include: (1) date of licensure; (2) medical education; (3) location of practice; (4) self-reported specialty; (5) nature of medical practice; and (5) board certification. For hospital defendants, data include: (1) number of beds; (2) type of corporate control; (3) teaching status; (4) geographic location; and (5) case mix.

For claimant characteristics and damage awards, the data collection instrument developed by GAO for its study of claims closed in 1984 was used.[1] Whenever possible, information on diagnosis, procedures performed, and injuries came directly from the patient's hospital chart for the treatment episode in which the alleged malpractice occurred. A registered medical records administrator coded data on diagnoses, injuries, procedures, and operations using the ICD-9-CM disease classification system.[2]

For allegations of negligence, the classification categories developed by the Risk Management Foundation of the Harvard Medical Institutions were used.[3] The Risk Management Foundation protocols provide for seventy-seven individual allegations of negligence, which may be grouped into twelve larger categories: (1) diagnosis; (2) anesthesia; (3) surgery; (4) medication selection; (5) medication administration; (6) intravenous procedures; (7) obstetrics; (8) treatment; (9) patient monitoring; (10) biomedical equipment; (11) blood products; and (12) other allegations not elsewhere classified.

Severity of injury was classified according to the nine-level system developed by the National Association of Insurance Commissioners.[4]

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1. US Gen Acct'g Office, *Medical Malpractice: Characteristics of Claims Closed in 1984* (April 1987).
2. US Dep't of Health and Human Services, Health Care Fin Admin, ICD-9-CM: International Classification of Diseases, 9th Revision, Clinical Modification (1980).
3. See Harvard Risk Management Foundation, *Risk Management Foundation Information System* (1987).
4. Nat'l Ass'n Ins Commissioners, *Medical Malpractice Closed Claims, 1975-1978* (1980). For a listing of the nine categories of injury, see note 94 in main text.

Commentary

Lessons for Tort Reform from Indiana

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Malpractice reform is back in the headlines (Kosterlitz 1991; Glazer 1991). George Bush's White House announced in May what appears to be the first presidential initiative for reform of medical liability (Hilts 1991). The Bush approach would virtually mandate that states adopt the central elements of conventional tort reform. Senator Pete V. Domenici in early June introduced an even more sweeping bill, nearly mandating that private health plans develop alternative mechanisms to resolve disputes about medical injury, without recourse to courtrooms.[1] Meanwhile, Senator Orrin G. Hatch has thoroughly revised his approach to reform, now emphasizing state-by-state experimentation with broader approaches.[2] It is thus most timely and welcome to have detailed explication of a leading state's experience under landmark 1975 legislation (Gronfein and Kinney 1991), the subject of this commentary.

"Conventional" tort reform means legislating any of a great variety of limitations on judicial practice. Such reform seeks to limit many of the now traditional legal prerogatives of plaintiffs in personal injury cases. Reform leaves in place the current liability system of courtroom justice and payment through liability insurance but modifies the rules and procedures of the traditional, court-developed law. The standard approach began in response to the "malpractice crisis" of the 1970s, spreading further during the more widespread "liability crisis" of the 1980s (Robinson 1986; Bovbjerg 1989). Every juris-

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1. S. 1232, The Medical Injury Compensation Fairness Act of 1991, introduced June 6, 1991. For discussion, see Havighurst and Metzloff 1991.
2. S. 489, Ensuring Access through Medical Liability Reform Act of 1991, introduced February 26, 1991.

diction has now enacted some element of conventional reform, which medical and other potential defendants continue to promote. Nonconventional reforms largely remain on the drawing board.

Indiana in 1975 enacted archetypical reform. Its key elements are (a) capping medical liability, (b) also capping the time plaintiffs have to bring suit after an injury, and (c) requiring review by a medical screening panel before any judicial trial (Gronfein and Kinney 1991).[3] The general approach was blessed by the federal Department of Health and Human Services during the stewardship of Secretary Otis R. Bowen, a physician and previously the reforming governor of Indiana (DHHS 1987). Along with California's legislation, this Indiana program stands as the most thoroughgoing, longest lasting, and best upheld set of tort reforms now in existence. It also stands as a refreshing reminder to the bicoastal policy community that useful initiatives can also originate in the heartland.

This commentary focuses on caps. Politically, caps are the centerpiece of conventional state tort reform, now elevated to presidential status. Legally, they are the prototypical limitation on plaintiffs in favor of defendants. Empirically, they achieve the biggest impact on plaintiffs' claims and defendants' premiums—the most buck for the bang, one might say.

Caps curb claims

Most caps limit only the "noneconomic" elements of loss, most commonly to about $250,000, as in California, but the ceilings range widely. Noneconomic losses are those with no obvious pecuniary valuation, such as "pain and suffering" or "loss of enjoyment of life." Most states set no cap for economic losses like medical bills or lost earnings. Rarely, as in Indiana, all losses are capped, tangible and intangible alike. Indeed, Indiana's provision works as two interrelated caps: First, the liability of participating medical providers is capped at $100,000 per occurrence. If more than one defendant is involved, their total liability is still $100,000.[4] To participate, physicians and others must show primary coverage for this first $100,000. Second, larger awards against participating providers are paid only by a state Patient Compensation Fund, whose liability was itself capped at $500,000 per injury (including the first $100,000) during the time examined by Gronfein and Kinney (1991).[5] Above

3. Originally, panels were absolute prerequisites to trial, but since 1985, parties by mutual consent have been allowed to waive this requirement; small cases, under $15,000, have also been able to go directly to court (Kinney and Gronfein 1991).

4. All payments need to total $100,000, with $75,000 in current dollars; up to $25,000 can be accounted for by future payments under a "structured settlement" providing for periodic payments rather than the traditional lump sum.

5. The overall cap was subsequently increased, and for claims arising since January 1990 claimants have been able to collect up to $750,000 from participating medical providers and the Fund. The initial $100,000 amount was left unchanged.

this overall cap, claimants can collect nothing from medical providers, except from the tiny fraction who do not participate. Claimants can, however, recover unlimited amounts against defendants falling outside the act, such as drug companies, medical supply firms, and manufacturers of radiological equipment.

Both total and noneconomic caps impose a significant constraint on traditional, court-developed measures of liability damages. About half the states now have some cap on nonpecuniary or total damages (Bovbjerg 1989; AMA 1991).[6]

Caps are a political success. First, they are popular and widely enacted. Second, caps in general clearly work as intended. That is, they have saved money for defendant medical providers (and their insurers) at the expense of those with large malpractice claims (and their lawyers)—a lot of money. Paid claims in cap states have been found to average almost 40 percent lower than elsewhere, other factors equal (Sloan et al. 1989). They have also been found to reduce by about a third the liability premiums that physicians must pay (Zuckerman et al. 1990).

Since the inconclusive early years of reform (Sloan 1985), empirical findings of caps' effects seem to have been consistent in direction if not in precise magnitude, regardless of whether the study lumped all caps together (Danzon 1984, 1986a) or distinguished among types of caps (Sloan et al. 1989; Zuckerman et al. 1990). Work has focused on physician claims and premiums because physicians account for many more of the dollars than hospitals and because physician data are more available. In addition to regression analyses using large data bases, evidence on this score comes from the systematically compiled opinion of experienced claims adjusters (Hamilton, Rabinowitz and Altschuler, Inc. 1987), as well as that ever-popular source, the judgment of informed individuals, especially from the defense side.[7] Practical confirmation of caps' importance comes also from the vehemence with which caps are supported by defense interests and opposed by the plaintiffs' bar.

A few other restrictions are also successful in this same limited sense of helping defendants. Notably, "collateral source offset" and reduced "statutes of limitations" of various kinds are thoroughly demonstrated to curb claims. Along with caps, these are the "big three" of conventional tort reform (Freudenheim 1991). Other limitations and changes in rules or procedures have not

6. Another tort reform, not addressed here, seeks to restrict the imposition of punitive damages. Quasi-criminal in nature, punitive damages are very rarely awarded, certainly not for malpractice, but when they are, their dollar amounts can be very large and are wholly within the discretion of the awarding jury or judge. Their reform seldom takes the form of a dollar cap, does not exist in Indiana, and has not been shown to affect malpractice payments or premiums.

7. These are too numerous even to cite a representative sampling. For a good one, see Ludlam 1990.

been shown to help defendants, at least not consistently so in published analysis. It may be, however, that enacting a combination of reforms has a collective impact on liability settlements and judicial awards that has not been disentangled by statistical analysis. Certainly, practical advocates of the defense position are convinced of the desirability of periodic rather than lump-sum payment for future losses, requirements for certification of meritorious suit, and other such limitations. Two final notes on findings: Empirical analysis has not clarified just *how* caps and other limits achieve their dollar cuts and with what other effects in law, medicine, and insurance. Also, trends in claims seem to follow some separate dynamic of their own, as claims filings have twice waxed and waned nationally over the past twenty years, seemingly without direct relation to specific legal developments in individual states.[8]

Indiana has dealt its doctors a strong reform hand—nearly a royal flush. Its cap is the strongest yet enacted, applying to all damages, not merely noneconomic ones. Its collateral source provisions are not especially strong,[9] but its statute of limitations is particularly tight.[10] Moreover, claimants typically must also undergo panel screening before they can get to a courtroom, attorneys' fees from Fund payments are stringently limited, and other restrictions apply (Symposium 1975; Kinney and Gronfein 1991). Finally, Indiana's courts acted quickly and thoroughly to uphold the reforms, including the cap, unlike many other states (Blumstein and Smith 1985; Bovbjerg 1989). So one should find strong effects of reform in Indiana if anywhere.

Explaining empirical evidence

Enter Gronfein and Kinney. Their close-up examination of the Indiana experience complements the nationwide number crunching of multivariate analysis. They sought to identify what kinds of claimants get how much, at least among the large cases that normally dominate total spending. This is a welcome look behind the aggregate statistics.

What they found is counterintuitive in the extreme. Relative to its little reformed and noncapped neighbors of Ohio and Michigan during 1975

8. For a cross-national perspective emphasizing the importance of social in addition to legal and other factors in claims experience, see Dewees et al. 1991.

9. Indiana did not enact collateral source revisions in its 1975 act. Not until 1986 did a new collateral offset provision take effect, one that applies to all personal injuries, not merely medical ones, but that is permissive rather than mandatory: *Indiana Code* section 34-4-36-1 to -3 (1988). One quasi-collateral-source provision deserves passing reference: The state Medicaid program and other third parties are allowed by statute or common law right of subrogation to recoup from the Fund their contributions on behalf of a successful tort claimant. The claimant's maximum recovery from the Fund is correspondingly reduced below $400,000 (Kinney and Gronfein 1991).

10. The state reduced the basic time limit after an injury, or its discovery, that a plaintiff has to bring a case. The reform also restricted children's traditional ability to wait until the age of majority to sue, and set an overall time limit on any case: *Indiana Code* section 16-9.5-3-1 (1988).

through 1988, Indiana's new system on average paid *more* to its large claimants, those recovering over $100,000 (Gronfein and Kinney 1991). Although the very highest individual awards came in Ohio and Michigan, because no Indiana payment could exceed the cap, large Indiana payments averaged more than $100,000 higher per case than in Michigan or Ohio. The authors present no data tending to show whether Indiana's average is too high in some objective sense or its neighbors' too low. Elsewhere, Gronfein and Kinney (1991) suggest that the higher payout may occur because the state has not actively defended its Fund. By law, the state cannot contest liability, only the amount of damages, so compromise settlements (discounted for difficulties of proving liability later, at trial) may be less likely than elsewhere (Kinney and Gronfein 1991). Whatever the precise reasons for this surprising differential, its mere existence once again illustrates that unintended consequences are ubiquitous, a maxim of policy analysis very familiar to disciples of Pressman and Wildavsky (1973).

