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A History of the Medical Liability Issue

Indiana Compensation Act for Patients (INCAP)

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Indiana Compensation Act for Patients

Executive Summary

For health care providers and health care consumers, development of a fair and efficient system for adjudicating malpractice claims is an issue that threatens the accessibility, affordability and quality of health care in the United States.

The U.S. Department of Health and Human Services estimates that defensive medicine and unreasonable awards for non-economic damages add $60 to $108 billion to the cost of health care annually.

Throughout the nation, states are experiencing the high cost of medical liability insurance. The ever-increasing likelihood of litigation directly affects shortages of physicians and has caused dangerous gaps in the availability of specific medical procedures, such as obstetrics.

Access to physicians and medical care was one of the driving issues in the development of Indiana's groundbreaking 1975 malpractice legislation. Not only was Indiana the first state in the nation to adopt comprehensive malpractice reforms, but it has maintained them. Indiana's law has become a model for other states contemplating tort law changes.

Referred to as the Indiana Compensation Act for Patients (INCAP), this new law was the first comprehensive patient compensation statute in the nation. The law's goal was, and is, to protect the health of the citizens of Indiana by preventing a reduction of health care services.

In 2003, the American Medical Association identified 18 states that were experiencing a malpractice crisis. For example,

- High malpractice insurance costs drove 44 doctors from Delaware County, Pa., at the height of their careers.
- The only Level I trauma center in Las Vegas, Nev., closed for 10 days because physicians serving the center could no longer afford to pay medical liability premiums.

- In Mississippi, 324 physicians stopped delivering babies in the last decade, and only three physicians who do obstetrics now provide services for a population of more than 100,000.
- In West Virginia, the lack of physicians caused the Charleston Area Medical Center to be downgraded from a Level I to a Level III facility and at least two rural community hospitals have closed their OB units.

Before the Indiana General Assembly enacted the Medical Malpractice Act, the state's health care providers--and ultimately, the state's health care consumers – were faced with a crisis similar to the situation facing other states today. 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. Many physicians were retiring early; others abandoned high-risk fields such as obstetrics, neurology and anesthesiology.

INCAP approached the twin dilemmas of soaring liability costs and the accompanying threat of impaired access to medical care 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' malpractice premiums. Since July 1, 1999, the surcharge is based on an average of actual rates for all physicians in the same specialty class or discipline according to the specialty's risk to the PCF.
- 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 that is rendered is not legally binding, but members can be called upon to testify if the case proceeds to court.
- The law initially required providers to have at least $100,000 in malpractice insurance. This was increased to $250,000 in 1998.
- The 1975 law set an upper limit on recoverable awards, which has been increased two times. Originally this cap was set at $500,000. It was raised to $750,000 in 1990 and to $1.25 million in 1998. The 1998 changes to INCAP became effective after July 1, 1999.

- The law attempted to control attorneys' fees to ensure that awards for injured patients go where they are intended - to the patients. Attorneys' fees are unlimited on the first $250,000 and they are allowed up to 15 percent of any recovery from the PCF. There is no limit on the amount of expenses an attorney may charge.

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 proven to be both patient-friendly and physician-friendly.

INCAP, created as a balance of competing public policy agendas, has withstood multiple constitutional tests, and most importantly, 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, INCAP works.

White Paper on the
Indiana Compensation Act for Patients

The United States spent $1.4 trillion on health care in 2001 – with more than 45 percent of that total publicly financed. Health care expenditures, which expanded from 6 percent of the gross domestic product to nearly 14.1 percent in 2001, are expected to continue to grow in the next decade.[1]

All elements of health care have become more costly, but medical liability insurance increased on average 11.3 percent in 2001 – the largest increase in a decade.[2] At least two factors account for the increase. According to the National Conference of State Legislatures, costs are increasing because insurers must spend more to pay claims – 33 percent more from 2000-2001.[3]

So just how much do increased insurance premium costs and malpractice impact health care expenditures? Estimates vary, but significant numbers of consumers agree there is an effect. More than seven out of 10 Americans (71 percent) said medical liability litigation is one of the primary forces driving up health care costs. [4] By January 2003, a Gallup Survey found that 74 percent of Americans believed medical malpractice insurance was either a major problem or a crisis.[5] A recently released study by the American Association of Health Plans conducted by PricewaterhouseCoopers says litigation is responsible for 7 percent or $5 billion of new health care costs.[6]

Tillinghast, an actuarial and management firm, has tracked tort costs for some time. Its records indicate that in 1991 medical malpractice cases cost the nation $9.1 billion, up 15

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[1] Centers for Medicare & Medicaid Services. "*Highlights -- National Health Expenditures, 2001,* accessed 8 January 2003; http://cms.hhs.gov/statistics/nhe/historical/highlights.asp;
Internet, excerpted from Levit, K. et al: "Trends in U.S. Health Care Spending, 2001," Health Affairs 22 January-February 2003.

[2] "Hype outraces facts in malpractice debate," *USA Today,* March 6, 2003, http://usatoday.printthis.cliclability.com/pt/cpt?action=cpt&expire=.

[3] Ibid.

[4] Wirthlin Worldwide Survey, April 2002, http://65.217.254.54/wwinnews/show.asp?id=20.

[5] Gallup Poll Tuesday Briefing, www.gallup.com/plll/tb/healthcare/20030204.asp. Results of the poll were based on interviews with 1,006 national adults, conducted Jan. 20-22, 2003. The margin of error is =/-3% at the 95% confidence level.

