

**IC 34-18**

**ARTICLE 18. MEDICAL MALPRACTICE**

**IC 34-18-1**

Chapter 1. Application

**IC 34-18-1-1**

**Application of article**

Sec. 1. This article does not apply to an act of malpractice that occurred before July 1, 1975.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-2**

### **Chapter 2. Definitions**

## **IC 34-18-2-1**

### **Application of definitions**

Sec. 1. The definitions in this chapter apply throughout this article.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-2-2**

### **Terms of art**

Sec. 2. A legal term or word of art that is used in this article, if not otherwise defined, has the meaning that is consistent with the common law.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-2-3**

### **Repealed**

*(Repealed by P.L.205-2003, SEC.44.)*

## **IC 34-18-2-4**

### **"Ambulance service"**

Sec. 4. "Ambulance service" means a person who employs:

- (1) emergency medical technicians;
- (2) emergency medical technicians-basic advanced;
- (3) emergency medical technicians-intermediate; or
- (4) paramedics.

*As added by P.L.1-1998, SEC.13. Amended by P.L.205-2003, SEC.40.*

## **IC 34-18-2-5**

### **"Annual aggregate"**

Sec. 5. "Annual aggregate" means the limitation on a health care provider's liability as provided in IC 34-18-4.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-2-6**

### **"Authority"**

Sec. 6. "Authority" refers to the residual malpractice insurance authority established under IC 34-18-17 (or IC 27-12-17 before its repeal).

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-2-7**

### **"College", "university", and "junior college"**

Sec. 7. "College, university, or junior college" means an institution for postsecondary school education accredited by the North Central Association.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-2-8**

#### **"Commissioner"**

Sec. 8. "Commissioner" refers to the insurance commissioner.  
*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-2-9**

#### **"Community health center"**

Sec. 9. "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.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-2-10**

#### **"Community mental health center"**

Sec. 10. "Community mental health center" means a public or private mental health center established under IC 12-29.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-2-11**

#### **"Community mental retardation center"**

Sec. 11. "Community mental retardation center" means a public or private community mental retardation and other developmental disabilities center established under IC 12-29.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-2-12**

#### **"Emergency medical technician"**

Sec. 12. "Emergency medical technician" has the meaning set forth in IC 16-18-2-112 but does not include such a person while operating an emergency vehicle.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-2-12.1**

##### **"Emergency medical technician-basic advanced"; exclusion**

Sec. 12.1. (a) "Emergency medical technician-basic advanced" has the meaning set forth in IC 16-18-2-112.5.

(b) The term does not include a person while the person is operating an emergency vehicle.

*As added by P.L.205-2003, SEC.41.*

#### **IC 34-18-2-12.2**

##### **"Emergency medical technician-intermediate"; exclusion**

Sec. 12.2. (a) "Emergency medical technician-intermediate" has the meaning set forth in IC 16-18-2-112.7.

(b) The term does not include a person while the person is operating an emergency vehicle.

*As added by P.L.205-2003, SEC.42.*

### **IC 34-18-2-13**

#### **"Health care"**

Sec. 13. "Health care" means an act or treatment performed or furnished, or that 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.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-2-14**

#### **"Health care provider"**

Sec. 14. "Health care provider" means any of the following:

(1) An individual, a partnership, a limited liability company, 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 16-18-2-107), dentist, registered or licensed practical nurse, physician assistant, midwife, optometrist, podiatrist, chiropractor, physical therapist, respiratory care practitioner, occupational therapist, psychologist, paramedic, emergency medical technician-intermediate, emergency medical technician-basic advanced, or 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 16-27-1-2).

(5) A health maintenance organization (as defined in IC 27-13-1-19).

(6) A health care organization whose members, shareholders, or partners are health care providers under subdivision (1).

(7) A corporation, limited liability company, partnership, or professional corporation not otherwise qualified under this section 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 article 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.

*As added by P.L.1-1998, SEC.13. Amended by P.L.205-2003,*

SEC.43.

**IC 34-18-2-15**

**"Health facility"**

Sec. 15. "Health facility" means a facility licensed under IC 16-28.

*As added by P.L.1-1998, SEC.13.*

**IC 34-18-2-16**

**"Hospital"**

Sec. 16. "Hospital" means a public or private institution licensed under IC 16-21-2.

*As added by P.L.1-1998, SEC.13.*

**IC 34-18-2-17**

**"Insurer"**

Sec. 17. "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 under IC 27-1-5-1.

*As added by P.L.1-1998, SEC.13.*

**IC 34-18-2-18**

**"Malpractice"**

Sec. 18. "Malpractice" means a tort or breach of contract based on health care or professional services that were provided, or that should have been provided, by a health care provider, to a patient.

*As added by P.L.1-1998, SEC.13.*

**IC 34-18-2-19**

**"Midwife"**

Sec. 19. "Midwife" means a registered nurse who holds a limited license to practice midwifery under IC 25-23-1-13.1.

*As added by P.L.1-1998, SEC.13.*

**IC 34-18-2-20**

**"Migrant health center"**

Sec. 20. "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 United States Public Health Service Act (42 U.S.C. 254b).

*As added by P.L.1-1998, SEC.13.*

**IC 34-18-2-21**

**"Paramedic"**

Sec. 21. (a) "Paramedic", except as provided in subsection (b), has the meaning set forth in IC 16-18-2-266.

(b) The term does not include such a person while operating an emergency vehicle.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-2-22**

##### **"Patient"**

Sec. 22. "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 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.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-2-23**

##### **"Physician"**

Sec. 23. "Physician" means an individual with an unlimited license to practice medicine under IC 25-22.5.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-2-24**

##### **"Psychiatric hospital"**

Sec. 24. "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 or IC 12-24-1-3.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-2-24.5**

##### **"Qualified provider"**

Sec. 24.5. "Qualified provider" means a health care provider that is qualified under this article (or by IC 27-12 before its repeal) by complying with the procedures set forth in IC 34-18-3 (or IC 27-12-3 before its repeal).

*As added by P.L.111-1998, SEC.4.*

#### **IC 34-18-2-25**

##### **"Representative"**

Sec. 25. "Representative" means the spouse, parent, guardian, trustee, attorney, or other legal agent of the patient.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-2-26**

##### **"Risk"**

Sec. 26. "Risk" means a health care provider that must apply for malpractice liability insurance coverage under IC 34-18-17.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-2-27**

**"Risk manager"**

Sec. 27. "Risk manager" means an insurance company that is:

- (1) admitted to make insurance and actively engaged in making in this state Class 2 insurance under IC 27-1-5-1; and
- (2) appointed by the commissioner to manage the authority.