Gronfein and Kinney also report that Indiana liability premiums for physicians' primary coverage ($100,000 per occurrence/$300,000 aggregate per year) are about half as large as those for Ohio, a quarter or less as in Michigan. The price remains low even counting in the surcharge. Recent national premium data also show Indiana ranks near the bottom of U.S. states (GAO 1986a), as it long has. The premium advantage is even greater than Gronfein and Kinney report because Indiana physicians typically can still buy full *occurrence* insurance policies, which protect against all claims arising from policy-year incidents, no matter how long afterward the claim may be brought. In the rest of the nation, though not in Michigan until recently, most policies cover only claims made during the policy year, so that policyholders retain liability for as yet unbrought claims based on current incidents. To get the future protection equivalent to occurrence coverage, needed when doctors retire, for instance, they must buy an additional "tail" policy, at considerable additional expense. An Indiana occurrence policy bought at the same price as an Ohio claims-made policy is thus a much better buy for the policyholder.

Unlike high awards, low premiums are not counterintuitive but rather expected, especially in light of the cap. But the two phenomena together create another puzzle: How can premiums be low when payments per claim are high, at least for the large claims that dominate total spending?[11] After all, number of claims times amount per claim equals total payout, which must be funded by premiums, including the Fund surcharge. Understanding developments in Indiana more fully calls for going beyond the article here, to the authors' other work and to other sources.

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11. Most claims are small, 58% settling for under $25,000 in Indiana (Kinney and Gronfein 1991); the 30% that settle for over $100,000 on average settle for very much over (some $405,000, in fact) and hence dominate total spending.

The most obvious place to start looking for answers is the claims rate. In 1980, Indiana had 5.7 claims opened per 100 physicians under the malpractice act (Kinney and Gronfein 1991). This rate rose to a high of 9.7 in 1985 before starting to decline, to 8.5 in 1986, and lower thereafter. This pattern mirrors national developments of rapid rise, then fall, with about the same percentage increases involved over roughly the same time period (Sloan and Bovbjerg 1989). However, Indiana was about 40–90 percent lower in absolute frequency of claims than the national average of about 10 per 100 in 1980 and 16 in 1986. Comparative claims data for Michigan and Ohio or for pre-tort-reform Indiana are not in the sources reviewed for this commentary. More analysis is needed to determine why Indiana has a low rate of opened claims. Reforms like the reduced statute of limitations and requirement of panel review may have deterred some claims, but the cap on its face should mainly affect claims severity, not frequency.

What might explain low premiums besides the relatively low rate of claims opened in Indiana? One might speculate that Indiana also has a low rate of claims *closed* with payment, perhaps because the panels operate less by deterring than by weeding out nonmeritorious claims, denying payments that would occur in other states. Alas, one would be wrong. Kinney and Gronfein (1991) report that only 32 percent of all closed Indiana claims were closed without payment, compared with 57 percent nationally (GAO 1987). Indeed, anecdotally, Indiana insurers of the first $100,000 in loss are said to settle sizeable claims quite readily, so as to minimize primary defense costs, which are not capped, thereby putting claimants quickly into the Fund (Kinney and Gronfein 1991). Thereafter, the Fund simply pays, as it cannot contest liability.

A second possible explanation for low premiums is that Indiana may pay claims more slowly, thereby deferring obligations, and premium hikes, under its pay-as-you-go Fund. Nationally, claims typically close within two years of filing, especially if they are not paid (GAO 1987), and the Indiana average for those claims that do close is similar (Kinney et al. forthcoming). However, Indiana's paid large claims took longer time to close than those in Ohio and were not statistically different from Michigan (Gronfein and Kinney 1991).[12] Moreover, the authors do not compare what percentage of a year's claims remain open in Indiana versus elsewhere, and Indiana has a huge backlog of open claims. Fully two-thirds of all cases opened since the 1975 reform were still pending as of the end of 1988, note Kinney and Gronfein (1991). This backlog was highlighted in some Pulitzer Prize journalism last summer (Hallinan and Headden 1990; Morgan 1991). Indiana courts have upheld the reforms despite the delays, finding them no worse than for civil justice gen-

12. To fully understand time to closure and its influence on premiums, one needs to know about smaller claims as well.

erally.[13] It would be good to have better indications of whether the length of time to closure for all claims is growing, as seems to be the case.[14] One would also like to know whether the delays seem more attributable to operations of the panels, of the Fund, of attorneys, or some other factor; on its face, the cap seems unlikely to slow dispute resolution. Comparisons with other states and the nation would also be instructive, especially with regard to how quickly Indiana resolves all claims submitted in a given year. This requires looking at claims data by cohort—forward from the year of claim, not backward from the year of settlement.

Third, Indiana claims under $100,000 might be substantially lower than their counterparts across state borders. Much lower small claims could conceivably offset the relatively larger size of the large claims, thus holding down premiums (including the surcharge). Again here, however, the data presented elsewhere are not supportive: Kinney et al. (forthcoming) report that the proportion of paid Indiana claims that are under $25,000 is about the same as nationally (GAO 1987), that the proportion of those between $25,000 and $100,000 is lower, and those over $100,000 higher. The authors do not seem to report the average size of non-Fund claims.

Fourth, premiums may be artificially low, despite high large claims, because the state Fund may be underfunded. The Fund essentially operates on a pay-as-you-go basis. It pays accumulated claims at the end of each accounting period (formerly a calendar year, now each six months). The legislature through amendments sets the Fund's surcharge to keep collections and payouts in rough balance. The Fund is not allowed to build large reserves to cover future payouts from pending claims.[15] In contrast, a private insurer in Michigan or Ohio would be insolvent, and shut down by vigilant state regulators, if it did not collect today for anticipated future obligations that arise under today's policies. Because the state plays by different rules, its surcharges can always be expected to lag behind the rates charged by its fully funded private counterparts, especially when size of settlements is rising over time, as has been true for generations, and more especially if delay to payment

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13. Cha v. Warnick, 476 N.E.2d 109, 112 (Ind. 1985), cert. denied, 474 U.S. 920 (1985); see generally Kemper et al. 1986, explaining causes of medical review panel delay and constitutionality despite delay.

14. Slomski (1991) charts data from the Indiana Department of Insurance on panels' resolution of claims; average delay has increased linearly over time, from just under 10 months in 1976 to about 35 months in 1988. However, Hallinan (1991) cites Insurance Department data that delay averaged 32 months in 1989 and 34 months in 1990. There is a backlog of over 1,200 panel cases, which would take over four years to eliminate at the current pace, even if no new cases were brought (Hallinan and Headden 1990).

15. The Fund is allowed to accumulate a kind of reserve for future claims if the surcharge for a year exceeds payouts. But by statute, the accumulation may not exceed approximately $15 million. See *Indiana Revised Code*, section 16-9.5-4-1.

is increasing in Indiana relative to elsewhere. Further, the Fund's collections may be too low in any event. The surcharge has risen rapidly, from only 10 percent for 1976 to 125 percent for 1988 (Gronfein and Kinney 1991) and since to 135 percent (Slomski 1991). Its growth has become a matter of considerable state concern (GAO 1986b).

Finally, misreporting of claims and their resolutions or faulty record keeping are always possibilities (Kinney et al. forthcoming). A combination of factors could also be at work.

Clearly, the Indiana case study offers a rich source for investigating the overall operations of a reformed system. For example, the Indiana data go beyond anecdotes in illustrating systematically which people are most hurt by the operation of the overall cap. The "losers" under a capped regime are mainly those with very high medical bills and other economic losses. Their situation is especially poignant where the money they recover is reduced by refunds to Medicaid (Kinney and Gronfein 1991). Medicaid collects dollar for dollar any of its spending on behalf of a successful Fund claimant, regardless of non-Medicaid losses or of attorneys' fees.[16] This leaves less money to pay the high costs of severe, permanent injury—such as quadriplegia or profound developmental disability in a newborn. Obviously, medical defendants will contribute little of the long-term cost in such a case. Presumably, nonliability insurance, families, and state programs (including Medicaid) ultimately cover such losses. Details like this are not available in controlled, national studies.

On the other hand, the study's detail comes at a cost: A weakness inherent in a three-state study is its diminished ability to use multivariate techniques. Analysts cannot be sure which observed effect is caused by what tort reform or other characteristic of the different states.

What do we know from Indiana? We know that Indiana physicians save money on premiums compared with their fellows elsewhere, though just how this saving relates to high average Fund payments is not at all clear. We also know that physicians and other health professionals are very happy indeed with the Indiana reforms, most notably including the cap. Not only are pre-

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16. For example, suppose a claimant had a million dollars of pecuniary losses above the first $100,000, above which only the Fund covers liability. At least 60 percent of these pecuniary losses, along with 100 percent of the accompanying intangible losses, would go unrecognized by the Fund because of the $500,000 cap in force for the claims Gronfein and Kinney (1991) describe. Suppose further that the million dollars in pecuniary loss were split evenly between wage loss and medical bills, with Medicaid covering half the medical. Then, the claimant would receive from the Fund a net maximum of $90,000, or under 10 percent of economic losses above $100,000 because $60,000 (15 percent) would go for lawyers' fees and $250,000 for Medicaid. (Moreover, uncapped lawyers' fees on the non-Fund, first $100,000 may reach 100 percent.) For an actual case of even lower recovery, see Kinney and Gronfein 1991; see also Hallinan and Headden 1990 (June 26: Fund claimant received 17 percent of losses).

miums low but physicians and other medical defendants also seem to feel that claims are more accurately resolved because of the medical panels and the administrative Fund. This is possible, even though panels are used in only a small percentage of closed claims (Kinney and Gronfein 1991). Certainly, the panels overwhelmingly rule in favor of defendants—finding negligence in only about one-fifth of cases.[17]

Some medical professionals may also take satisfaction from the Fund's limitation on fees paid to lawyers, often not physicians' favorite species of fellow professional. The fee limit also assures that severely injured patient-claimants receive a larger share of available dollars, though it may decrease legal effort spent on cases. Finally, it is obviously a considerable relief not to have to practice medicine with the specter of open-ended liability and bankruptcy hanging over one's head. This last point may be the main benefit of a cap, all out of proportion to any overall claims dollars actually saved. Full protection against enormous awards is possible only with a total cap, as in Indiana, although a cap on nonpecuniary damages protects against the most variable element of awards.

However, more work remains to be done. We still lack broader evidence of reform's helpful effects other than for the medical fisc and the physician psyche. What is really important is the influence of law, reformed and unreformed, on medical practice, particularly on medical quality. And the influence of tort reform on legal quality—that is, accuracy and consistency of decisions on liability, especially under the medical panels, and on damages, especially under the Fund. We could benefit from direct comparisons of Indiana with its neighbors along these dimensions as well. These thoughts lead to a broader view of caps.

Personal perspectives on policy

Arguments against caps. Are caps good policy? The simplistic case against caps is that they take their savings after the fact from seriously injured claimants, unfairly penalizing this class of people, without compensating benefit to any other litigants. Some state courts have accepted this claim, holding caps unconstitutional for failing to offer a quid pro quo. Others have overturned caps on the grounds that they deny jury trial or single out medical defendants (and claimants) for different treatment from other litigants (Blumstein and Smith 1985). The publicity from some of these adverse decisions has often given caps a bad name, at least in certain legal circles. In fact, as

17. Kinney and Gronfein (1991) report a figure of 22.4% of closed claims; Slomski (1991) reports 19%. In contrast, nationwide, about half of all malpractice cases receive some payment (Danzon 1985; GAO 1987), and up to one-third of juries award damages in malpractice cases (Bovbjerg, Sloan, et al. 1991).

many caps have been explicitly upheld as overturned, and many have not even been constitutionally challenged, at least not addressed in reported appellate decisions (Bovbjerg 1989).