[6] PricewaterhouseCoopers, *The Factors Fueling Rising Healthcare Costs,* April 2002. p 3-4.

percent from 1974.[7] By 2001, medical malpractice tort costs had risen to $21 billion, a 55-percent increase over 10 years.[8] In fact, viewed in the aggregate, medical malpractice tort costs have grown at an annual rate of 11.6 percent since 1975 versus 9.5 percent annual growth for all U.S. tort cases, representing a major change.[9] Yet, these totals do not include the costs of defensive medicine – another significant component.

Defensive medicine, ordering unnecessary medical tests to fend off litigation and cope with steep liability premiums, accounts for an estimated $50 billion per year, according to the *Quarterly Journal of Economics*.[10] When compared to previous studies, results show estimates have risen as much as 30 percent in the last nine to 10 years.

Highlighting this issue, Lewin-VHI, a Virginia health economics-consulting firm, estimated in 1993 that the nation spends nearly $25 billion on unnecessary medical tests each year. Lewin was not able to identify exactly what percentage of those tests were motivated by malpractice concerns, but conservatively estimated a range between $5 billion and $15 billion per year.[11] In 1994, the Competitiveness Center of Hudson Institute found empirical evidence that defensive medicine contributes to the rise in health care costs. Working closely with a large Indiana hospital, researchers determined defensive medicine added 3.7 percent to the hospital's operating expenditures, or nearly $15 million per year. The study estimated the national cost of defensive medicine and malpractice insurance exceeds $15 billion per year.[12] The U.S. Department of Health and Human Services says defensive medicine and unreasonable awards for non-economic damages adds $60 billion to $108 billion to the nation's health care costs each year.[13]

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[7] *Tort Cost Trends: An International Perspective,* Tillinghast, 1992; pp 1-14.
[8] *U.S. Tort Costs: 2002 Update, Trends and Findings on the Costs of the U.S. Tort System,* Tillinghast-Towers Perrin, p 16.
[9] Ibid. p 13.
[10] York Daily Record, January 20, 2002.
[11] Mendelson DJ, Rubin RJ: *Estimating the Costs of Defensive Medicine,* (Fairfax, Va: Lewin-VHI, January 27, 1993).
[12] McIntosh DM, Murray DC: *Medical Malpractice Liability: An Agenda for Reform,* The Competitiveness Center of Hudson Institute, 1994.
[13] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System,* (24 July 2002). p 7.

Yet, the impact on health care costs does not stop there. As tort costs have grown, malpractice premiums have inflated as well. According to an A.M. Best Statistical Study, doctors spent $6.3 billion on malpractice insurance premiums in 2001. [14]

None of these studies, however, addressed the cost to society of patients who could not obtain treatment because physicians stopped performing high-risk procedures due to liability concerns.

For both health care providers and consumers, the development of an equitable and efficient system for adjudicating medical malpractice claims is a complex issue that potentially threatens the accessibility, affordability and quality of health care in the United States.

Part of the difficulty in establishing an equitable and efficient system lies in the determination of the difference between an "adverse event" and a "negligent adverse event" in a medical diagnosis, procedure or course of treatment. Technological advances have created opportunities for improved health care. However, they have also created more opportunities for error in either diagnosis or treatment, and those errors may result in more visible and more severe adverse events. Today's ability to save a severely injured, low-birth weight infant who might not have survived 20 years ago, for example, carries with it the potential for litigation.[15]

No evidence exists to directly correlate the higher number of professional liability claims and the explosive growth in the size of awards with a decline in quality of health care. However, high profile errors like the one at Duke University where Jèsica Santillàn died as a result of receiving a transplanted organ that did not match her blood type undoubtedly undermine confidence in the quality of care.

Research indicates that the failure of health care systems, not individuals, is responsible for most errors. New efforts involving patient safety and the provision of quality care are underway. But these undertakings require a legal environment that encourages health care professionals and organizations to work together to identify errors, evaluate the causes and use that information to improve care for all patients.[16]

Currently, determination of medical malpractice and assessment of appropriate levels of compensation have been entrusted to the legal system. Criticism of the system abounds.

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[14] Ibid. As cited in A.M. Best Statistical Study, July 16, 2001.
[15] Jacobson PD: "Medical malpractice and the tort system," *JAMA*, 1989; 262: p 3324.
[16] U.S. Department of Health and Human Services, p 22.

Critics say the current structure relies too heavily on the vagaries of the jury system, which neither appropriately compensates nor effectively deters. At best, the tort system is an imperfect instrument for weighing risk and resolving medical practice disputes between physicians and patients.

The Harvard University Medical Practice Study published an exhaustive investigation in 1991 based on admissions to 51 hospitals in the state of New York in 1984. The study showed that 1 percent of patients admitted to hospitals were injured due to medical malpractice. Of those, only eight out of 306 Harvard-certified malpractice victims filed lawsuits. However, an additional 39 patients – not victims of any medical misconduct, according to the study – also sued.[17] Of those cases compensated, 60 percent of the money spent on malpractice went to lawyers and court administration; only 40 percent went to injured patients.[18]

Although juries resolve a small percentage of malpractice claims, jury awards influence the level of settlements and attorneys' incentive to pursue claims. In 1999-2000, 52 percent of awards were in excess of $1 million.[19] This compared to the period 1994-1996 when only 34 percent of all verdicts assessed awards of $1 million. In the high-risk specialty of obstetrics/gynecology, the median award jumped 43 percent in one year, from $700,000 to $1 million in 2000.[20]

In another example of the explosion in general liability awards, juries in 2002 gave $31.4 billion in damages to individuals in the 10 largest liability cases in the United States, according to a survey by Lawyers Alert, a Boston-based news magazine. [21] That amount is more than three times the $9 billion awarded in 1999.[22]