*As added by P.L.1-1998, SEC.13.*

**IC 34-18-2-28**

**"Tort"**

Sec. 28. "Tort" means a legal wrong, breach of duty, or negligent or unlawful act or omission proximately causing injury or damage to another.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-3**

### **Chapter 3. Need to Qualify; Qualification Procedure**

## **IC 34-18-3-1**

### **Application of article**

Sec. 1. A health care provider who fails to qualify under this article is not covered by this article and is subject to liability under the law without regard to this article. If a health care provider does not qualify, the patient's remedy is not affected by this article.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-3-2**

### **Qualifications; proof of financial responsibility**

Sec. 2. For a health care provider to be qualified under this article, the health care provider or the health care provider's insurance carrier shall:

- (1) cause to be filed with the commissioner proof of financial responsibility established under IC 34-18-4; and
- (2) pay the surcharge assessed on all health care providers under IC 34-18-5.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-3-3**

### **Qualification of officers, agents, and employees of health care providers**

Sec. 3. The officers, agents, and employees of a health care provider, while acting in the course and scope of their employment, may be qualified under this chapter if the following conditions are met:

- (1) The officers, agents, and employees are individually named or are members of a named class in the proof of financial responsibility filed by the health care provider under IC 34-18-4.
- (2) The surcharge assessed under IC 34-18-5 is paid.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-3-4**

### **Claims against governmental entities and employees**

Sec. 4. (a) As used in this section, "employee of a governmental entity" has the meaning set forth in IC 34-6-2-38.

(b) As used in this section, "governmental entity" has the meaning set forth in IC 34-6-2-49.

(c) A claim against a governmental entity or an employee of a governmental entity based on an occurrence of malpractice is governed exclusively by this article if the governmental entity or employee is qualified under this article.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-3-5**

### **Receipt of proof of financial responsibility and surcharge;**



### **timeliness of compliance; penalties**

Sec. 5. (a) Except as provided in subsection (b), the receipt of proof of financial responsibility and the surcharge constitutes compliance with section 2 of this chapter:

- (1) as of the date on which they are received; or
- (2) as of the effective date of the policy;

if this proof is filed with and the surcharge paid to the department of insurance not later than ninety (90) days after the effective date of the insurance policy.

(b) If an insurer files proof of financial responsibility and makes payment of the surcharge to the department of insurance at least ninety-one (91) days but not more than one hundred eighty (180) days after the policy effective date, the health care provider is in compliance with section 2 of this chapter if the insurer demonstrates to the satisfaction of the commissioner that the insurer:

- (1) received the premium and surcharge in a timely manner; and
- (2) erred in transmitting the surcharge in a timely manner.

(c) If the commissioner accepts a filing as timely under subsection (b), the filing must, in addition to any penalties under IC 34-18-5-3, be accompanied by a penalty amount as follows:

- (1) Ten percent (10%) of the surcharge, if the proof of financial responsibility and surcharge are received by the commissioner at least ninety-one (91) days and not more than one hundred twenty (120) days after the original effective date of the policy.
- (2) Twenty percent (20%) of the surcharge, if the proof of financial responsibility and surcharge are received by the commissioner at least one hundred twenty-one (121) days and not more than one hundred fifty (150) days after the original effective date of the policy.
- (3) Fifty percent (50%) of the surcharge, if the proof of financial responsibility and surcharge are received by the commissioner at least one hundred fifty-one (151) days and not more than one hundred eighty (180) days after the original effective date of the policy.

*As added by P.L.1-1998, SEC.13. Amended by P.L.91-1998, SEC.21; P.L.111-1998, SEC.5; P.L.1-1999, SEC.69.*

### **IC 34-18-3-6**

#### **Notification of qualification**

Sec. 6. Within five (5) business days after the department of insurance receives the information required under section 2 of this chapter for the qualification of a health care provider, the commissioner shall notify the health care provider of the following:

- (1) Whether the provider is qualified.
- (2) If the provider is qualified, the date the provider becomes qualified.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-3-7**

#### **Adoption of rules; minimum annual aggregate insurance amount**

Sec. 7. (a) The commissioner shall adopt rules under IC 4-22-2 to establish the following:

(1) Criteria for determining, upon application, whether a corporation, limited liability company, partnership, or professional corporation is subject to IC 34-18-2-14(7) and thus is eligible to qualify as a health care provider under this chapter.

(2) The minimum annual aggregate insurance amount necessary for the corporation, limited liability company, partnership, or professional corporation to become qualified under IC 34-18-2-14(7).

(b) The criteria to be established by rule under subsection (a)(1) must include the identification of the health care purpose and function of the corporation, limited liability company, partnership, or professional corporation.

(c) The minimum annual aggregate insurance amount to be set by rule under subsection (a)(2) may not exceed five hundred thousand dollars (\$500,000).

(d) The commissioner may require a corporation, limited liability company, partnership, or professional corporation that seeks to qualify under IC 34-18-2-14(7) and this chapter to provide information necessary to determine eligibility and to establish the minimum annual aggregate amount applicable to the corporation, limited liability company, partnership, or professional corporation.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-4**

### **Chapter 4. Establishment of Financial Responsibility**

#### **IC 34-18-4-1**

##### **Establishment of financial responsibility**

Sec. 1. Financial responsibility of a health care provider and the provider's officers, agents, and employees while acting in the course and scope of their employment with the health care provider may be established under subdivision (1), (2), or (3):

(1) By the health care provider's insurance carrier filing with the commissioner proof that the health care provider is insured by a policy of malpractice liability insurance in the amount of at least two hundred fifty thousand dollars (\$250,000) per occurrence and seven hundred fifty thousand dollars (\$750,000) in the annual aggregate, except for the following:

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

(i) For hospitals of not more than one hundred (100) beds, five million dollars (\$5,000,000).

(ii) For hospitals of more than one hundred (100) beds, seven million five hundred thousand dollars (\$7,500,000).

(B) If the health care provider is a health maintenance organization (as defined in IC 27-13-1-19) or a limited service health maintenance organization (as defined in IC 27-13-34-4), the minimum annual aggregate insurance amount is one million seven hundred fifty thousand dollars (\$1,750,000).

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

(i) For health facilities with not more than one hundred (100) beds, seven hundred fifty thousand dollars (\$750,000).

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

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

(3) If the health care provider is a hospital or a psychiatric hospital, by submitting annually a verified financial statement that, in the discretion of the commissioner, adequately demonstrates that the current and future financial responsibility of the health care provider is sufficient to satisfy all potential malpractice claims incurred by the provider or the provider's officers, agents, and employees while acting in the course and scope of their employment up to a total of two hundred fifty thousand dollars (\$250,000) per occurrence and annual aggregates as follows:

(A) For hospitals of not more than one hundred (100) beds,

five million dollars (\$5,000,000).