Moreover, the simple assault is too simple by half. Such opponents of caps misperceive who is meant to be helped and when. Caps and other conventional reforms are meant to help *non*-claimants—by reducing their doctors' premiums and their defensiveness. Patients in general are to benefit *before* any injury occurs—by virtue having higher access to care (more practitioners and institutions willing to practice) and lower medical charges (because of savings on liability premiums and reduced defensive medicine).[18]

A more sophisticated argument against caps—and other reforms—is that they hurt deterrence. Supporters of unreformed liability law claim that its "deterrent" effect makes doctors more careful and medicine safer (Goddard 1985). It is logical that making providers pay for their mistakes through judicial process should lead them to make fewer mistakes. Even if almost all payments come from liability insurance, doctors still strive mightily to avoid the process. But, though there are many stories of better precautions taken, there is no systematic evidence of a helpful deterrent effect on medical outcomes.

On the other side of the argument, physician opponents assert that the current system only makes doctors wastefully defensive, not more careful. That is, they say they order many extra tests and procedures, at great expense, for legal rather than medical reasons. Further, to avoid lawsuits, they withdraw from certain areas of practice (especially obstetrics) or from certain patients (especially poor people). There are very suggestive indications of such defensive behavior, and large dollar figures have been promulgated (Reynolds et al. 1987; IOM 1989a, 1989b), although not definitively proven (Sloan and Bovbjerg 1989). In short, although understanding deterrence versus defensiveness is critical to the evaluation of any malpractice regime, the evidence is inconclusive. We could all benefit from more in-depth examinations of these issues, in Indiana and elsewhere.

Arguments for caps. The simplistic case for caps is that the legal system sets damages by emotion rather than reason and that juries too often run amok.[19] Less emotionally stated, the charge is that the law has very vague rules on damages and gives astonishing discretion to nonexpert decision makers—jurors and, to some extent, claims adjusters (AMA 1988). Hence, jury

18. This commentator first heard this point made in favor of caps by Professor Clark C. Havighurst; it also appears in Danzon 1991. What is known about caps' performance here is considered below, under the arguments for caps.

19. Peter Huber (1988: 50) writes, for example, of "the mounting randomness and incoherence of jury outcomes."

awards and even settlements can be extremely high, and results can differ enormously from case to case.[20] It is certainly true that the law of damages is vague and that legal practice grants juries great discretion, which allows juries to award whatever they like, especially for nonpecuniary losses. Thus, results can occur that doctors find arbitrary. Of course, trial lawyers and others defend variable results as tailoring of each verdict precisely to the unique circumstances of its case.

In truth, the legal system is not crazy, despite what some defendants believe. In the aggregate, though not in every case, it does much better at fitting damages to loss than defendants contend. This point needs emphasis here, but space does not permit full support.[21] Moreover, the argument against juries "proves too much." It suggests that juries are horribly unreliable, along with all the claims adjusters who operate in the shadow of juries (most of whom now work, by the way, for physician- or hospital-run liability insurers). If so, however, conventional reform that leaves the basic legal system intact does not go far enough. Only systemic reform will do, going well beyond caps.[22]

Sometimes, although not in Indiana, the pro-cap position directly targets the traditional law of intangible damages. Some commentators, often legal ones, assert that pain, suffering, and the like are simply not real losses or at best are not quantifiable (Seavey 1958).[23] This is wrong. "Noneconomic" losses have a very real and quantifiable *economic* value, as shown by the costs that people are willing to pay to increase their safety and health and by their demand to be paid a wage premium for accepting higher workplace risks (Miller 1989). People are concerned about undergoing the risk of "noneconomic" losses, above and beyond the risk of economic losses that are largely met by health, disability, and life coverage, as well as Workers' Compensation. The law, however, does not use such economic evidence either systematically or in measured fashion.

Another legally oriented argument in favor of caps is more sophisticated. It asserts that the legal system should not cover nonpecuniary damages because

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20. In one set of claims data familiar to the author, the amounts actually paid for one type of obstetric injury varied from high to low by a factor of 100. See Bovbjerg, Tancredi, and Gaylin 1991.

21. Support really calls for a literature review essay. For a short version, see Bovbjerg 1991. For a detailed match of liability payments to actual losses, see Sloan and van Wirt 1991, which concludes that for permanent emergency-room and birth-related injuries in Florida, paid malpractice claimants received substantially less than economic losses. Similar evidence suggests that the system of law and liability insurance also does better at determining liability than defendants believe, although this point is less central to a discussion of caps on damages.

22. Indiana has gone beyond caps, also setting up medical panels between claimants and juries as well as having large awards determined by Fund administrators rather than juries. Although claimants may sue if dissatisfied with a Fund award, the deck is stacked against them: the total award is capped, and their lawyers' incentive to sue is also capped along with their contingent fee. Apparently, such suits are almost unknown.

23. For an extended discussion, see Bovbjerg et al. 1989: 931–32.

insurance programs do not do so (Danzon 1986b; Huber 1988). If people wanted such losses to be covered, runs this thought, they could buy their own coverage (or vote in politicians to create such public plans). This argument overlooks the differences between purely *compensatory* insurance and a liability system grounded in *deterrence*. It also overlooks the other, practical reasons that "pain and suffering" coverage is not feasible outside the mandatory liability system.[24] This line of thinking also implies that no tort recovery at all is appropriate, as patients are free to bring their own coverage for pecuniary losses, as well as to bargain with their providers for contractual remedies for malpractice damages (Epstein 1976; Havighurst 1986).

A different kind of pro-cap argument attacks not the law per se but rather its influence on medicine. It holds that caps are necessary to maintain insurance stability and a good climate for medical practice. What is the evidence here? It is certainly clear that the medical establishment loves Indiana's reforms. This is not an insubstantial benefit. It is plausible that happier physicians are better and more productive physicians. In addition, it is often asserted that the cap and other reforms have attracted physicians into the state, although such claims seem poorly documented.[25] It seems probable that growth in fees has slowed. Certainly, the evidence from elsewhere during rapid increases in liability premiums was that physicians more than kept pace by raising fees (Sloan and Bovbjerg 1989). One trusts that fees go the other direction now that premiums are falling, as they have been doing in the late 1980s.[26]

It would, however, be reassuring to have more concrete evidence of lower fees, improved access to obstetric and other care, reduced likelihood of cesarean sections for childbirth, fewer tests of marginal value, and the like—in short, evidence of benefits for patients and society at large. This commentary has taken a "first cut" at the issue of access to service by examining readily available statistics on the number of physicians per population, by state and nationwide (Appendix). These straightforward data indicate that Indiana's

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24. Voluntary insurance would face such problems as adverse selection, the tendency to attract those at risk of higher losses, and moral hazard, the tendency of insurance to alter the behavior of insureds. For a longer discussion, see Bovbjerg et al. 1989: 932–36.

25. Slomski (1991), for instance, reports on two physicians who moved to Indiana in large part because of the state's reformed malpractice system. The article also asserts that Indiana now has far more doctors than in 1975 to serve only a slightly larger population. However, though population growth is correctly reported at about 4.6 percent (Bureau of the Census 1980, 1990), physician growth is drastically exaggerated—at 107 percent, double the actual 1975–89 increase in nonfederal physicians (AMA 1985, 1990) (50.8 percent rise for all nonfederal physicians, 55.9 percent for those in patient care). See also the appendix and its discussion in text immediately below.

26. Slomski (1991) cites two physicians who lowered their fees on moving into Indiana from similar communities, even though one came from California, which has nearly as stringent tort reform. Of course, a new business in town often shaves prices to attract customers.

population continues to have considerably lower per capita access to physicians than the national average. Moreover, the state has not markedly improved its relative position since 1975. The best that can be said for the post-tort-reform era is that, although Indiana by 1970 had ceased to fall further behind the rest of the nation, beginning with the reform year of 1975, it began to climb . . . slightly.

It would also be reassuring to have more state-specific detail, as from Gronfein and Kinney (1991), on just how caps achieve their savings for practitioners. Who wins and who loses—and do they deserve to?

Toward better caps and better policy. Caps are a legitimate response to the chilling effect of open-ended legal liability. It is not reasonable that every jury should have virtually unfettered discretion in deciding the value of injuries. Especially not for nonpecuniary losses like pain and suffering or loss of enjoyment of life, where quantitative legal guidance is currently nonexistent. Where the sky is the limit, some awards inevitably soar too high. And consistency across cases is impossible to guarantee under an unreformed system.[27] But one arbitrarily sized cap cannot possibly fit all heads. It is not reasonable that every injury should have the same maximum award, whether minor or major, temporary or permanent, lifelong for a child or lifelong for an octogenarian. There should be a better way to rein in the legal system.

Instead of fitting one cap to all cases in Procrustean fashion, better reform would create new structures to guide damages at all levels. It is not logical that juries need mandatory quantitative guidance at the cap level and none whatsoever below that. In place of one noneconomic cap, a set of values could readily be created, based mainly on severity and duration of injury, that would prescribe, or guide, allowable damages for all levels of injury.[27] True, the top level of such an improved system would create one ceiling, but only as part of an entire structure, with floors and ceilings and compartments appropriate to different areas. Various approaches to such structuring exist, both within the current legal framework (Levin 1989) and under an alternative administrative or insurance approach, such as that proposed by the AMA (1988). Indeed, the AMA plan would feature caps graduated by severity—though not floors.

Similarly, methods of calculating economic damages also merit measured reform in place of arbitrary capping. In general, the goals should be to improve the accuracy, predictability, and consistency of awards and to reduce the time

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27. For longer versions of this line of argument, see Bovbjerg et al. 1989 and Blumstein et al. 1991.

28. See Bovbjerg et al. 1989 for full discussion of award matrices, valuation scenarios to aid juries, and flexible ranges (caps plus floors)—all feasible alternatives to rigid caps. For another article calling for a scheduled approach to pain and suffering, see Levin 1989.

and cost of adjudicating cases. Damage rules should be clarified, and juries or other decision makers should be informed of typical awards or settlements in other, similar cases—just as judges are told what other judges have ruled on matters of substantive law. Moving toward such quantitative "precedent" has been suggested (DHHS 1987; Blumstein et al. 1991), but apparently never tried. Other changes with regard to structuring awards are also worthy of consideration, especially for the future losses that loom so large in high awards (Blumstein et al. 1991).[29] Most of these ideas apply beyond malpractice and should be considered for liability law in general.[30] Finally, it should be noted that in Indiana, the state-administered Fund has the opportunity to promote clarifying standards on damages to create more consistency in results. Unlike the disparate juries and judges who make legal decisions, one agency controls the Fund's decisions. It is not clear to what extent the Fund has sought to standardize loss calculations, set rules of thumb on how to calculate future damages, establish logical and consistent ways to discount future losses to current value, and otherwise improve valuations.

Summing up. Conventional caps on malpractice awards are a "halfway technology." Caps legitimately treat one symptom of the general legal problem of damage valuation—the open-ended nature of liability. But they do not cure the entire syndrome of vague rules of damages, little guidance to decision makers, and unnecessarily inconsistent valuations. They merely prescribe crude amputation for the cases of most severe injury. And, in Indiana, the cap may not in practice cut as much as intended.

Restructuring there should be. It is time, however, for more advanced approaches to damages. Not to mention time to address what is probably the major shortcoming of the legal approach to medical injury—its failure to address the vast majority of negligent injuries (Mills et al. 1977; Meyers 1987;

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29. Patricia Danzon has often written of the desirability of somehow "scheduling" *all* damages under tort law, by analogy to the practice of Workers' Compensation and disability insurance, but without making specific proposals. See, for example, Danzon 1985; compare Danzon 1991.