While efforts to readjust the system continue, some insurance carriers have gone bankrupt. Others face serious financial trouble. Health care providers in at least 18 states

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[17] Localio, et al: "Relation between malpractice claims and adverse events due to negligence," *New England Journal of Medicine*, 1991; 325:pp 245-251.
[18] Ibid.
[19] U.S. Department of Health and Human Services, p 9, as reported in "Current Award Trends in Personal Injury," by *Jury Verdict Research, 2001.*
[20] Ibid. As reported in "Trends in Personal Injury," by *Jury Verdict Research,* 2001.
[21] http://kansascity.bizjournals.com/kansascity/stories/2003/01/06/daily 19.html.
[22] Associated Press, as reported by ABC News, http://more.abcnews.go.com/sections/us/dailynews/verdicts000111.html.

cannot obtain malpractice insurance without significant rate increases and/or coverage restrictions. Some physicians – notably obstetricians and gynecologists – are abandoning their practices. Many hospitals are limiting risky procedures or even closing departments because malpractice coverage costs have made it uneconomical to continue them. Today, in the face of spiraling liability risks, young men and women all too often are avoiding the medical profession, while older, experienced physicians are retiring early. [23]

One of the greatest dangers of the medical litigation explosion has been its potential for reducing patients' access to specialized medical care. For example, obstetrics has been, and continues to be, one of the most adversely affected areas of medicine. By 1999, 76.5 percent of American College of Obstetrics and Gynecology Fellows across the nation had been sued at least once in their careers. On average, ob/gyn physicians can expect to be sued 2.5 times in their careers.[24]

Access to physicians and medical care was one of the driving issues in the development of Indiana's trend-setting 1975 malpractice legislation.[25] Many news reports from the immediate period leading up to the 1975 Indiana General Assembly warned of potential emergency room shutdowns, curtailments of surgery and an ongoing exodus of physicians to states where malpractice insurance was more available or less costly. Indiana legislators were confronted with the serious question of how to maintain the availability and affordability of health care services for citizens in their state. [26]

HISTORICAL CONTEXT OF THE LAW

The medical profession has always been monitored in one form or another. The Babylonian Code of Hammurabi, established around 2000 B.C., spelled out one of the harshest penalties known to date: If a patient died as a result of an operation, the attending physician was punished by having his hand cut off. The code also required doctors to treat the sick, even

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[23] "The Need for Civil Justice Reform: Georgia's Emerging Crisis in Medical Liability," presentation by David Cook, Executive Director, Medical Association of Georgia.
[24] Testimony on "Who will Deliver American's Babies? The Impact of Excessive Litigation," by Shelby L. Wilbourn, M.D., FACOG, The American College of Obstetrics and Gynecologists, before the Senate Judiciary Committee and Senate HELP Committee of the United States Senate, Feb. 11, 2003
[25] Bowen OR: *Notre Dame Journal of Legislation*, vol. 11, no. 1, winter 1984, p 16, citing *Committee on Labor and the Economy, Report to the House of Representatives,* 99th General Assembly, 1st Session.
[26] Bowen.

those unable to pay for the services. The Oath of the Hindu Physician, dating from around 1500 B.C., required the physician to devote himself to healing, even if it jeopardized his life. Medical practitioners took similar vows in ancient China.[27]

Although a malpractice case was recorded in England as early as 1374, the first case in America did not occur until 1794. In the early to mid-1800s, both the English and American medical professions set specific rules of conduct. At its first meeting in 1847, the American Medical Association adopted the Hippocratic oath and a set of rules based on a code published in 1803 by the English physician Thomas Percival. [28]

The legal underpinning of medical malpractice in the United States was established by two famous cases. In 1898, the New York Supreme Court wrote that a doctor must possess "that reasonable degree of learning and skill that is ordinarily possessed by physicians and surgeons in the locality in which he practices…" The court went on to specify that a physician was obliged "to use his best judgment in exercising his skill and applying his knowledge."[29]

Forty years later, the Supreme Court of Indiana wrote that the implied contract between the physician and patient "does not include a promise to effect a cure, and negligence cannot be imputed because a cure is not effected…" The court emphasized, however, that a doctor must use "due diligence and ordinary skill in his treatment of the patient." [30]

When Congress and state legislatures liberalized liability laws in the 1960s, they opened the floodgates for civil lawsuits.[31] As early as 1969, the U.S. Senate Government Operations Subcommittee on Executive Reorganization under the chairmanship of Abraham Ribicoff warned doctors, hospitals, insurance companies and the rest of the American public of increasing malpractice litigation and rising jury awards in many states. The subcommittee cautioned, "The situation threatens to become a national crisis." [32] The issue also received national attention in 1973 when the Department of Health, Education and Welfare's Commission on Medical Malpractice published its final report.

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[27] de Lesseps S: "Malpractice insurance crunch," *Congressional Quarterly Publications*, Dec. 18, 1975; 2: pp 926-944.
[28] Ibid.
[29] Pike vs. Honsinger, 49 NE 760 (N.Y. 1898).
[30] Adkins vs. Robb, 14NE 2d 727 (Ind. 1938).
[31] "U.S. seeks a cure to legal dilemma," *Chicago Tribune*, July 26, 1991; p 1.
[32] "Medical malpractice: The patient vs. the physician, " *U.S. Government Printing Office*, Nov. 20, 1969; pp 2-3.