(B) For hospitals of more than one hundred (100) beds, seven million five hundred thousand dollars (\$7,500,000).

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

*As added by P.L.1-1998, SEC.13. Amended by P.L.111-1998, SEC.6.*

#### **IC 34-18-4-2**

##### **Security; manner of holding; withdrawal**

Sec. 2. Security provided under section 1(2) of this chapter may be held in any manner mutually agreeable to the commissioner and the health care provider. The agreement must provide that the principal may not be withdrawn before receiving the written permission of the commissioner. However, any interest earned may be withdrawn at any time by the health care provider.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-4-3**

##### **Hospital bed size determined by health department**

Sec. 3. For the purposes of section 1 of this chapter, the bed size of a hospital shall be considered to be the bed size published annually by the state department of health.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-4-4**

##### **Partners and members of professional corporations**

Sec. 4. To establish financial responsibility under this chapter, each individual who is a member of a partnership or professional corporation must establish financial responsibility separate from the partnership or professional corporation, as well as pay the surcharge required under IC 34-18-5. However, this section does not require a health care provider to qualify under this article.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-5**

### **Chapter 5. Surcharge**

#### **IC 34-18-5-1**

##### **Annual surcharge on health care providers**

Sec. 1. To create a source of money for the patient's compensation fund, an annual surcharge shall be levied on all health care providers in Indiana.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-5-2**

##### **Amount of surcharge**

Sec. 2. (a) As used in this section, "actuarial program" means a program used or created by the department to determine the actuarial risk posed to the patient compensation fund under IC 34-18-6 (or IC 27-12-6 before its repeal) by a hospital. The program must be:

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

(b) Beginning July 1, 1999, the amount of the annual surcharge shall be one hundred percent (100%) of the cost to each health care provider for maintenance of financial responsibility. Beginning July 1, 2001, the annual surcharge shall be set by a rule adopted by the commissioner under IC 4-22-2.

(c) The amount of the surcharge shall be determined based upon actuarial principles and actuarial studies and must be adequate for the payment of claims and expenses from the patient's compensation fund.

(d) The surcharge for qualified providers other than:

- (1) physicians licensed under IC 25-22.5; and
- (2) hospitals licensed under IC 16-21;

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

(e) There is imposed a minimum annual surcharge of one hundred dollars (\$100).

(f) Notwithstanding subsections (b), (c), and (e), beginning July 1, 1999, the surcharge for a qualified provider who is licensed under IC 25-22.5 is calculated as follows:

- (1) The commissioner shall contract with an actuary that has experience in calculating the actuarial risks posed by physicians. Not later than July 1 of each year, the actuary shall

calculate the median of the premiums paid for malpractice liability policies to the three (3) malpractice insurance carriers in the state that have underwritten the most malpractice insurance policies for all physicians practicing in the same specialty class in Indiana during the previous twelve (12) month period. In calculating the median, the actuary shall consider the:

(A) manual rates of the three (3) leading malpractice insurance carriers in the state; and

(B) aggregate credits or debits to the manual rates given during the previous twelve (12) month period.

(2) After making the calculation described in subdivision (1), the actuary shall establish a uniform surcharge for all licensed physicians practicing in the same specialty class. This surcharge must be based on a percentage of the median calculated in subdivision (1) for all licensed physicians practicing in the same specialty class under rules adopted by the commissioner under IC 4-22-2. The surcharge:

(A) must be sufficient to cover; and

(B) may not exceed;

the actuarial risk posed to the patient compensation fund under IC 34-18-6 (or IC 27-12-6 before its repeal) by physicians practicing in the specialty class.

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

(1) must be sufficient to cover; and

(2) may not exceed;

the actuarial risk posed to the patient compensation fund under IC 34-18-6 by the hospital.

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

*As added by P.L.1-1998, SEC.13. Amended by P.L.111-1998, SEC.7; P.L.233-1999, SEC.14.*

### **IC 34-18-5-3**

#### **Collection of surcharge; time for payment**

Sec. 3. (a) The surcharge shall be collected on the same basis as premiums by each insurer, risk manager, or surplus lines producer.

(b) The surcharge is 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 producer from a health care provider in Indiana. If a surcharge is not paid as required by this section, the insurer, risk manager, or surplus lines producer responsible for the delinquency is liable for the surcharge plus a penalty equal to ten percent (10%) of the amount of the surcharge.

(c) If the annual premium surcharge is not paid within the time

limit specified in subsection (b), the certificate of authority of the insurer, risk manager, and surplus lines producer shall be suspended until the annual premium surcharge is paid.

*As added by P.L.1-1998, SEC.13. Amended by P.L.178-2003, SEC.96.*

#### **IC 34-18-5-4**

##### **Adoption of rules; comparability of rates**

Sec. 4. (a) The commissioner may adopt rules establishing the following:

(1) The manner of determination of the surcharge for a health care provider that establishes financial responsibility in a way other than by a policy of malpractice liability insurance.

(2) The manner of payment of the surcharge by such a health care provider.

(b) The surcharge calculation established under subsection (a) must provide comparability in rates for insured and self-insured hospitals. This surcharge may not 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.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-6**

### **Chapter 6. Patient's Compensation Fund**

#### **IC 34-18-6-1**

##### **Creation of fund**

Sec. 1. (a) The patient's compensation fund is created to be collected and received by the commissioner for exclusive use for the purposes stated in this article.

(b) The fund and any income from the fund shall be held in trust, deposited in a segregated account, invested, and reinvested by the commissioner as authorized by IC 27-1-13 and does not become a part of the state general fund.

(c) Proceeds of the annual surcharge levied on all health care providers in Indiana under IC 34-18-5 shall be deposited in the fund.  
*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-6-2**

##### **Protection of fund; legal services; expenses**

Sec. 2. (a) The commissioner, using money from the fund, as considered necessary, appropriate, or desirable, may purchase or retain the services of persons, firms, and corporations to aid in protecting the fund against claims. The commissioner shall retain the services of counsel described in subsection (b) to represent the department when a trial court determination will be necessary to resolve a claim against the patient's compensation fund.

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

(c) The commissioner has sole authority for the following:

(1) Making a decision regarding the settlement of a claim against the patient compensation fund.

(2) Determining the reasonableness of any fee submitted to the department of insurance by an attorney who defends the patient compensation fund under this section.

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

*As added by P.L.1-1998, SEC.13. Amended by P.L.111-1998, SEC.8.*

#### **IC 34-18-6-3**

##### **Repealed**

*(Repealed by P.L.111-1998, SEC.16.)*

#### **IC 34-18-6-4**

##### **Payment of claims; time for payment**

Sec. 4. (a) 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 not 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 not later than the following January 15.