30. The 1970s tort reforms almost always applied only to medical malpractice, whereas in the 1980s generic reforms became more common (Bovbjerg 1989). Medical societies have sometimes joined coalitions supporting generic reform, sometimes continued to promote malpractice-specific reform. For one summary of arguments for and against malpractice-specific relief, see Bovbjerg 1990; for empirical evidence on how juries value malpractice injuries compared with others, see Bovbjerg et al. 1991, which builds on the jury verdict research of RAND's Institute for Civil Justice, for example, Hammitt et al. 1985. For Indiana, it seems especially unfortunate that a distinction is drawn between licensed medical providers and other defendants in cases of medical injury. Thus, where physician judgment about radiology, hospital maintenance of equipment, and manufacturer provision of defective equipment are all at issue, only the doctor and hospital benefit from the Indiana reform. Not only do all the old problems of unstructured and limitless valuation remain for nonmedical defendants, but there is a new prospect of needing three duplicative proceedings—for primary responsibility of medical provider(s), for the Fund, and for any other defendant(s).

Harvard Medical Practice Study 1990). For that we need approaches that go well beyond conventional tort reform to address problems of medical quality and legal quality more directly. Practice guidelines and other approaches have at least the potential to reduce medical injury (Kinney and Wilder 1989; Brennan 1991), although they are as yet only rudimentary, except for anesthesiology. There are also more thoroughgoing and potentially more promising reforms, one sponsored by organized medicine (AMA 1988), that deserve testing in our state "laboratories" (Wadlington 1991). And there are at least suggestions of willingness to consider more fundamental medical-legal reforms in the current crop of federal proposals. But that is another story.

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Appendix

Indiana Has Not Attracted More Than Its Share of Physicians after Its Tort Reform.

Table 1 presents data relevant to the access that Indiana residents may have to physicians in the state. Basically, Indiana has relatively few physicians for the size of its population—whether compared to the nation or to its neighbors Michigan and Ohio. Nor has this relationship changed by very much—whether before or after tort reform. One must note, however, that it is not certain that fewer doctors means either that patients have less access to needed care or that service is inferior, especially if lessened defensiveness frees Indiana physicians to supply care more efficiently.

Table 1. Physicians per Population for Indiana, Michigan, Ohio, and Total U.S., 1963–1989

	Pre-tort-reform			Post-tort-reform			
Statistic	1963	1965	1970	1975	1980	1985	1989
Physicians per 100,000 population							
Total U.S.	135	139	148	169	195	220	234
Indiana	100	100	102	116	135	156	167
Michigan	119	121	125	145	166	190	198
Ohio	129	131	133	147	170	199	209
Average annual percentage increase							
Total U.S.		1.5	1.3	2.7	2.9	2.4	2.1
Indiana		0.0	0.4	2.6	3.1	2.9	2.3
Michigan		0.8	0.7	3.0	2.7	2.7	1.4
Ohio		0.8	0.3	2.0	3.0	3.2	1.7
Ratio of state/total U.S. (as percentage)							
Indiana	74.1	71.9	68.9	68.6	69.2	70.9	71.4
Michigan	88.1	87.1	84.5	85.8	85.1	86.4	84.6
Ohio	95.6	94.2	89.9	87.0	87.2	90.5	89.3
State rank (1 = high, 51 = low)							
Indiana	34	31	36	39	34	41	42
Michigan	24	22	21	25	22	25	30
Ohio	19	18	20	24	19	22	22

Sources: AMA 1986, 1990; Tables A-9, A-10, and A-11; AMA 1975: Table 1.

Note: "Total U.S." is for all 51 states, including Washington, DC; data for each year are as of 31 December, except for 1989, which is 1 January. "Physicians" are total nonfederal physicians, and "population" is civilian population. "Average annual percentage increase" is the annual compound rate of change, calculated from these per capita ratios, with 1985–1989 counted as three years (31 December 1985–1 January 1989).

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Malpractice Law Deemed A Model For Other States

But 16-year-old Indiana statute under attack

BY DAN SPALDING
Times-Union Staff Writer

A legislative battle is brewing between supporters of Indiana's malpractice law and people who oppose the nation's lowest cap on compensation awards.

Changes in the law, known as INCAP (Indiana Compensation Act for Patients), could upset the delicate balance between retaining doctors in the state and providing adequate compensation for injured parties, supporters said.

But for victims of malpractice in cases of severe injury, the maximum award in Indiana appears inadequate and greatly unfair, according to the Indiana Trial Lawyers Association.

Most states cap the amount that can

See MALPRACTICE— Page 2

The Malpractice Debate

"It's proven to be the premiere law in the United States for malpractice."

- Medical spokesman

"I've represented several clients who've had several million dollars in out-of-pocket expenses ... What happens is they end up on the public dole."

- Attorney

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Continued From Page 1

be awarded for pain and suffering, but four states, including Indiana, place absolute limits on all damages. While Indiana's limit is $750,000, the other three states have a $1 million cap.

Originally, Indiana's law had a $500,000 maximum, but was later revised.

The 1975 law was established during a malpractice insurance crisis that saw rates rise so fast that physicians began abandoning some types of medical practice. It was the first comprehensive patient compensation statute in the nation.

Since then, 24 other states have enacted limits on medical malpractice awards, but Indiana's remains the most restrictive.

But the number of doctors in Indiana has increased more than 100 percent since 1975, according to ISMA.

"It's proven to be the premiere law in the United States for malpractice," said Jerry Melchior, a representative of the Indiana State Medical Association.

Despite assumptions that INCAP would result in smaller settlements, that is not the case, according to a study conducted at Indiana University.

Patients with malpractice claims of more than $100,000 received more lucrative awards in Indiana than in nearby states that have no statutory liability limits. The average payment for large claims in Indiana between 1975 and 1988 was $404,832. The study indicated Michigan's average for the same time period was $290,002 and Ohio's was $303,220.

But detractors say Indiana's law is woefully inadequate. Arguments that a higher cap would disturb the program is "absolutely not based on fact," said Lance Cline, a spokesman for the trial lawyers association. Compensation exceeding $100,000 is funded through a state fund paid into by physicians.

That fund, believed to be about $90 million, is more solvent than ever, he said.

Lawyers would like to see the cap raised to a level consistent with inflation. Most suggest about 1.3 million. Exceptions should be made for catastrophic injuries, but that level is still being debated, Cline said.

Only a handful of patients annually would require additional compensation for catastrophic injuries, he said.

"I've represented several clients who've had several million dollars in out-of-pocket expenses, past and future," Cline said. "What happens is these people end up on the public dole, they end up on Medicaid."

Although lawyers are not limited in the amount of fees they can charge for the first $100,000 collected by the plaintiff, INCAP places a 15 percent limit on fees beyond $100,000.

But Cline says the 15 percent limit on fees is about half of what is normally sought in other cases.

A confrontation is bound to arise in January when the Indiana General Assembly convenes.

Among the issues being raised, most attention will focus on the cap, says interim study committee chairman Rep. Craig Fry, a Mishawaka Democrat who said he sees strong arguments on both sides. "I'm stuck in the middle trying to find some common ground, and it doesn't look like I'm going to be able to," Fry said. "That issue is going to be a hot one."

He said he believes the $750,000 cap is "generally adequate," but that provisions should be made so that victims who require lifelong assistance as a result of an injury can be protected financially.

Legislative efforts could possibly attack all aspects of the law.

"I have heard individual attorneys comment adversely on every point," Melchior said. "If you change anything, you will definitely have the possibility of ruining the effectiveness of the act," Melchior said.

He said attorneys, like everyone else, benefit from better access to medical services.

"It might not benefit them as much as they wished it would financially, (but) there's a lot of lawyers that make a very good living by being plaintiff lawyers in the state of Indiana," Melchior said. "I don't see too many in the welfare lines."

Cline says attorneys' interest isn't financial. "We can turn this around ... and say doctors are interested in one reason and one reason only; They don't want to pay any more insurance premiums whatsoever."

Both Cline and Fry said they want the length of time in resolving malpractice suits reduced from the current 33-month average. Cline said that could be achieved by concurrently filing claims with the panel and the court system.

Others want to see the same judge rule on all malpractice cases. A legislative effort is also being made to protect the identity of doctors accused of malpractice until after the case is completed.

Doctors, lawyers disagree on malpractice act

By CHRIS BOWMAN
Tribune Staff Writer

SOUTH BEND — Doctors' and lawyers' groups are at odds about whether the state's landmark malpractice act is still the right prescription.

The Indiana State Medical Association has hit the campaign trail early this year to get the jump on any changes to the malpractice law proposed by the Indiana Trial Lawyers Association.

"We think this is going to be an issue in the next legislative session," said Dr. William H. Beeson, president-elect of the ISMA, during an interview Monday. "We would hate to see the act changed."

Beeson and other ISMA officials herald the act as having curtailed runaway malpractice insurance costs and helped keep physicians from leaving the state or quitting their practices altogether.

But trial lawyers say the law needs to be revised to remain effective. The cap of $750,000 on medical malpractice awards has not kept pace with the cost of living, much less the rise in medical costs since the malpractice law was enacted in 1975, according to Michele Wilson, executive director for the Indiana Trial Lawyers Association.

The cap was increased by 50 percent in 1990 from $500,000. But Wilson said plaintiffs should be allowed to "pierce" the cap for catastrophic cases.

"Clearly, this ought to be looked at," Wilson said Tuesday.

Beeson said the cap serves to stabilize the insurance industry as well as ensure adequate access to medical care in the state. Insurance companies and physicians both can figure their potential risks better than if there were no cap on judgments, he said.

"We really think if the Indiana act were used as a national template, we could really see some significant changes (across the country)," Beeson said.

But James F. Groves, a South Bend attorney who isn't a member of the trial lawyers association, believes the cap isn't enough to satisfy extreme cases.

"There are an awful number of catastrophic claims for which $750,000 just isn't enough," Groves said.

Groves has been on both sides of the courtroom, representing roughly the same number of plaintiffs as defendants in malpractice suits during his career. He also has served as moderator for several hundred medical review panels, the first stop for a claim of medical malpractice.

Probably the majority of the general public would favor some sort of increase in the cap, Groves said.

As for him, he believes there shouldn't be any limits on awards.

"There should be no caps. Period," he said. "It should be like any other tort claim. Once it gets to court, a jury should be allowed to settle the damages."

But Beeson disagrees. "When there's no limit on liability, sometimes it's an unrealistically high award," he said.

Beeson believes $750,000 is an adequate amount as long as it is invested and managed properly during the life of the person awarded the judgment.

Groves favors a hybrid malpractice act that would retain the medical review panel but eliminate the cap on awards. He conceded, however, that controling malpractice insurance premiums still would be an issue.

The Indiana Compensation Act for Patients was bipartisan legislation enacted in 1975 in response to a crisis in the medical malpractice insurance industry. Malpractice awards were on the rise across the nation, and many malpractice insurance carriers either were dropping malpractice coverage or raising premiums extraordinarily high.

Malpractice insurance covers the first $100,000 of a judgment. The remainder, if there is any, is covered by a patient's compensation fund administered by the Indiana Department of Insurance. Doctors pay an amount equal to 150 percent of their malpractice insurance premium into the fund.

Awards paid from the patient's compensation fund totalled a st $19 million for 1989. In 1987, the fund paid out almost $31 million.

"We feel very strongly that this act has worked," Beeson said, adding that the act has stood the test of time and constitutionality.

"We're not looking at dismantling the act. What we're proposing are things that will make the act work," she said.

"It's a public policy question," she said. "The doctors aren't the bad guys and neither are the lawyers."

Each side of the argument claims the other side's position is motivated by self gain. Beeson suggested trial lawyers support eliminating the award cap so their cut will be larger; Wilson called that a "cheap shot" and said doctors, with their personal liability limit of $100,000, are protected better than the average person involved in an automobile accident.

ELEMENTS OF CURRENT MALPRACTICE ACT

- Establishes cap of $750,000 on amount awarded in a malpractice suit.
- Requires all physicians to have proof of insurance.
- Requires all prospective malpractice cases to go before a medical review panel. Plaintiff's and defendant's attorneys each select a physician to be on the panel, and the two physicians select a third. An attorney moderates the panel discussion.