Malpractice insurance premiums continued to rise, and by 1974 the problem reached crisis proportions. New York's leading malpractice insurer doubled its rates in that year and early in 1975 asked the state's permission to triple new rates. In some other states requested increases ran as high as 700 percent. Indiana was among the group of states hit hardest by premium increases; others included Alaska, Maryland, Michigan and North Carolina.[33]

Before the Indiana General Assembly enacted the Medical Malpractice Act, the state's health care providers – and ultimately, the state's health care consumers – were faced with a crisis of monumental proportions. 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.[34] Nevertheless, the insurance companies reported a net operating loss during the period. [35]

Many insurance companies across the nation threatened to end malpractice coverage altogether if their requests for higher premiums were not met. In Indiana, major insurance companies handling such coverage announced plans to eliminate medical malpractice underwriting to concentrate on more profitable lines of insurance.[36]

In 1973 and 1974, the number of lawsuits and amounts of damage awards involved were increasing at such a rate that all malpractice insurance carriers except St. Paul Fire and Marine Insurance Company and Medical Protective Company of Fort Wayne were withdrawing from covering physicians in Indiana.[37] Many doctors, left with inadequate coverage or no insurance at all, "were taking early retirement in areas which were already in short supply and surgeons stopped doing more complicated procedures which entailed greater risk." [38]

Indiana was one of the first states in the nation to adopt comprehensive malpractice reforms. The state has maintained those reforms. In fact, Indiana's law has become a model for other states seeking to ensure adequate patient compensation through tort law changes.

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[33] de Lesseps. As found in note 26.
[34] *Final Report of the Medical Malpractice Study Commission,* 5.100. (Dec. 31, 1976).
[35] Ibid.

[36] *The Indiana Medical Malpractice Interim Study Committee* (July 13, 1984) (Statement of the Medical Protective Company of Fort Wayne, presented by Michael S. Mullen.)
[37] Davis JB: "A look at Indiana's Medical Malpractice Act," *American College of Surgeons Bulletin,* November 1988; 73(11):pp 10-13.
[38] Bowen. As found in Note 24.

INDIANA COMPENSATION ACT FOR PATIENTS (INCAP)

Before discussing medical malpractice laws, it is important to understand the definition of "malpractice." By law, a finding of malpractice suggests that a doctor has been negligent in some way. The law has generally interpreted negligence as failure to treat a patient according to the standards of care that are followed by other doctors with similar training. However, when things go wrong that are not the doctor's fault, according to the law, it is not malpractice.

Indiana took a giant leap forward in 1975 when the Indiana General Assembly enacted the Indiana Medical Malpractice Act. Former Gov. Otis R. Bowen signed the Act into law April 17, 1975.

Referred to as the Indiana Compensation Act for Patients (INCAP), this new law was hailed by lawyers and the medical profession alike as an encapsulation of major solutions to the medical crisis occurring at that time.[39] Supported by the legislature, consumers, hospitals and labor, INCAP ultimately became a piece of consensus legislation.

The first comprehensive patient compensation statute in the nation, INCAP had a goal of protecting the health of the citizens of Indiana by preventing a reduction of health care services.[40] Indiana's tort reforms have been recommended by the Department of Health and Human Services, and have been substantially adopted by other states, such as Nebraska and Louisiana.[41]

Among the many provisions of INCAP are:

- Limits on recovery
- A statute of limitations
- A medical review panel
- A Patient's Compensation Fund (PCF)
- Limitations on attorney fees awarded by the PCF

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[39] "Malpractice law hailed by doctors, bar," *Indianapolis Star*, April 18, 1975.
[40] "Medical Malpractice Case Study on Indiana," U.S. General Accounting Office, December 1989; p 9.
[41] HHS 1987a, 1987b; as found in Gronfein WP, Kinney ED: "*Controlling large medical malpractice claims: The unexpected impact of damage caps,*" March 1991; p 2. Research supported by a grant from The Robert Wood Johnson Foundation.

Limits on Recovery

Health care providers, as defined in the Indiana Code, are required to show proof of financial responsibility.[42] Originally, the law required providers to have malpractice liability insurance of at least $100,000 per occurrence and $300,000 in the annual aggregate. Hospitals that have 100 beds or fewer were required to carry a minimum of $2 million in the annual aggregate, and $3 million for hospitals with more than 100 beds.

In 1998, these amounts were increased. For individual physicians, insurance carriers must file proof that the health care provider has malpractice liability insurance in the amount of at least $250,000 per occurrence, and $750,000 in the annual aggregate. Hospitals that have 100 beds or fewer are required to carry a minimum of $5 million in the annual aggregate, and $7.5 million for hospitals with more than 100 beds.[43]

Statute of Limitations

A two-year statute of limitations was established for filing a claim against a health care provider. The statute of limitations usually begins at the time of the alleged act, omission or neglect – not at the time the alleged act was discovered. An exception for children with possible birth injuries allows those injured prior to the age of six, until their eighth birthday, to file any claim.[44] The statute of limitations has been challenged in court repeatedly. Most recently, it was tested in a July 1999 Supreme Court case, Martin vs. Richey. In Martin, the court held that the two-year statute of limitations could be extended in those limited number of cases where the plaintiff demonstrated that the act of malpractice was concealed.