(b) 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.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-6-5**

#### **Warrant for payment from fund; vouchers**

Sec. 5. The auditor of state shall issue a warrant in the amount of each claim submitted to the auditor 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 the commissioner 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.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-6-6**

#### **Processing of claims; conditions of payment; settlement**

Sec. 6. (a) If an annual aggregate for a health care provider qualified under this article has been paid by or on behalf of the health care provider, all amounts that may subsequently become due and payable to a claimant arising out of an act of malpractice of the 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:

- (1) A health care provider whose annual aggregate has been exhausted has no right to object to or refuse permission to settle such a claim.
- (2) If a health care provider or the commissioner and claimant agree on a settlement, the following procedure must be followed:

(A) 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.

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

(C) The commissioner may agree to the settlement, or the commissioner may file written objections to the settlement. The agreement or objections shall be filed within twenty

(20) days after the petition is filed.

(D) 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.

(E) 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 the evidence 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, 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.

(F) A settlement approved by the court may not be appealed. A judgment of the court fixing damages recoverable in a contested proceeding is appealable under the rules governing appeals in other civil cases tried by the court.

(b) The commissioner may adopt rules under IC 4-22-2 implementing this section.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-6-7**

#### **Exemptions from state procurement statutes**

Sec. 7. The following are exempt from IC 5-22 governing state purchasing:

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

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

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-7**

### **Chapter 7. Statute of Limitations**

#### **IC 34-18-7-1**

##### **Limitations period**

Sec. 1. (a) This section applies to all persons regardless of minority or other legal disability, except as provided in subsection (c).

(b) A claim, whether in contract or tort, may not be brought against a health care provider based upon professional services or health care that was provided or that should have been provided unless the claim is filed within two (2) years after the date of the alleged act, omission, or neglect, except that a minor less than six (6) years of age has until the minor's eighth birthday to file.

(c) If a patient meets the criteria stated in IC 34-18-8-6(c), the applicable limitations period is equal to the period that would otherwise apply to the patient under subsection (b) (or IC 27-12-7-1(b) before its repeal) plus one hundred eighty (180) days.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-7-2**

##### **Time for filing claim; those under legal disability**

Sec. 2. Notwithstanding IC 34-18-1-1, any claim, whether in contract or tort, by a minor or other person under legal disability against a health care provider stemming from professional services or health care provided based on an alleged act, omission, or neglect that occurred before July 1, 1975, shall be brought only within the longer of the following:

(1) Two (2) years after July 1, 1975.

(2) The period described in section 1 of this chapter.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-7-3**

##### **Tolling of statute of limitations; filing of proposed complaint**

Sec. 3. (a) 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.

(b) A proposed complaint under IC 34-18-8 is considered filed when a copy of the proposed complaint is delivered or mailed by registered or certified mail to the commissioner.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-8**

### **Chapter 8. Commencement of a Medical Malpractice Action**

#### **IC 34-18-8-1**

##### **Commencement of action; complaint**

Sec. 1. Subject to IC 34-18-10 and sections 4 through 6 of this chapter, a patient or the representative of a patient who has a claim under this article for bodily injury or death on account of malpractice may do the following:

(1) File a complaint in any court of law having requisite jurisdiction.

(2) By demand, exercise the right to a trial by jury.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-8-2**

##### **Fees**

Sec. 2. 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.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-8-3**

##### **Demand; reasonable damages**

Sec. 3. Except for the declaration called for in section 6(a) of this chapter, a dollar amount or figure may not be included in the demand in a malpractice complaint, but the prayer must be for such damages as are reasonable in the premises.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-8-4**

##### **Prerequisites to commencement of action; presentation of claim to medical review panel**

Sec. 4. Notwithstanding section 1 of this chapter, and except as provided in sections 5 and 6 of this chapter, an action against a health care provider may not be commenced in a court in Indiana before:

(1) the claimant's proposed complaint has been presented to a medical review panel established under IC 34-18-10 (or IC 27-12-10 before its repeal); and

(2) an opinion is given by the panel.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-8-5**

##### **Agreements not to present claims to medical review panels**

Sec. 5. Notwithstanding section 4 of this chapter, 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.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-8-6**

##### **Claims not greater than \$15,000; commencement of action; dismissal without prejudice**

Sec. 6. (a) Notwithstanding section 4 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 not greater than fifteen thousand dollars (\$15,000). In an action commenced under this subsection (or IC 27-12-8-6(a) before its repeal), 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) (or IC 27-12-8-6(a) before its repeal) in the reasonable belief that damages in an amount not greater 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 subject to section 4 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) (or IC 27-12-8-6(a) before its repeal).

(c) If a patient:

- (1) commences an action under subsection (a) (or IC 27-12-8-6(a) before its repeal);
- (2) moves under subsection (b) (or IC 27-12-8-6(b) before its repeal) for dismissal of that action;
- (3) files a proposed complaint subject to section 4 of this chapter based upon the same allegations of malpractice as were asserted in the action dismissed under subsection (b) (or IC 27-12-8-6(b) before its repeal); 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 34-18-7-1(c).

(d) A medical liability insurer of a health care provider against whom an action has been filed under subsection (a) (or IC 27-12-8-6(a) before its repeal) shall provide written notice to the state health commissioner as required under IC 34-18-9-2.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-8-7**

#### **Commencement of action while claim being considered by medical review panel**

Sec. 7. (a) Notwithstanding section 4 of this chapter, beginning July 1, 1999, a claimant may commence an action in court for malpractice at the same time the claimant's proposed complaint is being considered by a medical review panel. In order to comply with this section, the:

- (1) complaint filed in court may not contain any information that would allow a third party to identify the defendant;
- (2) claimant is prohibited from pursuing the action; and
- (3) court is prohibited from taking any action except setting a date for trial, an action under IC 34-18-8-8 (or IC 27-12-8-8 before its repeal), or an action under IC 34-18-11 (or IC 27-12-11 before its repeal);

until section 4 of this chapter has been satisfied.

(b) Upon satisfaction of section 4 of this chapter, the identifying information described in subsection (a)(1) shall be added to the complaint by the court.

*As added by P.L.111-1998, SEC.9.*

### **IC 34-18-8-8**

#### **Motion to dismiss filed by commissioner**

Sec. 8. If action has not been taken in a case before the department of insurance for a period of at least two (2) years, the commissioner, on the:

- (1) motion of a party; or
- (2) commissioner's own initiative;

may file a motion in Marion county circuit court to dismiss the case under Rule 41(E) of the Indiana Rules of Trial Procedure.

