

HEALTH CARE LAW: A SURVEY OF 1997 DEVELOPMENTS

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INTRODUCTION

The 1997 Survey period had several notable developments in the expanding area of health care law. While both subtle and profound changes continue in this area of law, this Survey concentrates on those areas most likely to be of interest and use to practitioners. The Survey neither intends to be comprehensive in its scope nor all inclusive, but seeks to present a summary of significant changes in areas of provider liability, employment, contracts, reimbursement, legislation, and taxation.

I. HEALTH CARE PROVIDER LIABILITY: JUDICIAL DECISIONS

The Indiana judiciary decided several significant cases during the Survey period relating to liability of Indiana health care providers. The nature of the cases varied widely; several involved various aspects of the common law of medical malpractice while others involved interpretations of the Indiana Medical Malpractice Act.⁴

A. Statutory Construction of the Indiana Medical Malpractice Act

Under Indiana law, medical malpractice claims against a qualified health care provider are governed by the Indiana Medical Malpractice Act.⁵ If a health care provider chooses to qualify under the Malpractice Act, the provider or the provider's insurance carrier is required to file proof of financial responsibility with the Indiana Department of Insurance and pay a surcharge to the patients' compensation fund.⁶ Upon qualification, a health care provider's liability is

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4. IND. CODE §§ 27-12-1-1 to -18-2 (1993 & Supp. 1997). The term "Act" or "Malpractice Act" as used throughout this section of the Survey refers to the Indiana Medical Malpractice Act.

5. *Id.* § 27-12-3-1 (1993).

6. *Id.* § 27-12-3-2.

limited to \$100,000 per occurrence of medical malpractice.⁷ In the event a patient's damages exceed \$100,000, the patient may seek additional compensation from the patients' compensation fund to a maximum statutory limit of \$750,000.⁸ With few exceptions, a claim for medical negligence against a qualified health care provider may not be brought as an initial matter in court.⁹ Instead, the Malpractice Act requires the claim must first be filed with the Indiana Department of Insurance for presentation to a medical review panel for an opinion.¹⁰

Other significant benefits accrue to a health care provider upon qualification under the Act. For example, the statute of limitations contained in the Act requires that a competent, adult patient bring a malpractice action against a health care provider within two years from the occurrence of the specific act of medical malpractice,¹¹ rather than from the date that the cause of action accrues as required in the general tort statute of limitations.¹²

1. *State Constitutional Challenges to the Malpractice Act.*—During the Survey period, the Indiana courts explored the constitutionality of the distinction between the statute of limitations embodied in the Malpractice Act and the statute of limitations applicable to general tort cases. Specifically, the issue presented to the Indiana Court of Appeals in *Martin v. Richey*¹³ was whether the occurrence-based statute of limitations contained in the Malpractice Act¹⁴ violates the equal privileges and immunities clause¹⁵ or the open courts provision¹⁶ of the Indiana State Constitution.

In *Martin*, Ms. Martin visited the office of Dr. Richey, her obstetrician/gynecologist, in March 1991, complaining of a lump in her right breast. Dr. Richey was out of town at the time of Ms. Martin's office visit, but

7. *Id.* § 27-12-14-3(b).

8. *Id.* § 27-12-14-3(a), (c).

9. *Id.* § 27-12-8-4.

10. *Id.*

11. *Id.* § 27-12-7-1(b).

12. IND. CODE § 34-1-2-2 (1993).

13. 674 N.E.2d 1015 (Ind. Ct. App. 1997).

14. Section 27-12-7-1(b) provides the following:

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.

IND. CODE § 27-12-7-1(b) (1993).

15. IND. CONST. art. I, § 23 (The equal privileges and immunities clause provides the following: "The General Assembly shall not grant to any citizen, or class of citizens, privileges or immunities which, upon the same terms, shall not equally belong to all citizens.").