PROPOSED CHANGES BY TRIAL LAWYERS

- A concurrent filing provision would allow claimants to file both with the court and with the Indiana Insurance Commission at the same time, thereby speeding up the litigation process. Currently, the claimant files first with the insurance commission and, upon the findings of the medical review panel, then files in court.
- Would raise the cap on malpractice judgments, with inflation, or allow cap to be exceeded in catastrophic cases.

Vincennes Sun-Commercial
May 3, 1992

Malpractice law justified by ISMA

By JIM MILLER
staff writer

Why would the medical profession go out of its way to defend a malpractice compensation program that results in higher than average payments to offended patients?

The Indiana Compensation Act for Patients does, and the Indiana State Medical Association is.

A team of ISMA spokesmen who stopped here Wednesday said they're out stumping for the law just to remind Hoosiers how good their situation has been since ICAP was adopted in 1975.

They said the Indiana law has led to higher payments for injured patients while saving doctors and hospitals much of the time, trouble and money needed to defend malicious or baseless malpractice claims.

The law does this through a four-member state review commission, three health care providers and a lawyer who examine all claims before they go to court. Their verdict is not binding, but if they fail to find grounds for the complaint it discourages most claimants from continuing. The commission members can testify as expert witnesses when a case does go to court.

An insurance fund to pay damage awards of more than $100,000 was established under another section of the law. Physicians pay an amount based on their malpractice insurance premiums, currently 150 percent. The doctors are required to carry their own insurance coverage for claims up to $100,000 per occurrence and $300,000 a year.

The law limits payment of damage claims to $750,000, up from $500,000, for malpractice occurring in 1990 or later. It also limits attorney fees to 15 percent on the amount paid by the state.

"The law provides an environment in which the physician can practice quality medicine while maintaining access to the care we have come to expect," said Dr. Michael A. Herrell, president of the Vanderburgh County Medical Society.

Herrell and Dr. Stephen D. Tharp, an ISMA board member from Frankfort, both said Indiana has become a more attractive place than neighboring states to

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Malpractice

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practice medicine since ICAP took effect. Herrell told of a southern Illinois obstetrician who moved to the Evansville area and found that his insurance costs were so much less that he was able to cut his fees.

The number of doctors practicing in Indiana has increased 7 percent since 1975, the ISMA reports.

"One result is that little towns in Indiana still have access to obstetrical care," Herrell said. "The emergency rooms are still open. In a lot of other areas they don't have that luxury.

"Indiana institutions are able to recruit the specialists they need," he continued. "In Michigan, 57 percent of the specialists leave the state soon after they finish their training."

A recent experience of Good Samaritan Hospital supported that observation. Planning to set up a vascular surgery department, hospital officials were expecting a long search for a surgeon, but they heard from several qualified applicants almost immediately.

Studies show that the Indiana law has been good for patients, too. The Indiana University School of Law found that Hoosiers who collected on malpractice claims in excess of $100,000 received an average of $404,832, compared with $290,022 in Michigan and $303,220 in Ohio.

At the same time, only 32 percent of Indiana malpractice claims were closed without payment, compared with an average of 57 percent in other states.

The 1975 Indiana law, first of its kind in the nation, has been adjusted to keep it up to date but its basic provisions remain the same. Tharp said proposals to change it are frequent, but none has won out to date.

He said the current publicity campaign is not in response to any special assault on the law.

"The cost of health care is in the news these days, and we felt that gave us a good opportunity," he said.

"We're hoping to get across just why we in Indiana have a better situation than our neighbors. We have a definite public policy to protect the rights of both patients and providers.

"Of course we listen to constructive criticism, too," he said. "We constantly weigh our capabilities, the public's access in urban and rural areas to both general and special care.

"To do their best, all medical communities have to have an informed populace and good dialogue," he concluded.

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Malpractice law needs very little suturing

ZEROING IN

By
JIM McKINNEY
Executive editor

The doctors and the lawyers apparently are getting ready to go at it again over Indiana's Compensation Act for Patients.

The scuttlebutt that doctors are getting is that attorneys want to open old wounds and attack INCAP, perhaps in the General Assembly as soon as next year.

So the Indiana State Medical Association is sending its top emissaries around the state, trying to drum up support for leaving INCAP alone.

There is little evidence that INCAP needs much, if any, suturing in the first place. It was enacted in 1975, when the state just happened to have a physician for a governor in Otis Bowen, and for the most part, the law has worked well.

So well, in fact, that is has been copied by Nebraska, Louisiana and New Mexico, and some INCAP provisions are not all that different from President Bush's plan to curb runaway health care costs.

Mounting malpractice claims in Florida, Georgia, Wisconsin, Michigan and Illinois could either force those states to adopt laws similar to INCAP or lose a good percentage of their doctors.

Obstetricians and gynecologists are taking down their shingles in those states because they simply cannot, or will not, pay malpractice insurance premiums that take money from the doctor's practice and force fees so high that patients will go elsewhere.

The medical association's president, Dr. Michael Mellinger of LaGrange, a strong advocate of INCAP, said in a recent Shelbyville visit that "people expect perfection when they go to the doctor, especially when a child is born. If there is a problem somewhere, they sue the doctor."

Indiana was facing the same dilemma in the early 1970s. Young doctors either refused to locate in the state or moved elsewhere if they had an established practice. Older doctors simply retired rather than pay a 410 percent increase in malpractice insurance. And insurance companies still contended they were losing money.

The administration of INCAP does not cost the taxpayers a dime. The review panel that hears malpractice suits is paid for by the litigants, and the pool money from which damage awards are paid comes from a state-run insurance fund created by an annual surcharge on physicians equal to 150 percent of their annual malpractice premium.

There is a cap on compensation, raised from $500,000 to $750,000 in 1990, and the review board's findings are not binding. Attorneys still can sue, but the findings of the medical review board also are admissible in court. Major provisions of INCAP have been appealed to the Indiana Supreme Court at least four times, and the constitutionality of the law has been upheld.

Health care providers must have $100,000 in malpractice liability insurance per occurrence and $300,000 in annual aggregate.

Panel selection and legal fees are the sore points with attorney groups, or at least that is the view of physicians.

The medical review panel is composed of three health care providers and one attorney who has no voting power. That means people who know medicine are deciding the cases and not lay juries that can get caught up in emotions and courtroom theatrics.

The law also was written so that the patient receives the compensation without a huge outlay for legal costs. Fees for attorneys are limited to 15 percent of the first $100,000 or less, although there is no limit on expenses.

Since the law was enacted, Mellinger said patients have won about 40 percent of the cases. In 1990, 693 complaints were filed, and 105 received judgments totaling $31.8 million, or an average of $300,000 per judgment. The state medical association said that is 50 percent higher than other states with similar programs. From 1975 through 1988, the average payment for large claims was $404,832. Michigan and Ohio, which have no compensation plans, had comparative averages of $290,022 and $303,220.

Malpractice has been defined by law and suggests that a doctor has been negligent in some way by failing to treat a patient according to the standards of care that are followed by other doctors with similar training. The mere fact that things went wrong that were not the doctor's fault does not constitute malpractice.

Mellinger added that a malpractice award made against a doctor does not mean he or she is a bad doctor.

"Many times, the ones found negligent or guilty of malpractice are those who handle complicated, high-risk cases, rather than basic cases," the medical association president said.

Medicine and surgery have never been without risk.

Law may draw doctors to state

By MARI EMSWELLER
Assistant Editor

Throughout the nation, states are experiencing physician shortages and decreasing accessibility to medical care as a result of the high costs of medical liability insurance and medical providers' fears of litigation, says the immediate past president of the Indiana State Medical Association (ISMA).

But an Indiana law which limits the amount of damages a plaintiff can receive and which attempts to control outrageous attorney fees has helped to ease physician shortages in the state, says Michael O. Mellinger, M.D., past president of ISMA.

The Indiana Compensation Act for Patients (INCAP) passed the Indiana legislature in 1975 and became the first comprehensive patient compensation statute in the nation. Although the law has been challenged nearly every year since its inception, Mellinger said key elements in the law have remained unchanged.

Mellinger said INCAP's goal is to prevent a reduction in health care services, thereby protecting the health of citizens.

"It helps Hoosiers by insuring them access to medical care," Mellinger said. Mellinger said the state's doctor shortage is mostly the effect of a doctor distribution problem and Indiana needs "to do something to entice doctors to practice in areas which are underserved."

Mellinger said he believes INCAP provisions have enticed doctors from surrounding states to move their practices to Indiana. Because of a cap set on the amount of money a patient can be awarded in a malpractice lawsuit, physicians pay less for liability insurance, he said.

Mellinger said since 1975, Indiana has had a 4.6 percent population increase accompanied by a 107 percent increase in the number of doctors.

Despite INCAP's apparent benefits, the law is challenged every year in state government, Mellinger said. "We find ourselves every year in kind of a defensive posture," he said. "We're trying to disseminate some factual information at a time when it is not a burning issue." Mellinger said since Indiana had adopted the INCAP bill, other states have passed similar laws.

Not everyone is pleased with INCAP. The law is challenged yearly by the Plaintiff's Bar, which argues that the cap on the amount of money which can be collected in a malpractice suit is unfair to the plaintiff in the suit, among offering other concerns, according to Adele Lash, communications director of the Indiana State Medical Association.

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INCAP

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Since INCAP's inception, the cap has been raised from $500,000 to $750,000.

Mellinger said before laws similar to INCAP came into place, states severely suffered from doctor shortages and gaps in the availability of certain medical procedures, especially in the area of obstetrics. Mellinger said doctors and hospitals often choose to eliminate obstetric services due to the high cost of medical malpractice insurance.

Rush Memorial Hospital eliminated its obstetrics services in late 1988, according to Chief Executive Officer Bill Hartley. Hartley said part of the reason for the discontinued obstetrics services was the medical liability risks of the physicians. "The risks (of being sued) seemed to be getting greater and greater," Hartley said. "Expense and risk were some of the reasons why we discontinued the service."

Hartley said there is a national inclination to sue a doctor or hospital if something goes wrong, especially in the area of obstetrics and gynecology. Because of the high costs of medical malpractice insurance, Hartley said it was difficult to draw doctors to a small community.

INCAP calls for complaints to be reviewed by a powerless medical panel which determines whether or not they believe negligence has occurred in each case. The panel is composed of three health care providers and one attorney, who has no voting power. The panel opinion is not legally binding, according to information in a media package provided by Mellinger.

The amount of money a plaintiff can receive for incidences of malpractice is $750,000. Attorney's fees are unlimited on the first $100,000 recovered by a plaintiff; and they are allowed up to 15 percent of any recovery from a Patient's Compensation Fund, according to the news release. The PCF is a state run insurance fund set up to pay large legal claims. The fund was created by levying an annual surcharge on physicians equal to 150 percent of their annual malpractice premium.

the times

Frankfort, Indiana
June 12, 1992 Vol. 98, No. 56

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Malpractice caps keep doctors here

By DAVE OMMEN
Times staff writer

Waiting in the doctor's office is frustrating.

Driving 30 miles to find a physician is more frustrating.

Paying increasingly higher fees is even worse.

Yet, Indiana retains more doctors at a lower cost than its neighbors, thanks in part to the Indiana Compensation Act for Patients (INCAP).

INCAP deals with medical malpractice and resulting insurance costs.

Since it's establishment in 1975, the policy has set limits on malpractice settlements patients can claim, and thus the amount of insurance physicians need.

"We've been able to keep physicians while other states are losing them," said Dr. Tim Brown, a spokesman for INCAP. "This is especially true in high risk areas like obstetrics.

"Florida has dropped 25 percent of its doctors who deliver babies. Several states have counties that severely lack health care. In Indiana, we don't have county holes like the other states."