*As added by P.L.111-1998, SEC.10.*

## **IC 34-18-9**

### **Chapter 9. Reporting and Review of Claims**

#### **IC 34-18-9-1**

##### **Proposed complaints; notice to named defendants**

Sec. 1. Within ten (10) days after receiving a proposed complaint under IC 34-18-8, the commissioner shall forward a copy of the complaint by registered or certified mail to each health care provider named as a defendant, at the defendant's last and usual place of residence or the defendant's office.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-9-2**

##### **Medical liability insurers; notice of suit to commissioner**

Sec. 2. A medical liability insurer of a health care provider against whom an action has been filed under IC 34-18-8-6(a) shall provide written notice to the commissioner within thirty (30) days after:

- (1) the filing of the action; and
- (2) the final disposition of the action.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-9-3**

##### **Notice of reserve by medical liability insurer; report of final adjudications and settlements**

Sec. 3. (a) A health care provider's insurer shall notify the commissioner of any malpractice case upon which the insurer has placed a reserve of at least one hundred twenty-five thousand dollars (\$125,000). The insurer shall give notice to the commissioner under this subsection immediately after placing the reserve. The notice and all communications and correspondence relating to the notice are confidential and may not be made available to any person or any public or private agency.

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

- (1) The nature of the claim.
- (2) The damages asserted and the alleged injury.
- (3) The attorney's fees and expenses incurred in connection with the claim or defense.
- (4) The amount of the settlement or judgment.

*As added by P.L.1-1998, SEC.13. Amended by P.L.111-1998, SEC.11.*

#### **IC 34-18-9-4**

##### **Fitness reviews of health care providers**

Sec. 4. (a) The medical review panel (as described in IC 34-18-10) shall make a separate determination, at the time that it renders its

opinion under IC 34-18-10-22, as to whether the name of the defendant health care provider should be forwarded to the appropriate board of professional registration for review of the health care provider's fitness to practice the health care provider's profession. The commissioner shall forward the name of the defendant health care provider if the medical review panel unanimously determines that it should be forwarded. The medical review panel determination concerning the forwarding of the name of the defendant health care provider is not admissible as evidence in a civil action. In each case involving review of a health care provider's fitness to practice forwarded under this section, the appropriate board of professional registration and examination may, in appropriate cases, take the following disciplinary action:

- (1) censure;
- (2) imposition of probation for a determinate period;
- (3) suspension of the health care provider's license for a determinate period; or
- (4) revocation of the license.

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

(c) The appropriate board of professional registration and examination shall report to the commissioner the board's findings, the action taken, and the final disposition of each case involving review of a health care provider's fitness to practice forwarded under this section.

*As added by P.L.1-1998, SEC.13. Amended by P.L.111-1998, SEC.12.*



## **IC 34-18-10**

### **Chapter 10. Medical Review Panel**

#### **IC 34-18-10-1**

##### **Establishment of medical review panels**

Sec. 1. This chapter provides for the establishment of medical review panels to review proposed malpractice complaints against health care providers covered by this article.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-10-2**

##### **Request for formation of panels**

Sec. 2. 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.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-10-3**

##### **Members; chairman; powers and duties**

Sec. 3. (a) A medical review panel consists of one (1) attorney and three (3) health care providers.

(b) The attorney member of the medical review panel shall act as chairman of the panel and in an advisory capacity but may not vote.

(c) The chairman of the medical review panel shall expedite the selection of the other panel members, convene the panel, and 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.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-10-4**

##### **Selection of panel members**

Sec. 4. A medical review panel shall be selected in the following manner:

(1) Within fifteen (15) days after the filing of a request for formation of a medical review panel under section 2 of this chapter, the parties shall select a panel chairman by agreement. If no agreement on a panel chairman 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 who:

(A) are qualified to practice;

(B) are presently on the rolls of the supreme court; and

(C) maintain offices in the county of venue designated in the proposed complaint or in a contiguous county.

(2) Before 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.

(3) The clerk shall notify the parties, and the parties shall then strike names alternately with the plaintiff striking first until one (1) name remains. The remaining attorney shall be the chairman of the panel.

(4) After the striking, the plaintiff shall notify the chairman and all other parties of the name of the chairman.

(5) If a party does not strike a name within five (5) days after receiving notice from the clerk:

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

(B) the clerk shall strike for that party.

(6) 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.

(7) Within fifteen (15) days after being notified by the clerk of being selected as chairman, the chairman shall:

(A) send a written acknowledgment of appointment to the clerk; or

(B) show good cause for relief from serving as provided in section 12 of this chapter.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-10-5**

##### **Eligibility for panel membership**

Sec. 5. Except for health care providers who are health facility administrators, all health care providers in Indiana, 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.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-10-6**

##### **Selection of members by parties**

Sec. 6. Each party to the action has 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.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-10-7**

##### **Selection of panel members by multiple parties**

Sec. 7. If there are multiple plaintiffs or defendants, only one (1) health care provider shall be selected per side. The plaintiff, whether single or multiple, has the right to select one (1) health care provider and the defendant, whether single or multiple, has the right to select one (1) health care provider.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-10-8**

### **Panelists to be members of defendant's profession**

Sec. 8. 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 34-18-2-14(1) of which the defendant is a member. 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.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-10-9**

#### **Selection periods; notification; selections by chairman**

Sec. 9. Within fifteen (15) days after the chairman is selected, both parties shall select a health care provider and the parties 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 the providers fail to make a selection, the chairman shall make the selection and notify both parties.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-10-10**

#### **Challenges to panel member selections**

Sec. 10. Within ten (10) days after the selection of a panel member, 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, the panel members 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) panelist. The party whose appointment was challenged shall strike last, and the remaining member shall serve.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-10-11**

#### **Formation of panel; notice to commissioner and parties**

Sec. 11. When a 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 following:

(1) The names and addresses of the panel members.

(2) The date on which the last member was selected.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-10-12**

#### **Excusing members from service**

Sec. 12. (a) A member of a medical review panel who is selected under this chapter shall serve unless:

- (1) the parties by agreement excuse the panelist; or
- (2) the panelist is excused as provided in this section for good cause shown.

(b) To show good cause for relief from serving, the attorney selected as chairman of a medical review panel must serve an affidavit upon the clerk of the supreme court. The affidavit must set out the facts showing that service would constitute an unreasonable burden or undue hardship. The clerk may excuse the attorney from serving. The attorney shall notify all parties, who shall then select a new chairman as provided in section 4 of this chapter.