Medical Review Panel

A medical review panel is composed of three health care professionals and one attorney who serves as chairman and facilitator but has no voting authority.[45] The three panel members are chosen as follows: The plaintiff and defendant each choose one health care provider; these two providers choose a third. If the defendant is a health care professional who

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[42] Ind. Code 34-18-3-2, (Section 2); 1999.
[43] Ibid. 34-18-4-1; (1 A), (i), (ii).
[44] Ibid. 34-18-7-1 (b).
[45] Ind. Code 34-18-10-3 (a), (b).

specializes in a limited area of medicine, two of the panelists selected must be from the same field as the defendant.[46] Panel members are compensated for their efforts; health care providers receive no per diem and not more than $350 plus travel, while the attorney-chairman receives $250 per diem and not more than $2,000 plus travel. The side in whose favor the majority opinion is written pays these fees.[47]

To begin the process, the claimant must file a complaint with the insurance commissioner. The commissioner then notifies the health care provider by registered mail within 10 days, and the panel may be formed within 20 days after filing of the complaint.[48]

A panel opinion must be rendered within 180 days after selection of the last member of the panel. Once the panel has reviewed all evidence, it has 30 days to render an expert opinion, in writing, to be signed by the panelists. Though the panel's findings are not legally binding, each panel member can be called upon to provide expert testimony should the case proceed to court for a ruling. The report also is admissible as evidence in any action brought by the claimant in a court of law.[49] The medical review panel must render its decision before any court action can take place, unless the claim is less than $15,000 or both parties agree to bypass this step. The filing of a complaint stops the statute of limitations until 90 days after receiving a panel decision.

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

- Nature of the claim
- Damages asserted
- Alleged injury
- Attorney's fees
- Expenses incurred in connection with the claim or defense

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[46] Ibid. 34-18-10-6.
[47] Ibid. at 34-18-10-25 (a), (b).
[48] Ibid. at 34-18-9-1, Sec. 1.
[49] Ibid. 34-18-10-23, Sec. 3.

- Amount of any settlement or judgment[50]

If a decision is rendered against the health care provider, the insurance commissioner is responsible for forwarding the health care provider's name to the appropriate board of professional registration and examination for review of the health care provider's fitness to practice his profession. The board has the power 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

The board must then report to the commissioner its findings, the action taken and the final disposition of each case.[51]

The Patient's Compensation Fund

A Patient's Compensation Fund (PCF) was established to make money available to individuals permanently disabled as a result of medical malpractice.[52] Indiana allows recovery only when the defendant's fault, in this case the health care provider, exceeds the plaintiff's.[53] Originally, if the health care provider's fault was established, the fund paid any claims exceeding a $100,000 limit per occurrence.

Effective July 1, 1998, the underlying coverage limit was increased to $250,000 per occurrence for cases occurring after June 30, 1999.[54]

The PCF was created by levying an annual surcharge, determined by the commissioner, on all health care providers in Indiana. From 1975 to 1982, the insurance surcharge was 10 percent of the health care provider's malpractice premium.[55] In 1987, the surcharge was raised to 125 percent of the amount paid by the health care provider to his insurance carrier. Between October 1991 and July 1999, the surcharge was 150 percent of the health care provider's malpractice premium.

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[50] Ibid. 34-18-9-3 (b).
[51] Ibid. 34-18-9-4 (c).
[52] Bowen OR: "Medical malpractice law in Indiana," *Journal of Legislation*, 1984; 11(15): p 20.
[53] Kinney ED, Gronfein WP: "*Indiana's malpractice system: No fault by accident?*", 1990.
[54] Ind. Code, 34-18-14-3 (b).
[55] Sandrick K: "Indiana's malpractice law: Is everybody a winner?", *Private Practice*, April 1991; p 22.

Changes to INCAP in 1998 created a new surcharge formula for physicians. In the mid 1990s an actuarial review indicated the PCF was under-funded by at least $250 million. An adjustment to the surcharge formula and several other changes discussed here successfully addressed the solvency of the fund. Effective July 1, 1999, the insurance commissioner contracts with an actuary to calculate the average of the three leading malpractice insurers' actual rates for all physicians practicing in the same specialty. The actuary establishes a uniform surcharge for all licensed physicians practicing in the same medical specialty. The surcharge is required to be sufficient to cover the risk to the Patient's Compensation Fund from physicians practicing in the specialty class.[56]

All physicians, whether or not they have ever had a malpractice suit filed against them, pay into the PCF. This includes physicians insured by the Indiana Residual Malpractice Insurance Authority,[57] which provides coverage for physicians whom insurance companies would not underwrite. This, according to Bowen, was a necessity, especially for new physicians just entering practice who could not obtain coverage.[58] No provider is eligible for this coverage unless he can show evidence of coverage denial by at least two insurers.[59]

The amount any claimant may receive for injury or death of a patient under INCAP was originally set at $500,000. The amount was increased to $750,000 for alleged malpractice after January 1, 1990. After June 30, 1999, the total amount recoverable is $1.25 million.[60]

Until 1985, the health care provider's insurance carrier paid the first $100,000, and any amount exceeding that was paid by the PCF. As of 1985, as long as more than $75,000 of the $100,000 was paid at settlement, with a future payment of the remaining amount guaranteed, the claim qualified for PCF payment. Changes to the law effective after June 30, 1999, increased to $187,000 the amount a provider must pay if a claim is settled through immediate payment, thereby allowing the injured person to access the PCF for recovery. If there are multiple provider defendants, then one provider must pay at least $50,000, and the total payments must equal $187,000.[61]

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[56] Ind. Code, 34-18-5-2 (f) (1-2).
[57] Ibid. 34-18-17-2.
[58] Bowen. p 21 as found in note 51.
[59] Ind. Code, 34-18-17-6.
[60] Ibid. 34-18-14-3 (a).
[61] Ibid. 34-18-14-4.