Under INCAP, a plaintiff's maximum recovery is $750,000, raised from $500,000 in January 1990. Health care providers must carry at least $100,000 in malpractice liability per occurrence, and a $300,000 total.

Higher damage funding comes from the Patient's Compensation Fund. The PCF was created by charging doctors an annual surcharge equaling 150 percent of their annual malpractice premium. PCF uses no tax money.

If a physician's annual malpractice premium was $10,000, the payment into the PCF would be $15,000 -- or 150 percent of $10,000. The total annual cost for malpractice protection would be $25,000.

With so many variables in doctors' premiums, Dr. Brown couldn't say what an average fee was. He did say, however, INCAP keeps the cost below what insurance costs would be.

physicians and quality health care," Brown said. "And if compensations are needed there is adequate coverage."

In fact, large settlements, those over $100,000, are generally higher in Indiana than surrounding states.

An Indiana University for Law and Health study looking at settlements from 1975 to 1988 found Indiana's average to be $404,832. Michigan's average was $290,022 and Ohio's $303, 220.

"The difference with our law is that we have no bell-ringing suits like $23 million," said Mike Brown, a media consultant from Executive Media who works with the Indiana State Medical Association. "Because of this, doctors aren't forced to pay extra large sums and their costs are lower."

Still, Dr. Brown said insurance makes up only 3 to 5 percent of business costs.

"Some say it's the behavior, meaning tests," Dr. Brown said. "Because of the potential of a lawsuit doctors are now taking X-rays where before they might just diagnose a sprain and tell a patient to put ice on it and send them home.

"It's defensive medicine. This is how malpractice truly escalates the cost of every visit."

He said many physicians now run tests prior to seeing the patient just to have data on paper.

But a purpose is still served.

"It hasn't really lowered costs," Dr. Brown said, "but it has helped keep our fees from increasing."

The INCAP process begins with a hearing by the Medical Review Panel (MRP) comprised of three physicians and a lawyer, who serves as chairman. The panel reviews the facts and makes a decision whether or not malpractice has occurred.

Judges and courts may use the MRP's findings as expert testimony. It carries no more weight than any other professional testimony, but it serves as a balancing agent.

"We have very high medical technology," Dr. Brown said. "We all want everything to be nice and wonderful, but we know that's case like Dr. Welby.

"Expert testimony is often hard to find and this way it serves as a preview before the courts."

INCAP will be reviewed during the legislative session in January 1993.

No specific new proposals have been suggested, but Dr. Brown said lawyers aren't happy that INCAP restricts the amount they can receive on settlements over $100,000. Attorney's are allowed up to 15 percent of recovery from the PCF.

With attorneys already collecting better than half the rewards, Dr. Brown said it's said anything can happen.

"Up to 60 percent of awards go to administration and lawyers," Dr. Brown said. "Only 40 percent goes to the injured party."

A 1990 *New York Times* article indicated that only 8 percent of true negligence victims actually filed suit. But more than 80 percent of the cases lawyers chose to file involved no negligence.

That's one reason why Mike Brown feels INCAP should remain as is.

"The old saying's true: If it ain't bro-

Law encouraged local doctor

By DAVE OMMEN
Times staff writer

Nothing beats the conveniences of home.

Dr. Brett Eaton, a county family practitioner since January 1991, thinks so.

Although the Hoosier native wanted to stay in state, he's happy Indiana has INCAP legislation.

INCAP stands for the Indiana Compensation Act for Patients. It provides a balance for doctors and patients dealing with medical malpractice.

"I was from Indiana and planned on staying in the state," he said. But a chuckle broke when he added: "But I'm sure glad we have it."

Eaton said INCAP's policies are fair to him and his patients.

"You find so many people telling you how to practice medicine that you have to find a happy medium.

"Insurance companies are telling you one thing. Hospitals are saying when you should release patients. You try to give the best medical care to everyone and sometimes doctors are stuck in the middle of it."

INCAP has definitely kept his costs down. Eaton said if he delivered babies he'd have to charge an additional 40 to 50 percent on each delivery without INCAP.

"If I had to pay another $90,000 in malpractice insurance I'd probably start farming," he said.

Eaton said his insurance costs are roughly $8,000 a year, or about 1/12 of his operating costs. Dr. Tim Brown, a spokesman for INCAP, said the average is 4 or 5 percent.

Still, medical malpractice, said Eaton, doesn't affect doctors' location as much as their type of practice.

"I don't know if it limits location as much as it limits what they do Different practices have different consequences."

Guest Column

States copying Indiana's INCAP law, so leave well enough alone!

BY TIMOTHY N. BROWN, M.D.
Guest Columnist

For health care providers and health care consumers, the development of a fair and efficient system for adjudicating medical malpractice claims is an issue that threatens the accessibility, affordability and quality of health care in the United States.

Look for it to surface in some form in the 1993 Indiana legislature.

The American Medical Association has estimated that the threat of malpractice lawsuits adds $5.6 billion in insurance premiums each year to the nation's health-care bill, and approximately $15 billion in the form of defensive medicine procedures.

Throughout the nation, states are experiencing shortages of physicians and dangerous gaps in the availability of specific medical procedures, such as obstetrics, as a result of the high cost of medical liability insurance and the ever-increasing likelihood of litigation.

Access to physicians and medical care was one of the driving issues in the development of Indiana's 1975 malpractice legislation. Indiana was the first state in the nation to adopt comprehensive malpractice reforms, and has maintained them. The law has become a model for other states.

Referred to as the Indiana Compensation Act for Patients (INCAP), it was the first comprehensive patient compensation statute. The Indiana Supreme Court has upheld the constitutionality of key aspects of it. The law's goal is to protect the health of Hoosiers by preventing a reduction of health care services. In the past year Michigan, Wisconsin and Illinois have reported physician shortages, but Indiana has not, due to INCAP.

Researchers have theorized that reports of technological advances and headlines trumpeting medical breakthroughs have contributed to a heightened public perception that all maladies can, and should, be cured. As such, the liability problem is, in part, related to advancements in the field of medicine that have produced wholly unrealistic expectations.

According to a Gallup Poll cited this year in *Best's Review*, as many as 93 percent of national respondents believe today's higher medical malpractice insurance rates are directly linked to patients' increased tendency to sue their doctors. The same poll found 88 percent are convinced that doctors are being charged higher malpractice insurance rates because settlements in liability lawsuits are much larger than they used to be. But 72 percent of those polled do not believe physicians today are less competent than they use to be.

But in most states, more physicians are being sued for more money than ever. The result is fewer physicians and a dangerous lack of medical care.

Before the Indiana General Assembly enacted INCAP, the state's health care providers — and ultimately, the state's health care consumers — were faced with a crisis.

Insurance companies covering Indiana health care providers, in reaction to enormous jury awards for medical malpractice plaintiffs, increased medical malpractice premiums by an average of 410 percent between 1970 and 1975. Physicians were retiring early; others abandoned high-risk fields such as obstetrics, neurology.

INCAP approached the situation from a variety of directions:

A state-run insurance fund to pay large claims, called the Patient's Compensation Fund (PCF), was created by levying an annual surcharge on physicians equal to 150 percent of their annual malpractice premium, as of Oct. 1, 1991.

The law set up a medical review panel to determine, once a complaint has been filed, whether or not it believes negligence occurred. The panel is composed of three health care providers and one attorney, who has no voting power. The panel opinion rendered is not legally binding, but members can be called upon to testify if the case proceeds to court.

According to the statute, health care providers are required to have at least $100,000 malpractice liability insurance per occurrence and $300,000 in the annual aggregate.

As a means of curbing the runaway awards plaguing other states, the law set an upper limit on recoverable awards, which was increased by 50 percent last year. The amount a plaintiff can receive is $750,000 for incidences of alleged malpractice.

The law attempted to control attorneys' fees to ensure that awards for injured patients go where they are intended — to the patients. National studies have demonstrated that approximately 60 percent of the money spent on malpractice goes to attorneys and court administration.

Medical malpractice is not one problem, but a series of interrelated problems that involve the regulation and social control of medical practice, quality of care, insurance markets, consistent assessment of liability in the legal system and the existing paradigm of societal attitudes toward the practice of medicine. As such, the solution to this series of problems must involve action on multiple fronts. INCAP, with its multi-dimensional approach, has proved to be both patient-friendly and physician-friendly.

According to a three-year study conducted by the Indiana University Center for Law and Health, patients with malpractice claims of more than $100,000 received higher awards in Indiana than in nearby states without statutory liability limits.

During that period Indiana's malpractice claims were closed without payment 32 percent of the time, 57 percent in all other states.

As a result of the conducive atmosphere created by INCAP, the physician-population in Indiana is now 107 percent of what it was in 1975.

In short, INCAP works just as it is.

A Crawfordsville family practice physician, the writer is assistant treasurer of the board of the Indiana State Medical Association.

Guest columns, published when timely and of interest to the public, do not necessarily reflect the views of the Journal and Courier.

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Oct. 4, 1992

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William H. Beeson

INCAP, malpractice law that works

The lack of a fair and efficient system for deciding medical malpractice claims threatens the accessibility and quality of health care in the United States.

The American Medical Association has estimated that the threat of malpractice lawsuits adds $5.6 billion in insurance premiums each year to the nation's health care bill. It also adds approximately $20 million in the form of defensive medicine procedures.

Access to physicians and medicare was one of the driving issues in the development of Indiana's groundbreaking 1975 malpractice legislation. Indiana was the first state in the nation to adopt comprehensive malpractice reforms. It also has maintained them and provided a model for other states.

Referred to as the Indiana Compensation Act for Patients, this new law was the first comprehensive patient compensation statute in the nation.

Michigan, Wisconsin and Illinois have reported physician shortages, but Indiana has continued to provide affordable, accessible care to patients because of this law.

Before the Indiana General Assembly enacted the malpractice law, the state's health care providers — and ultimately the state's health care consumers — were faced with a crisis of monumental proportions. Insurance companies, reacting to enormous jury awards for medical malpractice plaintiffs, increased medical malpractice premiums by an average of 410 percent between 1970 and 1975. Physicians were retiring early; others abandoned high-risk fields such as obstetrics, neurology and anesthesiology.

'Referred to as the Indiana Compensation Act for Patients, this new law was the first comprehensive patient compensation statute in the nation.'

The new law approached the twin dilemma of soaring liability costs and the loss of medical care from several directions.

- A state-run insurance fund to pay large claims, the Patient's Compensation Fund, was created by levying an annual surcharge on physicians equal to 150 percent of their annual malpractice premium, as of Oct. 1, 1991.
- The law set up a medical review panel to determine, once a complaint has been filed, whether it believes negligence occurred. The panel is composed of three health care providers and one attorney, who has no voting power. The panel opinion is not legally binding, but members can be called upon to testify if the case goes to court.
- Health care providers are required to have at least $100,000 malpractice liability insurance per occurrence and $300,000 total coverage per year.
- To curb excessive awards, the law set an upper limit on awards, which was increased by 50 percent in 1990. The amount a plaintiff can receive is now $750,000, raised from $500,000, for malpractice after Jan. 1, 1990. This amount does not account for other reimbursement, such as health insurance.
- The law attempted to control attorneys' fees to ensure that awards of injured patients go where they are intended — to the patients. Attorneys' fees are unlimited on the first $100,000 recovered by the plaintiff, and they are allowed up to 15 percent of any recovery from the patient's compensation fund. There is no limit on the amount of expenses an attorney may charge. National studies have demonstrated that approximately 60 percent of the money spent on malpractice goes to attorneys and court administration.

Medical malpractice is not one problem, but a series of interrelated problems that involve the regulation and social control of medical practice, quality of care, insurance markets, consistent assessment of liability in the legal system and attitudes toward the practice of medicine. Indiana's law has proved to be both patient-friendly and physician-friendly.