(c) To show good cause for relief from serving, a health care provider member of a medical review panel must serve an affidavit upon the panel chairman. The affidavit must 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.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-10-13**

#### **Panel expert opinion; time for issuance**

Sec. 13. (a) The panel shall give its expert opinion within one hundred eighty (180) days after the selection of the last member of the initial panel. However, if:

- (1) the chairman of the panel is removed under section 15 of this chapter, another member of the panel is removed under section 16 of this chapter, 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 give an expert opinion.

(b) If the panel has not given an opinion within the time allowed under subsection (a), the panel shall submit a report to the commissioner, stating the reasons for the delay.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-10-14**

#### **Sanction for failure to act as required by chapter**

Sec. 14. 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.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-10-15**

#### **Removal of chairman**

Sec. 15. (a) 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 this chapter.

(b) If the chairman is removed under this section, a new chairman shall be selected under this chapter.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-10-16**

#### **Removal of panel member**

Sec. 16. (a) 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.

(b) If a member is removed under this section, a new member shall be selected under this chapter.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-10-17**

#### **Evidence; oath**

Sec. 17. (a) The evidence in written form to be considered by the medical review panel shall be promptly submitted by the respective parties.

(b) 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.

(c) Depositions of parties and witnesses may be taken before the convening of the panel.

(d) The chairman shall ensure that before the panel gives its expert opinion under section 22 of this chapter, each panel member has the opportunity to review every item of evidence submitted by the parties.

(e) 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; that I will render my opinion without bias, based upon the evidence submitted by the parties, and 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."

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-10-18**

#### **Communication with panel by parties or their agents prohibited**

Sec. 18. 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 giving of the panel's expert opinion under section 22 of this chapter.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-10-19**

### **Preparation of opinion by chairman**

Sec. 19. 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 22 of this chapter.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-10-20**

#### **Convening and questioning of panel**

Sec. 20. (a) Either party, after submission of all evidence and upon ten (10) days notice to the other side, has 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 the panel's report.

(b) The chairman of the panel shall preside at all meetings. Meetings shall be informal.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-10-21**

#### **Duties of panel in conduct of inquiry; access to information**

Sec. 21. (a) The panel has the right and duty to request all necessary information.

(b) The panel may consult with medical authorities.

(c) The panel may examine reports of other health care providers necessary to fully inform the panel regarding the issue to be decided.

(d) Both parties shall have full access to any material submitted to the panel.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-10-22**

#### **Expert opinions**

Sec. 22. (a) The panel has the sole duty to express the panel's 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.

(b) After reviewing all evidence and after any examination of the panel by counsel representing either party, the panel shall, within thirty (30) days, give one (1) or more of the following expert opinions, which must be in writing and signed by the panelists:

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

(2) 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.

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

(4) The conduct complained of was or was not a factor of the

resultant damages. If so, whether the plaintiff suffered:

(A) any disability and the extent and duration of the disability; and

(B) any permanent impairment and the percentage of the impairment.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-10-23**

#### **Report of panel as evidence at trial; members as witnesses**

Sec. 23. A report of the expert opinion reached by the medical review panel is admissible as evidence in any action subsequently brought by the claimant in a court of law. However, the expert opinion is not conclusive, and either party, at the party's cost, has the right to call any member of the medical review panel as a witness. If called, a witness shall appear and testify.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-10-24**

#### **Immunity from civil liability**

Sec. 24. A panelist has absolute immunity from civil liability for all communications, findings, opinions, and conclusions made in the course and scope of duties prescribed by this article.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-10-25**

#### **Compensation of members**

Sec. 25. (a) Each health care provider member of the medical review panel is entitled to be paid:

(1) up to three hundred fifty dollars (\$350) for all work performed as a member of the panel, exclusive of time involved if called as a witness to testify in court; and

(2) reasonable travel expense.

(b) The chairman of the panel is entitled to be paid:

(1) at the rate of two hundred fifty dollars (\$250) per diem, not to exceed two thousand dollars (\$2,000); and

(2) reasonable travel expenses.

(c) The chairman shall keep an accurate record of the time and expenses of all the members of the panel. The record shall be submitted to the parties for payment with the panel's report.

(d) Fees of the panel, including travel expenses and other expenses of the review, shall be paid by the side in whose favor the majority opinion is written. If there is no majority opinion, each side shall pay fifty percent (50%) of the cost.

*As added by P.L.1-1998, SEC.13. Amended by P.L.111-1998, SEC.13.*

### **IC 34-18-10-26**

#### **Copies of reports**

Sec. 26. The chairman shall submit a copy of the panel's report to:

(1) the commissioner; and

(2) all parties and attorneys;  
by registered or certified mail within five (5) days after the panel  
gives its opinion.

*As added by P.L.1-1998, SEC.13.*



## **IC 34-18-11**

Chapter 11. Preliminary Determination of Affirmative Defense or Issue of Law or Fact; Discovery

### **IC 34-18-11-1**

#### **Discovery; preliminary rulings**

Sec. 1. (a) 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, do one (1) or both of the following:

- (1) preliminarily determine an 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.

(b) 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 34-18-10-22(b)(1), IC 34-18-10-22(b)(2), and IC 34-18-10-22(b)(4).

(c) The court has jurisdiction to entertain a motion filed under this chapter only during that time after a proposed complaint is filed with the commissioner under this article but before the medical review panel gives the panel's written opinion under IC 34-18-10-22.

(d) The failure of any party to move for a preliminary determination or to compel discovery under this chapter before the medical review panel gives the panel's written opinion under IC 34-18-10-22 does not constitute the waiver of any affirmative defense or issue of law or fact.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-11-2**

#### **Invoking jurisdiction of the court; issuance of summons**

Sec. 2. (a) A party to a proceeding commenced under this article, the commissioner, or the chairman of a 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.

(b) The filing of a copy of the proposed complaint and motion with the clerk confers 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's fees, or both.

(c) The moving party or the moving party's 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 under Rules 4 through 4.17 of the Indiana Rules of Trial Procedure.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-11-3**

#### **Time for reply to motion; rulings**

Sec. 3. (a) 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 a written response to the motion, unless the court, for cause shown, orders the period enlarged.

(b) The court shall enter a ruling on the motion:

- (1) within thirty (30) days after the motion is heard; or
- (2) 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.

