Bulletin 119

INDIANA PATIENT'S COMPENSATION FUND -- FILINGS

July 29, 2003

This bulletin is directed to all insurers that provide coverage to health care providers under Indiana's Medical Malpractice Act. Bulletin 30 and Bulletin 68 are hereby withdrawn and replaced by this Bulletin 119.

Pursuant to IC 34-18-3-2 a health care provider may qualify under the Indiana Medical Malpractice Act by filing with the Department of Insurance proof of financial responsibility and payment of a surcharge to the Indiana Patient's Compensation Fund. Attached to this Bulletin as Exhibit A is the certificate that shall be used when filing proof of financial responsibility with the Patient's Compensation Fund.

IC 34-18-9 contains reporting requirements that currently are not being completed by insurers. These reports are necessary for the successful protection, defense and operation of the Patient's Compensation Fund.

IC 34-18-9-2 requires the health care provider's insurer to provide written notice, within thirty (30) days, of the filing of an action under IC 34-18-8-6 (action seeking payment for damages not greater than $15,000) and the final disposition of the action.

IC 34-18-9-3(a) states that the health care provider's insurer shall notify the Insurance Commissioner of any malpractice case upon which the insurer has placed a reserve of at least fifty thousand dollars ($50,000) for occurrences of malpractice before July 1, 1999, or one hundred twenty-five thousand dollars ($125,000) for occurrences of malpractice on or after July 1, 1999. Attached to this Bulletin as Exhibit B is the form to be used for reporting this information to the Patient's Compensation Fund.

IC 34-18-9-3(b) requires the health care provider's insurer or risk manager to report to the department all claims settled or adjudicated to final judgment against the health care provider. The report shall be made within sixty (60) days after the final disposition and shall include 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; and
(4) The amount of the settlement or judgment.

Attached to this Bulletin as Exhibit C is the form to be used for reporting this information to the Patient's Compensation Fund.

INDIANA DEPARTMENT OF INSURANCE
Sally McCarty, Commissioner

HOSPITAL EXPOSURE WORKSHEET FOR SURCHARGE CALCULATION

Name of Hospital: _____

License No: _____

List all facilities and/or services operated under the hospital license (as identified on the Department of Health Application for License to Operate a Hospital):

_____
_____
_____

CATEGORY	EXPOSURE	MANUAL	TOTAL
Provide # of Beds			Category x Manual=Total
	Hospital (Acute care and Intensive Care)	682.00	
	Mental Health/Rehabilitation	341.00	
	Extended Care/Intermediate Care/Residential	34.00	
	Nursing Home/Critical Extended Care	341.00	
	Health Institution/Assisted Living/Other	136.00	
	Bassinets	682.00	
# of Visits (in 100s)			
	Emergency Room	68.20	
	Clinics/Others	34.10	
	Mental Health/Rehabilitation	17.05	
	Health Institution	13.64	
	Home Health Care	34.10	
Provide # of Surgeries/Births (in 100s)			
	Births	2,728.00	
	Outpatient Surgeries	68.20	
	Inpatient Surgeries	1,364.00	
Employed Physicians Sharing Limits	50% of Specialty Code		
		SUB-TOTAL	
	Lack of Risk Management Program	10% Penalty x sub-total	
	Hospital with > 500 beds	3% multiplier of subtotal	
		TOTAL DUE	

CERTIFICATE OF INSURANCE

TO: INDIANA PATIENT'S COMPENSATION FUND
MEDICAL MALPRACTICE DIVISION
311 W. WASHINGTON ST. STE.300
INDIANAPOLIS, IN 46204-2787

		Surcharge	Effective Date
Cancellation:	☐	$_____	_____
Return/Additional Surcharge	☐	$_____	_____
Credit	☐	_____%	_____

Policy No.:	Occurrence Claims Made Reporting Endors.	☐ ☐ ☐	 Retro Date _____ Retro Date _____
Health Care Provider: Medical License No.:	Including employees ☐		Excluding employees ☐
Address (Street, City, State, Zip):	County:		
Coverage Dates: From: _____ To: _____	Classification Number:		
Limits of Liability $_____ per $_____annual occurrence aggregate	Premium Amount: Surcharge Amount: Penalty Amount:		

The undersigned Insurance Company, hereby certifies limits of liability on behalf of the above referenced Health Care Provider of not less than Two Hundred and Fifty Thousand ($250,000) Dollars for each occurrence and with an annual aggregate of Seven Hundred and Fifty Thousand ($750,000) Dollars as required, unless otherwise mandated by statute, for claims against said Health Care Provider as a result of Medical Malpractice, or allegation thereof, within the State of Indiana, and further that said policy of insurance complies in all respects with the provisions of the Indiana Patient's Compensation Act Indiana Code 34-18-1-1 et seq.

It is further certified that the surcharge for the above referenced coverage for the period specified in this policy is at the appropriate Class rate for the named specialty, is based upon the published calculation for a hospital, or is one hundred percent (100%) of the premium for non-physician or non-hospital providers. Said Company also agrees to collect and remit the rated surcharge or a minimum surcharge of one hundred ($100.00) dollars, whichever is larger, for each year of the period of coverage to the Department of Insurance, Patient's Compensation Fund, State of Indiana, within **thirty (30) days and not more than ninety (90) days from the effective date of said policy.**

It is further acknowledged that in the event of termination of the policy herein certified, or any reduction of liability limit, such termination or change shall not be effective unless notice of same has been delivered to the Department of Insurance, State of Indiana, not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States Mail by First Class Certified Mail, a copy of which shall have been mailed to the health care provider.

Dated this ____ day of _____, 20___ at the insurance office of _____

Signed by: _____
Authorized Signature
Printed: _____
Title: _____

EXHIBIT B

Indiana Patients' Compensation Fund

RESERVE NOTIFICATION
IC 34-18-9-3(a)

(Notice of cases with reserves of $50,000 or more through July 1, 1999, and cases with reserves of $125,000 July 1, 1999, forward)

Policy #	Date of Loss	Insured	Plaintiff's Name	Reserve

EXHIBIT C

Indiana Patient's Compensation Fund

SETTLEMENT NOTIFICATION
IC 34-18-9-3(b)

Policy #	Date of Loss	Insured	Plaintiff's Name	Damages Asserted and Alleged Injury	Settlement	Nature of Claim	Attorney Fees & Expenses