According to a three-year study by the Indiana University Center for Law and Health, patients with malpractice claims of more than $100,000 received higher awards in Indiana than in nearby states without statutory liability limits. The study found that the average payment for large claims in Indiana between 1975 and 1988 was $404,832. The average in Michigan was $290,022, and the average in Ohio was $303,220 in that span.

During the same 13-year period, Indiana's malpractice claims were closed without payment only 32 percent of the time, compared to 57 percent in all other states.

As a result of the conducive atmosphere created by the law, the physician-population in Indiana is now 107 percent of what it was before the 1975 crisis in Indiana.

This law has withstood multiple constitutional tests and has met the test of public need. Physicians in the state have a stable environment in which to practice. Hoosiers have access to quality medical care, and injured patients receive fair compensation.

In short, this law works.

Beeson is president of the Indiana State Medical Association and is a board-certified facial reconstructive plastic surgeon in private practice in Indianapolis.

by Karen Sandrick

Indiana's Malpractice Law: Is Everybody A Winner?

Photo by Michael Shepherd of Pro-Graphic Images

Indiana's malpractice reform of the mid-1970s went a long way toward improving the lot of doctors and other health-care providers in the Hoosier state. According to a recent study, the legislation also made things easier for patients.

Opponents of tort reform base their case on the principle that placing a statutory cap on liability awards hurts the people who can least afford the financial pain – victims of medical malpractice. However, according to a recent study, plaintiffs in Indiana, which limited awards with its 1975 comprehensive tort reform legislation, are treated better by the courts than plaintiffs in surrounding states.

The three-year study, conducted by the University of Indiana Center for Law and Health, revealed that patients with malpractice claims of more than $100,000 received more lucrative awards in Indiana than in nearby states without statutory liability limits. Between 1975 and 1988, the average payment for large claims in Indiana was $404,832, compared with $290,022 and $303,220 in Michigan and Ohio, respectively.

During the same 13-year period, only 32 percent of the Hoosier state's malpractice claims were closed without payment, compared with 57 percent in all other states, according to the General Accounting Office. Malpractice claims exceeding $100,000 comprised only 18.3 percent of closed claims nationwide, compared with 30.2 percent in Indiana.

"What we have known to be a physician-friendly and provider-friendly piece of legislation is an extremely friendly law for patients," Michael D. Mellinger, MD, president of the Indiana State Medical Society, says in response to criticism of the Hoosier state's liability laws.

When Indiana's tort reform package was passed in the mid-1970s, the state's medical community was in the midst of a medical malpractice crisis. In 1974, one of Indiana's largest insurers stopped writing malpractice policies for physicians.

"A thousand physicians all of a sudden were scrambling to try to find some type of malpractice coverage," Dr. Mellinger says. "There had been a 410-percent increase in the *Continued on page 21*

Continued from page 17

premiums physicians paid for medical malpractice insurance in the preceding five years, and hospitals were down to one malpractice insurance carrier.

"Everyone was getting pretty edgy about the availability of medical malpractice insurance for hospitals and physicians."

The Medical Malpractice Act of 1975, passed with the support of Gov. Otis R. Bowen, MD – who later served as secretary of Health and Human Services – attacked the liability crisis from a number of different directions:

•Lawmakers set an all-inclusive cap on damages. Originally established at $500,000, the cap was increased to $750,000 in 1990.

•The Act established an optional review board – consisting of three physicians and an attorney serving as a moderator – to rule on the liability of defendant physicians and hospitals and on how injuries were caused.

•The Act authorized the state-administered Patient Compensation Fund. Financed by a surcharge on medical malpractice premiums paid by health-care providers, the fund pays medical malpractice settlements of more than $100,000.

•The Act limited contingency fees for plaintiffs' lawyers to 15 percent of the excess of awards above $100,000.

•The Act established a state malpractice insurance authority to provide coverage for physicians rejected by two liability carriers.

The Medical Malpractice Act has created a favorable environment for Indiana's health-care providers by controlling the cost of medical malpractice insurance premiums. The Medical Protective Co. of Fort Wayne reports that in 1989, Indiana physicians paid less for malpractice coverage than physicians in Michigan and Ohio.

For example, doctors in Indianapolis paid $2,223 – including the Patient Compensation Fund surcharge – for $100,000 of malpractice occurrence coverage and $300,000 of total coverage. In contrast, physicians in Cincinnati paid $2,291, while those in Detroit paid $7,953 for similar coverage.

Physicians who are charged the highest malpractice insurance premiums – obstetricians, gynecologists and neurosurgeons – also paid much less in Indiana than in adjoining states. In Indianapolis, these specialists paid $18,896 in 1989 for basic malpractice coverage, while their counterparts in Cleveland and Kalamazoo paid $21,922 and $43,929, respectively.

"Financed by a surcharge on medical malpractice premiums ... the fund pays medical malpractice settlements of more than $100,000."

The Indiana law also has kept malpractice insurance premiums stable.

"Medical malpractice, occurrence-wise, is cyclic, so we've periodically taken our lumps like everyone else," Dr. Mellinger says. "When the

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incidence of malpractice lawsuits increased, our premiums increased markedly.

"However, there has been a note of stability to what we pay: we don't see the 400-percent increases like we did before the law was enacted."

"Cline suggests that claims are being settled in Indiana because insurers are not anxious to contest large awards."

Most important, the tort reform legislation has ensured that health-care providers could purchase liability coverage. "In most of the surrounding states, you can't get malpractice occurrence insurance; you must buy claims-made coverage and pay a huge tail to protect yourself for the duration of the statute of limitations," Dr. Mellinger says. "In Indiana, we can get an occurrence policy. We're covered even after we retire for something that happened before we left practice."

Subtle Incentives

Eleanor D. Kinney, JD, MPH, who administered the Indiana study, believes the state's tort reform system incorporates subtle incentives that encourage insurers and providers to settle claims. In the study summary, she pointed out that "Insurers have much to gain and little to lose by expeditiously pushing claims to the Patient Compensation Fund without adjudicating fault. ..."

However, Indiana trial lawyers have questioned some of the study's findings. "The sample of data is very limited," says Indianapolis attorney Lance Cline. "The claims data is from only one insurer, and it is not based on all claims information for all these years [from 1975 through 1988] in the state."

Specifically, trial lawyers challenge the conclusion that Indiana's tort reform system operates like a no-fault plan. Cline says it is "the farthest thing in the world from a no-fault system. You have to prove liability against a health-care provider before you can get an insurer to pay. And once you get into the Patient Compensation Fund, where you are only talking about damages, it is a war to get a malpractice insurer to agree to settle. This is not a no-fault system, I can promise you."

Cline suggests that claims are being settled in Indiana because insurers are not anxious to contest large awards.

"When liability insurers recognize that they have exposure, they may be a little more willing to go ahead and pay the $100,000 limit rather than fight it. They might fight harder if they were on the hook for more," he says.

However, Cline stresses that the unwillingness of some insurers to press ahead with such liability claims is actually hurting the most severely injured malpractice litigants.

"There are a small percentage of cases that involve catastrophic situations, probably less than 5 percent of all malpractice cases filed," Cline says. "Maybe only 10 percent or 20 percent of these cases, which are worth more than the damage award cap, get into the Patient Compensation Fund. These people are the ones who are being gypped: they are the ones who have to suffer financial loss and who usually end up on the public dole. There is nothing in the [medical malpractice law] that takes care of this small percentage of people."

Indiana's Medical Malpractice Act is not perfect. Individuals on all sides of the issue agree that it still takes far too long to resolve malpractice cases. For instance, the average time from filing to a medical review panel decision is 32 months.

There also is concern about the steady rise in surcharge payments to the Patient Compensation Fund. The fee was 10 percent of malpractice insurance premiums in 1975; by 1990, it was 125 percent of the premium.

However, Kinney says, the tort reform law is providing physicians and hospitals with reliable malpractice coverage. "We have better medical malpractice insurance in terms of the types of coverage that are available, and we have more general insurance, so doctors and hospitals are getting a better product for their money."

The system also seems to be working better than many expected for victims of medical malpractice. "We went into the study thinking that the law would result in lower average payments for people with large malpractice claims and that this would put into question the fairness of the tort reforms in Indiana," Kinney says. "We were surprised to find that Indiana was much more generous than other states." **PP**

Sandrick is a free-lance writer based in Chicago.

by Karen Sandrick

Southern Illinois Obstetricians Are Leaving For Greener Pastures

The obstetrics crisis in Southern Illinois has been fueled by two factors: soaring malpractice-insurance costs and slumping reimbursements from the government.

A crisis affecting physicians and patients alike is brewing in rural Southern Illinois because doctors and hospitals cannot afford to offer obstetric services, and the state of Illinois cannot afford to help them.

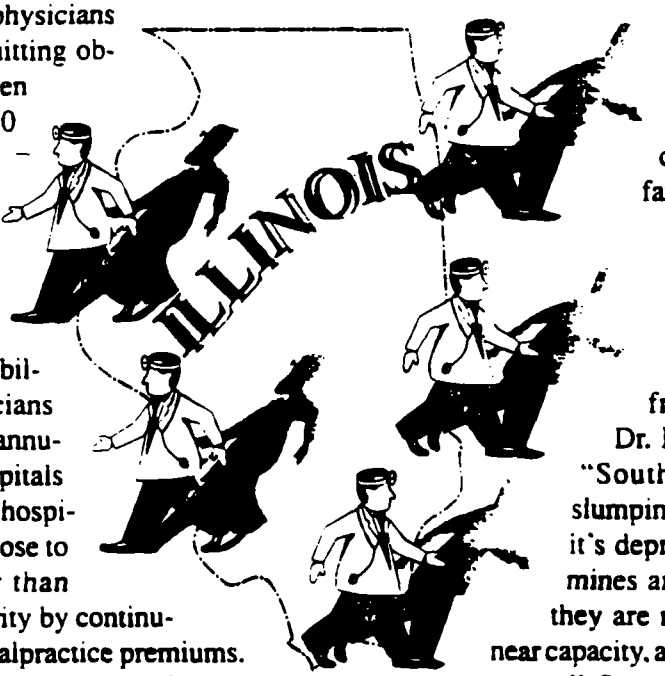
Indeed, many hospitals have closed their obstetric wards, and increasing numbers of physicians are moving to nearby states or quitting obstetrics altogether. As a result, women must travel anywhere from 30 to 50 miles to deliver their babies.

The number of rural counties in Southern Illinois without obstetric care has risen from eight in 1987 to 12 in 1989. The crisis has been fueled by the high cost of malpractice insurance. Liability coverage for Illinois obstetricians ranges from $60,000 to $100,000 annually, which weighs heavily on hospitals as well as on doctors. At least one hospital, Harrisburg Medical Center, chose to close its obstetric ward rather than threaten its overall financial security by continuing to help physicians pay their malpractice premiums.

The Center, an 85-bed facility in a town of about 9,000, stopped offering obstetric and maternity services in 1987 because its three staff obstetricians faced malpractice-insurance premiums approaching $100,000. Hospital officials feared for the Center's long-term financial health if they helped physicians meet their malpractice expenses, while doctors could not continue to provide obstetric services at the hospital without financial assistance.

Many Illinois physicians are moving their obstetric practices to more favorable malpractice climes. "A lot of doctors are saying, 'Why should I practice in Harrisburg when I can go across the border to Evansville, Ind., which is 20 miles away, and my malpractice insurance will drop by three-fourths? Or, I could move to Missouri and my chances of being sued would be much less,' " said Roger N. Klam, MD, a Carbondale obstetrician.

The other alternative for many Illinois physicians is simply to stop delivering babies. Ten hospitals in rural Southern Illinois have staff physicians who once practiced obstetrics but who, in recent years, have limited their services to gynecology or non-obstetric family medicine.