To obtain any funds from the PCF, the claimant must file a court petition seeking approval of an agreed settlement or demanding payment of damages from the PCF. Copies of this petition also must be given to the commissioner, the health care provider and his insurer. An agreement, or any objections, must be filed within 20 days of notification.[62]

If the commissioner, the health care provider, the insurer of the health care provider and the claimant cannot agree on an amount, if any, to be paid out of the PCF, the court will determine this amount.

Any claims from the PCF that become final during the first six months of the calendar year must be paid no later than July 15. Likewise, any claims for payment during the last six months of the year must be paid no later than January 15 of the following year.[63]

The PCF fulfills its obligation to any claimants using the periodic payment method. This allows the fund to accumulate larger amounts of interest, since the bulk of the monies can remain intact and help ensure the solvency of the fund.

Since 1985, the PCF has increased its use of periodic payments rather than lump-sum payments.[64] Periodic payments are designed to ensure that damage awards remain available to claimants for the entire time compensation is needed. They are useful to prevent plaintiffs from exhausting large damage awards quickly and then suffering when needs go unmet.[65]

Additionally, the periodic payment method can help prevent windfalls to unintended third parties upon the death of the claimant.[66]

Attorney Fees

When an attorney represents a plaintiff in a malpractice case, both parties enter into a contract to determine the amount of money the attorney will receive from the initial $250,000 paid by the provider's insurer. There is no limit on this amount. Additionally, no limit is imposed on the amount of expenses that can be charged above and beyond the attorney's fee. The attorney also is allowed by law to receive up to 15 percent of any recovery from the

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[62] Ibid. 34-18-15-3.
[63] Ibid. 34-18-6-4.
[64] Medical Malpractice Case Study, p 11 as found in note 39.
[65] Kinney, p 29 as found in note 52.
[66] Feldman WS: "Medical malpractice revisited," *Legal Aspects of Medical Practice,* 1988; 16(4): p 2.

PCF.[67] The exact amount the attorney will receive from the PCF is determined by the contract between the attorney and the plaintiff.

Challenges to INCAP

Since INCAP was enacted in 1975, several court cases have challenged its constitutionality. Most significant among those are the following cases:

1. Cha v. Warnick, 476 N.E.2d 109 (Ind.1985), cert. Den. 106 S. Ct. 249 (1985). The Supreme Court reversed and remanded an earlier case that found the Act unconstitutional. It held that evidence showing the extent of delays in obtaining a medical malpractice panel opinion in proceedings under the Act was insufficient to find the Act unconstitutional.
2. Rohrabaugh v. Wagoner, 413 N.E.2d 891 (Ind. 1980). The Supreme Court affirmed that the legislature is not constitutionally mandated to suspend application of statutes of limitation in cases of infancy or incapacity.
3. Johnson v. St. Vincent Hospital, Inc., Bova v. Knak, Mansur v. Carpenter, Hines v. Elkhart General Hospital, 404 N.E.2d 585 (Ind. 1980). The Supreme Court consolidated four appeals in which various aspects of the Act had been declared constitutional by a lower court decision. The Supreme Court affirmed the decision and, among other rulings, held that: 1) the requirement of the Act that a malpractice claim be submitted to a medical panel for an opinion did not violate one's constitutional right to trial by jury or access to the courts; 2) the recovery limitation imposed by the Act was consistent with state and federal due process clauses and with equal protection and did not violate the right of a trial by jury; and 3) the provision of the Act that created the Patient's Compensation Fund, administered by the Indiana Insurance Commissioner, did not violate the provision of the Indiana Constitution prohibiting credit of the state to be given or loaned in aid of any person, association or corporation, and did not violate the provision of the Indiana Constitution requiring that certain laws be general and of uniform operation throughout the state.

[67] Ind. Code, 34-18-18-1.

4. Martin v. Richey, 711 N.E.2d 1273 (Ind. 1999). In a decision rendered July 8, 1999, the Indiana Supreme Court held in a 4 to 1 decision that the medical malpractice statute of limitations was unconstitutional under both the Privileges and Immunities Clause (art. I 323) and the Open Courts Clause (art. I 312) of the Indiana Constitution *as it applied to the plaintiff in this case.* The court did not hold that the medical malpractice statute of limitations is unconstitutional on its face. The case's holding was very fact-sensitive and limited in scope. The decision leaves open many questions and must be tested to see how the courts interpret the ruling in future decisions.

Results of INCAP and National Activity from 1975 - 1990

Indiana's Compensation Act for Patients provided an atmosphere in which insurance companies could establish reasonable malpractice insurance rates for practicing physicians. Lower liability insurance rates helped restrain the growth of health care costs in the state, and they reversed the outflow of physicians. The physician population in Indiana increased 69 percent between 1975[68] and 1990 while the general population in the state increased by 3.8 percent in the same period.

Opponents of the law have disparaged Indiana's statutory cap on liability awards, but, in function, the law has allowed plaintiffs to collect at a higher average than anyone could have envisioned. According to a three-year study funded by the Robert Wood Johnson Foundation and 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. The study found that the average payment for large claims in Indiana between 1975 and 1988 was $404,832. By way of comparison, the average in Michigan was $290,022, and the average in Ohio was $303,220 during that span.[69]

In 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.[70]

Across the nation, other states have tried a wide variety of legislation to deal with the issues addressed by INCAP. Results have been mixed, at best. Without some of the safeguards

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[68] AMA Data Survey and Planning and census data.
[69] Kinney ED, Gronfein WP: "Evaluation of Indiana's Medical Malpractice Act," Presentation to the Robert Wood Johnson Foundation. Washington, DC; Oct. 10, 1990.
[70] Sandrick, pp 17-22 as found in note 54.

built into Indiana's Act, other state's liability coverage premiums – and accompanying health care costs – are extremely expensive. The result in some areas throughout the 1980s was reduced access to care.