(c) The court shall order the clerk to serve a copy of the court's 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 P.L.1-1998, SEC.13.*

### **IC 34-18-11-4**

#### **Stay of 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 a ruling on the motion.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-11-5**

#### **Enforcement**

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 P.L.1-1998, SEC.13.*

## **IC 34-18-12**

### **Chapter 12. Liability Based on Breach of Contract; Informed Consent**

#### **IC 34-18-12-1**

##### **Health care provider liability; actions based on breach of contract**

Sec. 1. Liability may not 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 the contract is in writing and signed by that health care provider or by an authorized agent of the health care provider.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-12-2**

##### **Informed consent; rebuttable presumption**

Sec. 2. 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.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-12-3**

##### **Informed written consent; explanation of proposed treatment, outcome, and risks**

Sec. 3. The explanation given in accordance with section 2(3) of this chapter 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.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-12-4**

##### **Duty to obtain informed consent**

Sec. 4. This chapter does not relieve a qualified health care provider of the duty to obtain an informed consent.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-12-5**

**Withdrawal of consent**

Sec. 5. This chapter does not prevent a patient, after having signed a consent, from withdrawing that consent.

*As added by P.L.1-1998, SEC.13.*

**IC 34-18-12-6****Writing not required**

Sec. 6. This chapter does not require that a patient's consent or the information described under section 3 of this chapter be in writing in all cases.

*As added by P.L.1-1998, SEC.13.*

**IC 34-18-12-7****Compliance with chapter**

Sec. 7. Compliance with this chapter is not required to create an informed consent.

*As added by P.L.1-1998, SEC.13.*

**IC 34-18-12-8****Patient refusal to receive information**

Sec. 8. A patient may refuse to receive some or all of the information described in section 3 of this chapter.

*As added by P.L.1-1998, SEC.13.*

**IC 34-18-12-9****Consent not required; mental disability or emergency**

Sec. 9. Sections 2 and 3 of this chapter do not apply to a person who is mentally incapable of understanding the information required to be provided by section 3 of this chapter. This section does not require consent to health care in an emergency.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-13**

### **Chapter 13. Malpractice Coverage**

#### **IC 34-18-13-1**

##### **Liability under chapter dependent upon maintenance of malpractice liability insurance**

Sec. 1. Only while malpractice liability insurance remains in force are the health care provider and the health care provider's insurer liable to a patient or the patient's representative for malpractice to the extent and in the manner specified in this article.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-13-2**

##### **Acceptance of article; filing of proof of financial responsibility**

Sec. 2. The filing of proof of financial responsibility with the commissioner constitutes, on the part of the insurer, a conclusive and unqualified acceptance of this article.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-13-3**

##### **Policy terms limiting liability void**

Sec. 3. A provision in a policy attempting to limit or modify the liability of the insurer contrary to this article is void.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-13-4**

##### **Included policy pensions**

Sec. 4. Every policy issued under this article (or IC 27-12 before its repeal) is considered to include the following provisions, and any change made by legislation adopted by the general assembly as fully as if the change were written in the policy:

(1) The insurer assumes all obligations to pay an award imposed against its insured under this article (or IC 27-12 before its repeal).

(2) A termination of this policy by cancellation initiated by the insurance company is not effective for 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 insured and the commissioner at their offices.

(3) A termination of this policy by cancellation initiated by the insured is not effective for 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.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-13-5**

**Insurer's failure to pay judgment; revocation 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 this article, in addition to any other legal remedy, the commissioner may also revoke the approval of the insurer's 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.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-14**

### **Chapter 14. Limits on Damages**

#### **IC 34-18-14-1**

##### **"Cost of the periodic payments agreement" defined**

Sec. 1. As used in this chapter, "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 section 3 of this chapter.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-14-2**

##### **"Periodic payments agreement" defined**

Sec. 2. As used in this chapter, "periodic payments agreement" means a contract between a health care provider (or its insurer) and the patient (or the patient's estate), under which 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.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-14-3**

##### **Recovery limitations**

Sec. 3. (a) The total amount recoverable for an injury or death of a patient may not exceed the following:

(1) Five hundred thousand dollars (\$500,000) for an act of malpractice that occurs before January 1, 1990.

(2) Seven hundred fifty thousand dollars (\$750,000) for an act of malpractice that occurs:

(A) after December 31, 1989; and

(B) before July 1, 1999.

(3) One million two hundred fifty thousand dollars (\$1,250,000) for an act of malpractice that occurs after June 30, 1999.

(b) A health care provider qualified under this article (or IC 27-12 before its repeal) is not liable for an amount in excess of two hundred fifty thousand dollars (\$250,000) for an occurrence of malpractice.

(c) Any amount due from a judgment or settlement that is in excess of the total liability of all liable health care providers, subject to subsections (a), (b), and (d), shall be paid from the patient's compensation fund under IC 34-18-15.

(d) If a health care provider qualified under this article (or IC 27-12 before its repeal) admits liability or is adjudicated liable solely by reason of the conduct of another health care provider who

is an officer, agent, or employee of the health care provider acting in the course and scope of employment and qualified under this article (or IC 27-12 before its repeal), the total amount that shall be paid to the claimant on behalf of the officer, agent, or employee and the health care provider by the health care provider or its insurer is two hundred fifty thousand dollars (\$250,000). The balance of an adjudicated amount to which the claimant is entitled shall be paid by other liable health care providers or the patient's compensation fund, or both.

*As added by P.L.1-1998, SEC.13. Amended by P.L.111-1998, SEC.14.*

#### **IC 34-18-14-4**

##### **Discharge of possible liability; periodic payments agreement**

Sec. 4. (a) If the possible liability of the health care provider to the patient is discharged solely through an immediate payment, the limitations on recovery from a health care provider stated in section 3(b) and 3(d) of this chapter apply without adjustment.

(b) If the health care provider agrees to discharge its possible liability to the patient through a periodic payments agreement, the amount of the patient's recovery from a health care provider in a case under this subsection is the amount of any immediate payment made by the health care provider or the health care provider's insurer to the patient, plus the cost of the periodic payments agreement to the health care provider or the health care provider's insurer. For the purpose of determining the limitations on recovery stated in section 3(b) and 3(d) of this chapter and for the purpose of determining the question under IC 34-18-15-3 of whether the health care provider or the health care provider's insurer has agreed to settle its liability by payment of its policy limits, the sum of:

(1) the present payment of money to the patient (or the patient's estate) by the health care provider (or the health care provider's insurer); plus

(2) the cost of the periodic payments agreement expended by the health care provider (or the health care provider's insurer); must exceed one hundred eighty-seven thousand dollars (\$187,000).

(c) More than one (1) health care provider may contribute to the cost of a periodic payments agreement, and in such an instance the sum of the amounts expended by each health care provider for immediate payments and for the cost of the periodic payments agreement shall be used to determine whether the one hundred eighty-seven thousand dollar (\$187,000) requirement in subsection (b) has been satisfied. However, one (1) health care provider or its insurer must be liable for at least fifty thousand dollars (\$50,000).