The malpractice situation is only part of the dismal story. Another significant factor is poor reimbursement from the government. Dr. Klam pointed out that "Southern Illinois is in a slumping economy right now; it's depressed. Either the coal mines aren't working at all or they are not running anywhere near capacity, and farming is not doing very well. So we have a lot more people on Medicaid, and Medicaid pays about half of what the usual and customary charges are for Southern Illinois."

In 1987, for example, private patients paid more than $900 for a normal delivery and six weeks of follow-up care, while for the same services, the Department of Public Aid reimbursed doctors less than $450, which does not begin to approach the cost of caring for high-risk mothers and their infants.

For a rural Illinois physician, high malpractice costs and low reimbursement can make delivering babies a losing proposition. "If you deliver

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Illustration by RCH

Obstetricians

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200 babies a year, it would cost you somewhere in the vicinity of $200 a delivery just for malpractice. If you happen to be a family practitioner and you deliver only 50 babies a year, malpractice premiums would cost you $400 a delivery. So even if you like to do obstetrics, if you are a family physician and the Department of Public Aid pays you only $350 a delivery, you would lose $50 every time you deliver a baby," Dr. Klam explained.

Only four family practitioners deliver babies in Murphysboro, a town of 10,000 just east of the Missouri state line. There are two family physicians who practice obstetrics in Herrin, which has a population of nearly 10,000; three obstetricians and three or four family practitioners who deliver babies in Mount Vernon, a city of 16,000 in the state's central farming region; and five physicians who practice obstetrics in Carbondale, whose 23,000 residents have around 1,750 babies a year, Dr. Klam reported.

"This is a large area, and, therefore, the few doctors who are doing obstetrics are very busy. They often get very tired, but they have no backup; in some places, they are the only ones doing obstetrics, and there is nowhere for them to turn," Dr. Klam stressed.

"... for something that occurred in the course of that employment, the patient would not be able to sue the physician but would have to sue the state," he added.

The Southern Illinois Medical Association, a 114-year-old organization of more than 400 physicians, recently unveiled a multipoint program aimed at alleviating the burden on practicing obstetricians and encouraging other obstetricians or family physicians to take up obstetrics again.

The Association proposes that the state Department of Public Health establish and financially support certified birthing centers in rural hospitals, as well as prenatal and obstetric services for low-risk obstetric patients in rural areas; coordinate transportation to birthing centers or tertiary care centers for high-risk or emergency obstetric patients; and make better use of obstetric paraprofessionals such as nurse midwives, under the supervision of physicians. "If you have fewer and fewer doctors taking care of the patients, you are going to have to have paraprofessionals to help out," Dr. Klam noted.

The plan also calls for the state to contract with physicians to provide services and to indemnify the physicians from malpractice liability. "The idea is to sign contracts with physicians to hire their services for X amount per year and to protect the physicians against unjustifiable lawsuits," said Dr. Klam. He explained that the plan would guarantee physicians a certain payment that would not be eaten away by malpractice costs. "It would allow physicians to be sued only for something that occurred outside the realm of their employment in obstetric centers; for something that occurred in the course of that employment, the patient would not be able to sue the physician but would have to sue the state," he added.

According to Dr. Klam, state legislators have been willing to absorb some of the cost of malpractice insurance for physicians who provide obstetric care in rural areas. Lawmakers have discussed the development of birthing centers, but they have been unable to loosen the state's purse strings.

Illinois has had difficulty paying for existing health-care services for the poor, let alone planning and budgeting for new services. Lack of funding has forced the state to stop all Medicaid reimbursements at least once in the past few years, and delays in Medicaid reimbursement are common. "The state says, 'It's March and we're out of money, so we will stop paying you until the fiscal year starts in July.' But doctors have to pay their nurses, the people they buy supplies from, and their rent, and they can't wait until July when they get paid by the state," Dr. Klam said. "The same thing with the hospitals. They have to buy food and pay salaries, but the state says, 'We're out of money; we'll pay you in six to eight months.' Hospitals can't afford that; they don't have that kind of money. And neither can physicians."

He continued: "It's not that the state legislators don't understand the problem. If money were not the issue, I think the obstetric crisis would be solved. The state knows what it has to do – it just takes money."

Meanwhile, where will pregnant women in Southern Illinois go for obstetric care? "Private-paying patients probably will find some place, but there would be problems even if you had all the money in the world," said Dr. Klam. "You still might have to drive 30 to 40 miles or go out of state if there were no hospital and no local physicians doing obstetrics." **PP**

Commentary by Peter Huber

MALPRACTICE LAW—A DEFECTIVE PRODUCT

"More medical malpractice than lawsuits," barked a recent front-page headline in the *New York Times*. "Thousands of hospital deaths and tens of thousands of injuries are tied to negligence each year," but "relatively few victims seek recourse in the courts." Says who? Says a major Harvard study of malpractice in New York hospitals, described by the newspaper as "perhaps the most comprehensive ever conducted in the U.S."

That description of the Harvard study reads like an advertisement for America's trial lawyers—which, in a way, it is. Defenders of the liability system are milking the study for all it's worth. In February, on separate podiums, I debated liability first with Robert Conason, a prominent New York plaintiffs' lawyer, then with Ralph Nader, surely the plaintiff bar's favorite consumer activist. Nader and Conason could hardly suppress their delight over the Harvard report and its attendant publicity.

Can it really be that we advocates of tort reform had it all wrong? That what America really needs is more malpractice litigation, higher insurance premiums and yet another overall rise in doctors' bills? Rest easy. The Harvard study, judging by the advance reports, is quite a different document than one might have been led to believe by the headline in the *New York Times*.

First revelation: Yes, there is negligence in New York hospitals. Substandard medical care harmed about 1% of hospital patients, according to the Harvard study. Extrapolating from which one may conclude that negligence "contributed to" 7,000 deaths and an additional 29,000 injuries in New York hospitals in 1984. Sometimes the "contribution" will be grave; sometimes it will shorten life by as little as a day, but this is detail. Extrapolate nationwide, as Nader and Conason both enthusiastically did, and you are talking "worse than Vietnam"

(Conason) or "worse than all highway accidents" (Nader). For my part, I can easily believe the Harvard numbers. Hospitals, being filled (like my Washington, D.C. neighborhood) with sharp knives and potent drugs, are dangerous places to frequent. I'm stuck with the neighborhood, but I heartily avoid hospitals except when my condition makes it even more dangerous to remain elsewhere.

Second revelation—the one that has Nader and Conason beaming: The Harvard study found that only 8 out of 306 Harvard-certified victims of negligence went to court. Which is to say, 97% didn't. For Nader and Conason the implication is obvious. The country needs more lawsuits. Just as they always told you, the crisis lies with malpractice itself, not with liability.

Third revelation, the one buried at the end of the *Times* story, the one not dwelt on by either Nader or Conason until I was rude enough to mention it: Only 8 of the negligence victims sued, but another 39 patients—who were *not* victims of any negligence, according to the study—also sued. In other words, over 80% of the patients who did sue had no basis for doing so.

So there we have it. Nader and his friends will tell you that the lawyers miss 97% of cases involving true negligence—though it may well be that many patients, wiser than many lawyers, simply choose not to sue. But over 80% of the cases lawyers do file involve no negligence. And this is only the beginning. Additional layers of error are inevitable when claims actually get to a jury.

Of course a 1% rate of negligently caused harm in hospitals is not acceptable; no avoidable harm is ever acceptable. Yes, we do need mechanisms to weed out the incompetent fringe of the medical profession. But most doctors fear, with some justification, that stricter disciplinary measures by hospital boards will be answered with yet another round of litigation, this time for libel, wrongful discharge, or anticompetitive denial of hospital privileges.

A doctor need not be paranoid to fear the lawsuit both coming and going. When college basketball star Hank Gathers died on the court last month, his family vowed to sue various doctors who—at Gathers' request—had reduced the dosage of a drug prescribed for his irregular heartbeat. A few days earlier, another player died of a heart attack following a game—but only after filing a career-disruption suit against the doctor who had advised him that he didn't have a heart for basketball. Hospital review boards face similar legal dilemmas in every disciplinary proceeding they consider.

The big news in the Harvard study is not that some patients get substandard medical care in hospitals. After all, we don't live in Lake Wobegone, where all the children are above average. On the medical side of the ledger, what's striking about the study is that an astonishing 99% of patients apparently received treatment without any negligently caused harm. My cynical mind is inclined to doubt that hospitals are really that good. But even if they're twice as bad as the Harvard study suggests, the doctors are obviously performing vastly better than certain other professions.

The legal profession, for example. Imagine that the manufacturer of a car or contraceptive delivered a product that was defective 80% of the time. Imagine that some diagnostic laboratory ran tests that produced 97% false negatives and 80% false positives. Or imagine that some doctor failed to diagnose 97% of all patients with gangrenous legs, and that when he did reach for a scalpel he applied it to the wrong limb over 80% of the time. Do you think that Nader might demand reform? I would. Lawyer, sue thyself. ■

Peter Huber, a senior fellow of the Manhattan Institute, is the author of Liability: The Legal Revolution and Its Consequences.

Despite tough law, Indiana's malpractice claims, awards high

INDIANAPOLIS (UPI) — Indiana's medical malpractice law is the nation's strictest but has proved more generous in compensating victims than states with less strict claims laws, a new study says.

Law scholar Eleanor D. Kinney said since Indiana enacted its law in 1975, seeking to make every victim prove a claim in order to collect on it, the number of claims per doctor has quadrupled and the average award has increased by more than 135 percent.

The three-year study by Kinney and a colleague at the Center for Law and Health at Indiana University law school in Indianapolis said a small number of malpractice victims who win more than $100,000 tend to receive far more on the average than their counterparts in Michigan and Ohio. Indiana's average benefit for people who got more than $100,000 was $404,832, while Michigan's was $290,022 and Ohio's was $303,220.

Kinney said she was surprised at the result for high claims, since during the study Indiana had a $500,000 cap on the amount of money malpractice victims could receive. The other states did not. Indiana's new payout ceiling is $750,000.

Center director Kinney said Indiana might have stumbled on a system that shares many characteristics of "no fault" compensation, because in only 11.7 percent of closed cases have medical review panels decided whether malpractice had been committed.

Associations for doctors and for plaintiffs' lawyers did not agree on the merits of the report.

The Indiana State Medical Association hailed the report as "excellent." Association Executive Director Richard King said it proves Indiana is more generous than other states in dealing with malpractice claims. He said the study also proves the act does not deter malpractice victims from filing lawsuits, as many people thought it would.

But Indiana Trial Lawyers Association President Louis Yosha said Indiana's law is not consistent with a "no-fault" system. He said a no-fault system is supposed to compensate every injured person, but the study shows that of 6,225 malpractice claims filed from 1975 to 1988, only 2,074 have been resolved. Of those, only 410 people received more than $100,000, Yosha said.

The report by Kinney and (Turn to Page 2, Col. 4)

MORE ABOUT
Claims

(Continued From Page 1)

William P. Gronfein showed the two factors that prompted the 1975 law still exist: the frequency and size of malpractice claims.

The scholars found that from 1978 to 1987, the average award rose from nearly $50,000 to more than $117,000, an increase of more than 135 percent.

Men got more money for their injuries than women did for theirs, the study said — $105,909 on averge, to $78,887. They professors speculated that "male lives are valued higher than female lives."

The 1977 average of two claims per 100 physicians rose to eight by 1987, the study showed.

A major difference between 1975 and now, the study found, was a shift in the burden of paying the claims — from insurance companies to the state.

A malpractice insurance company now must pay only for the first $100, 000 of any settlement. The rest comes from the Patient's Compensation Fund, a pool of money administered by the state and financed by a surcharge on doctors' insurance premiums.

The study found that more than half of all payments made from the fund were made without an opinion being issued by the medical review panel — one of the reasons Kinney said Indiana may be moving closer to a no-fault system.