In many states rising insurance costs in the 1980s once again led physicians to curtail high-risk procedures, particularly obstetrical care. For example, from 1982 to 1987, insurance costs for obstetricians/gynecologists increased 238 percent nationally. Studies by the American College of Obstetrics and Gynecology indicated large numbers of obstetrician/gynecologists stopped practicing or decreased high-risk care.

In states as diverse as Florida, Michigan, Georgia, New York and Wisconsin, patients found access to care a problem as physicians stopped delivering babies, moved to other states or decided not to carry insurance.

Throughout that decade and into the 1990s, the problem continued to grow. The State Medical Society of Wisconsin reported that as of July 1994, 48 counties in Wisconsin lacked adequate access to obstetricians and other physicians, compared to 25 counties in 1979.

In 1994, 40 Illinois counties had no obstetric care at all, compared to 12 counties in 1989. Unfortunately, doctors and hospitals often restrict or eliminate services because of high malpractice insurance costs. When doctors have to quit obstetrics or move to other states, pregnant women find themselves driving 30 to 50 miles to deliver their babies.[71]

Michigan faced a similar crisis regarding the migration of doctors to other states. Michigan State Medical Society surveys showed that 57 percent of the state's medical school graduates left the state because of the high cost of premiums.[72]

Overall, throughout the 1980s and early 1990s INCAP insulated Indiana from experiencing the problems occurring in surrounding states during the same period. Due to INCAP, physicians in Indiana could continue practicing without having to pay the exorbitant medical liability premiums paid by their colleagues in neighboring states. As those who drafted the law anticipated, doctors from other states relocated to Indiana.

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[71] Sandrick K: "Southern Illinois obstetricians are leaving for greener pastures," *Private Practice,* December 1989; p 35.
[72] Kellogg S: "Doctors demand insurance cost curb," *Ann Arbor (Mich.) News,* March 11, 1991.

Recent National Activity

While the majority of Indiana's physicians have enjoyed a stable malpractice environment, that has not been the case across the country. In addition to the growth in claims, a significant factor underlying the recent increase in the cost of claims is increased severity per claim.[73] From 1987 to 1999, malpractice claim severity nationally increased by 117 percent.[74] Not surprisingly, these mega-awards for non-economic damages have occurred in states that, unlike Indiana, do not have limitations on recovery amounts.[75] The factors indicated earlier combined to create a malpractice crisis in a dozen states including Florida, Georgia, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington and West Virginia.[76] An American Medical Association study indicated there were warning signs of a looming crisis in 30 other states.[77] Many of the states mentioned are noting a recurrence of the same problems experienced in the 1970s and '80s.

In lieu of skyrocketing premiums, insurers in some areas have simply withdrawn from the market, leaving physicians without access to malpractice coverage. St. Paul Cos., the largest writer of medical malpractice in the United States, announced in December 2001 that it would leave the market because underwriting losses threatened its solvency.[78]

PHICO was ordered to liquidate by the Pennsylvania Insurance Department and at least six other insurers have either stopped marketing malpractice insurance or limit coverage to certain states or large medical groups.[79]

When insurance companies leave the market, physicians often have difficulty finding another source for malpractice coverage. If they succeed in finding another underwriter, the premiums are frequently much higher than their previous coverage.[80]

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[73] The American Medical Association Council on Medical Service: "*The Rise in Professional Liability Insurance Premiums*" Report 12, June 2002, p 3.
[74] Ibid. p 3.
[75] U.S. Department of Health and Human Services, p 9.
[76] Insurance Information Institute, "Hot Topics and Insurance Issues," July 2002 p 2, referring to an AMA study.
[77] Ibid. p 2.
[78] Ibid. p 2.
[79] "Hard market wallops physicians; average rate increases more than double those in 2001," *Medical Liability Monitor,* October, 2002 p III.
[80] Ibid.

All of these factors have a chilling impact on access to medical care since physicians must curtail high-risk procedures or surgeries. Some physicians leave states where an adverse malpractice climate makes practicing medicine too risky, and others retire early.

From 2001 to 2003, these scenarios played out across the country. About 44 doctors at the height of their careers in Delaware County, outside Philadelphia, left the state in 2001 or stopped practicing because of high malpractice insurance costs.[81]

The only Level I trauma center in Las Vegas, Nev., closed for 10 days because physicians serving the center could no longer afford to pay medical liability premiums.[82]

Nearly 5,000 ob-gyns nationwide have stopped delivering babies; 10 percent have closed up shop because they couldn't afford malpractice insurance. And in Mississippi alone, 324 physicians stopped delivering babies in the last decade. Only three physicians who do obstetrics now provide services for a population of more than 100,000.[83]

Charleston Area Medical Center's trauma unit was downgraded from a Level I to a Level III facility because it does not have enough physicians around the clock, increasing risk for tens of thousands of West Virginians who may not receive needed trauma care if they are in a serious accident.[84] Two-dozen surgeons in Wheeling and Weirton, West Va., began leaves of absence in January 2003 over malpractice costs, resulting in the need to send patients to Ohio and Pittsburgh hospitals.[85] Nor is the situation for obstetrics in West Virginia any more favorable. In at least two rural areas, community hospitals have closed their OB units because obstetricians in those areas cannot afford malpractice insurance.[86]

In Fall 2002, an estimated 3,500 Ohio physicians rallied in Columbus before members of the legislature seeking to stem the huge rise in premiums that threatened their ability to continue to practice. Various insurers have increased malpractice insurance rates up to 60