*As added by P.L.1-1998, SEC.13. Amended by P.L.111-1998, SEC.15.*

#### **IC 34-18-14-5**

##### **Limitations on recovery from fund; direct payments; periodic payments**



Sec. 5. (a) If the possible liability of the fund to the patient is discharged solely through a direct payment made under IC 34-18-15-1, the limitations on recovery from the patient's compensation fund established under section 3 of this chapter apply without adjustment.

(b) If 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 commissioner on behalf of the fund;

for the purposes of the limitations on recovery from the fund established under section 3 of this chapter.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-15**

### **Chapter 15. Payment From the Patient's Compensation Fund**

#### **IC 34-18-15-1**

##### **Discharge of obligations**

Sec. 1. (a) The obligation to pay an amount from the patient's compensation fund under IC 34-18-14-3(c), IC 34-18-6-6, or section 3 of this chapter (or IC 27-12-14-3(c), IC 27-12-6-6, or IC 27-12-15-3 before their repeal) may be discharged as follows:

- (1) Payment in one (1) lump amount.
- (2) An agreement requiring periodic payments from the fund over a period of years.
- (3) The purchase of an annuity payable to the patient.
- (4) Any combination of subdivisions (1), (2), and (3).

(b) The commissioner may contract with approved insurers to insure the ability of the fund to make periodic payments under subsection (a)(2).

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-15-2**

##### **Periodic payments; combined payments**

Sec. 2. Notwithstanding IC 34-18-6, 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 IC 34-18-14-2); 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). However, the amount provided by the commissioner may not exceed eighty percent (80%) of the total amount expended for the agreement.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-15-3**

##### **Demand 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 two hundred fifty thousand dollars (\$250,000), and the claimant is demanding an amount in excess of that amount, the following procedure must be followed:

- (1) A petition shall be filed by the claimant in the court named in the proposed complaint, or in the circuit or superior court of Marion County, at the claimant's election, seeking:
  - (A) approval of an agreed settlement, if any; or
  - (B) demanding payment of damages from the patient's compensation fund.
- (2) A copy of the petition with summons shall be served on the commissioner, the health care provider, and the health care provider's insurer, and must contain sufficient information to inform the other parties about the nature of the claim and the

additional amount demanded.

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

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

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

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

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

*As added by P.L.1-1998, SEC.13. Amended by P.L.233-1999, SEC.15.*

#### **IC 34-18-15-4**

##### **Failure to pay settlement or judgment**

Sec. 4. If a health care provider or the health care provider's surety or liability insurance carrier fails to pay any agreed settlement or final judgment within ninety (90) days, the agreed settlement or final judgment shall be paid from the patient's compensation fund, and the

fund shall be subrogated to any and all of claimant's rights against the health care provider, the health care provider's surety or liability insurance carrier, or both, with interest, reasonable costs, and attorney's fees.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-16**

### **Chapter 16. Evidence of Advanced Payment; Assignability of Claim**

#### **IC 34-18-16-1**

##### **Advanced payment not admission of liability**

Sec. 1. Except as provided in IC 34-18-15-3, any advance payment made by the defendant health care provider or the health care provider's 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.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-16-2**

##### **Admissibility; payment exceeds liability of defendant; adjustment of judgments**

Sec. 2. (a) Evidence of an advance payment is not admissible until there is a final judgment in favor of the plaintiff. In this case the court shall reduce the judgment to the plaintiff to the extent of the advance payment. The advance payment inures to the exclusive benefit of the defendant or the defendant's insurer making the payment.

(b) If the advance payment exceeds the liability of the defendant or the insurer making the advance payment, the court shall order any adjustment necessary to equalize the amount that each defendant is obligated to pay, exclusive of costs. An advance payment in excess of an award is not repayable by the person receiving the advance payment.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-16-3**

##### **Claim not assignable**

Sec. 3. A patient's claim for compensation under this article is not assignable.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-17**

### **Chapter 17. Residual Malpractice Insurance Authority**

#### **IC 34-18-17-1**

##### **Purpose of chapter**

Sec. 1. The purpose of this chapter is to make malpractice liability insurance available to risks (as defined in this article).

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-17-2**

##### **Residual malpractice authority created**

Sec. 2. (a) The residual malpractice insurance authority is created.

(b) The department of insurance is designated as the residual malpractice insurance authority for the purposes of this article.

(c) The authority may engage in making malpractice liability insurance, as described in IC 27-1-5-1, Class 2(h), in Indiana.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-17-3**

##### **Appointment of risk manager; liability limit**

Sec. 3. The commissioner shall appoint a risk manager for the authority. The separate, personal, or independent assets of the risk manager are not liable for or subject to use or expenditure for the purpose of providing insurance by the authority.

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-17-4**

##### **Powers and duties of risk manager**

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

- (1) Obey all Indiana statutes and rules that apply to insurance described in IC 27-1-5-1, Class 2(h).
- (2) Prepare and file appropriate forms with the department of insurance.
- (3) Prepare and file premium rates with the department of insurance.
- (4) Perform the underwriting function.
- (5) Dispose of all claims and litigations arising out of insurance policies.
- (6) Maintain adequate books and records.
- (7) File an annual financial statement regarding its operations under this chapter with the department of insurance on forms prescribed by the commissioner.
- (8) Obtain private reinsurance for the authority, if necessary.
- (9) Prepare and file for approval of the commissioner a schedule of agent's compensation.
- (10) Prepare and file a plan of operations with the commissioner for approval.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-17-5**

#### **Compensation of risk manager**

Sec. 5. The risk manager shall receive, as compensation for services, a percentage of all premiums received by the risk manager under this chapter, as determined by the commissioner. The rate of compensation may be adjusted by the commissioner.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-17-6**

#### **Applications for insurance**

Sec. 6. If a risk, after diligent effort, has been declined by at least two (2) insurers, the risk may forward an application to the risk manager, together with evidence of the two (2) declinations.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-17-7**

#### **Rejection of risk by manager; 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 has ten (10) days after 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.

*As added by P.L.1-1998, SEC.13.*

### **IC 34-18-17-8**

#### **Investment of surplus premiums over losses; segregation of funds**

Sec. 8. All money appropriated by the state 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 within the limitations set forth in IC 27-1-13. Investment income generated shall remain in the segregated fund.

*As added by P.L.1-1998, SEC.13.*

## **IC 34-18-18**

### **Chapter 18. Attorney's Fees**

#### **IC 34-18-18-1**

##### **Limitation on fees**

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

*As added by P.L.1-1998, SEC.13.*

#### **IC 34-18-18-2**

##### **Per diem payment by written agreement**

Sec. 2. 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.

*As added by P.L.1-1998, SEC.13.*