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[81] U.S. Department of Health and Human Services, p 3
[82] Ibid. p 2.
[83] *Delta Democrat Times*, 24 June 2001.
[84] "West Virginia trauma center latest victim of medical liability crisis," as reported by AMA on line http://www.ama-assn.org/ama/pub/article/1616-6664.html. 26 August 2002.
[85] "W.Va. urges an end to doctors' walkout," Associated Press as reported in *The Philadelphia Inquirer* online http://www.philly.com/mld/inquirer/news/nation/4862772.htm. 3 January 2003.
[86] U.S. Department of Health and Human Services p 3, as cited in Advancing Health in America, June 12, 2002, Statement before the House Judiciary Subcommittee on Commercial and Administrative law.

percent.[87] Since 1998, several insurance companies in the state have stopped writing malpractice insurance or have been forced to close after review by state regulators, leaving many physicians without insurance.

As states across the country have initiated campaigns for legislative relief from the malpractice crisis, President George W. Bush has called for a federal liability law that would cap non-economic damages at $250,000 and limit punitive damages to twice the actual losses, up to $250,000. The law would curtail lawyer's fees and contain a statute of limitations. In the past, medical liability reform has stood little chance of making it through Congress. HR 5 has passed the House but has opposition in the Senate where it is expected to face an uphill battle.[88] However, if a federal medical malpractice law is enacted, it will not preempt INCAP in our state.

INCAP Current Status

For 28 years INCAP has continued to insulate Indiana from experiencing the same problems faced in the rest of the country. Physicians in Indiana are able to continue practicing without having to pay the exorbitant medical liability premiums faced by their colleagues in nearby states.

The number of malpractice complaints in Indiana has increased slightly since 1990, as well as the number of judgments paid. In 2000, the latest year for which data is available, 969 complaints were filed and 203 received judgments totaling $99,716,685. This equates to an average of more than $490,000 per judgment,[89] compared to an average judgment of $300,000 in 1993.

The cyclical nature of medical malpractice and the backdrop of the current national situation demand continued monitoring of INCAP and the PCF. The current proposals and the legislation proposed and enacted in states throughout the nation acknowledge one over-arching truth. 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

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[87] "Lawmakers prescribe caps on noneconomic damages," *Cincinnati Enquirer, The* (OH), Nov. 26, 2002, http://infoweb1.newsbank.com/iw-search/we/InfoWeb?p_action=doc&p_docid=0F7C1091.
[88] "House Passes Reform Bill," *Medical Liability Monitor,* vol. 27, March 19,2003, p 1.
[89] Indiana Department of Insurance, "PCF Calendar Year Statistics Through December 2000."

societal attitudes toward the practice of medicine.[90] As such, an equitable and efficient solution to this series of problems must involve action on multiple fronts.

While changes in legal doctrine and practice have contributed to increased claim frequency and award severity, such changes have evolved within an intertwined social, economic and regulatory framework. Therefore – given a cycle of rising health care costs and an increasingly litigious society with larger jury verdicts, higher malpractice insurance premiums, and rising health care costs – changes in legal doctrine alone are not likely to reverse current trends.

The active national dialogue concerning medical malpractice issues has contributed to some positive steps to maintain and improve the quality of care. Intensified peer review of health care provider performance, establishment of increasingly sophisticated systems to measure the quality of care of individual providers, and expanded efforts to document treatment actions and procedures will serve to upgrade medical standards.

As the quality of care receives additional monitoring, the practice of medicine becomes increasingly defensive. Greater emphasis is now placed on ensuring against mistakes. Providers are performing extra tests and treatment procedures, giving more attention to intensified medical record keeping, spending more time with patients to explain alternative treatments and obtaining patients' informed consent.[91]

As such, greater scrutiny has served to affect some extremely positive changes in the practice of medicine in the United States. Nevertheless, medical malpractice legislation – an additional aspect of intensified scrutiny – has proven ineffective in many other states, contributing to service delivery problems involving cost, access and medical discipline.

Yet, INCAP strikes a balance between certitude of reasonable compensation for injured patients while maintaining patients' access to medical care and protecting medical care providers from unreasonably high insurance costs. Premiums are significant, but insurance is affordable. INCAP has brought unparalleled stability to the medical liability market in Indiana and, accordingly, to health care consumers in the state.

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[90] Jacobson, as found in note 14.

[91] Subcommittee on Health, Committee on Ways and Means: Testimony of U.S. Comptroller General Charles A. Bowsher, Washington, DC, U.S. House of Representatives, April 26, 1990.

Indiana's medical malpractice law has served as a model for both federal and state legislation. Tenets of the law have withstood legal challenges in the years since its passage and, in light of other states' experiences, the philosophy behind the law has proven sound and effective.

Outward migration of physicians from the state more than 30 years ago has been transformed into an influx. Specialized practices, such as obstetrics, have stabilized in Indiana. Access to medical care has been enhanced by providing an atmosphere in which Indiana's physicians are allowed to practice medicine without the prevailing question faced daily by other states' physicians: Given the high cost of medical liability insurance, is continuing to practice medicine economically feasible?

According to Otis R. Bowen, former U.S. Secretary of Health and Human Services, INCAP has "stabilized malpractice insurance premiums and enabled physicians to return their full attention to the practice of medicine." [92]

The Indiana Compensation Act for Patients has done what it was intended to do. Injured parties are fairly and fully compensated, and quality medical care in the state is readily accessible and affordable. In short, INCAP works.

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[92] Bowen p 23.