16. *Id.* art. I, § 12. (The open courts clause provides, in pertinent part: "All courts shall be open; and every person, for injury done to him in his person, property, or reputation, shall have remedy by due course of law.").

his nurse made arrangements for Ms. Martin to have a mammogram. The results of the mammogram indicated that Ms. Martin had a benign cyst and a solid mass in the right breast. The nurse reported the results to Ms. Martin the following day and recommended that she schedule an excisional biopsy. Ms. Martin scheduled the biopsy to be performed by a surgeon five days following the office visit.¹⁷

Upon his return to the office, the nurse informed Dr. Richey of the results of Ms. Martin's mammogram and of the scheduled excisional biopsy. Dr. Richey contacted Ms. Martin, advised her to cancel her appointment for the excisional biopsy, and instead recommended that a needle aspiration be performed in his office. Dr. Richey performed the needle aspiration; the resulting pathology report indicated that there were no malignant cells present in the specimen. Dr. Richey's office record for Ms. Martin did not reflect any recommendations regarding follow-up care or subsequent examinations.¹⁸

Approximately three years later, Ms. Martin experienced increased pain from the lump in her breast and pain under her right arm. A mammogram revealed an abnormal mass in the right breast. A core biopsy produced a diagnosis of adenocarcinoma of the breast. Ms. Martin subsequently underwent a modified radical mastectomy of the right breast and a five-month course of chemotherapy.¹⁹

Ms. Martin filed a proposed complaint against Dr. Richey pursuant to the Malpractice Act alleging that Dr. Richey was negligent in his medical care and treatment due to his failure to diagnose and treat her breast cancer in a timely manner.²⁰ Dr. Richey filed a motion to dismiss, arguing that Ms. Martin's complaint was time barred under the occurrence-based statute of limitations contained in the Act.²¹ Dr. Richey supported his motion by demonstrating that the alleged negligence occurred on March 20, 1991, and that the physician-patient relationship between him and Ms. Martin ended no later than October 2, 1991. Since Ms. Martin's proposed complaint was not filed with the Indiana Department of Insurance until October 14, 1994, the trial court held that the complaint was time barred.²²

On appeal, the Indiana Court of Appeals reversed the trial court concluding that the statute of limitations contained in the Malpractice Act violated both the privileges and immunities clause and the open courts provision of the Indiana Constitution.²³ With respect to the privileges and immunities clause, the court explained that "[u]nder the legislative scheme now in force, plaintiffs of medical negligence whose statute of limitations has expired prior to the time they become aware of or *discover* the malpractice, are treated unequally" from the victims of

17. *Martin*, 674 N.E.2d at 1017.

18. *Id.*

19. *Id.* at 1017-18.

20. *Id.* at 1018.

21. *Id.*

22. *Id.*

23. *Id.* at 1029.

other torts.²⁴

In finding that the Malpractice Act's statute of limitations violated the "open courts" provision of the Indiana Constitution, the court of appeals examined the language of the provision and the purpose and structure of the Indiana Constitution as demonstrated by the case law interpreting the specific provision.²⁵ The court concluded that the intent of the framers of the Constitution in 1851 could "not have been other than to recognize two independent rights: the right of access to the courts and the right to a complete tort remedy."²⁶ Therefore, the court found that the limitation provision in the Medical Malpractice Act was an unconstitutional abrogation of the right to a complete tort remedy as guaranteed by the open courts provision.²⁷

The controversy regarding the constitutionality of the occurrence-based statute of limitations in the Malpractice Act was not laid to rest during the Survey period with the *Martin* decision. In direct opposition to *Martin*, a separate panel of the Indiana Court of Appeals in *Johnson v. Gupta*²⁸ held that the two-year occurrence-based statute of limitations did not violate the open courts provision or the equal privileges and immunities clause of the Indiana Constitution.²⁹ In *Johnson*, Dr. Gupta performed a surgical procedure on Ms. Johnson in September 1990. Following the surgical procedure, Ms. Johnson experienced medical problems that Dr. Gupta assured her would eventually subside. It was not until 1994 when another physician discovered that Dr. Gupta's surgery had been improperly performed resulting in a complete and total loss of control over Ms. Johnson's bowel function.³⁰

Upon discovery of the alleged medical malpractice, Ms. Johnson filed a proposed complaint pursuant to the Malpractice Act.³¹ Dr. Gupta moved for summary judgment asserting that the claim was initiated after the expiration of the two-year occurrence-based statute of limitations.³² The trial court granted summary judgment in favor of Dr. Gupta on the basis of the statute of limitations,³³ and Ms. Johnson appealed contending that the statute of limitations was unconstitutional.³⁴ The court of appeals acknowledged the appellate decision in *Martin v. Richey*, but rejected its analysis of both the open courts provision and the equal privileges and immunities clause of the Indiana

24. *Id.* at 1023 (emphasis original).

25. *Id.* at 1024.

26. *Id.* at 1025.

27. *Id.* at 1026. The reasoning and the holding of *Martin* was adopted in another medical malpractice case by a separate panel of the Indiana Court of Appeals in *Harris v. Raymond*, 680 N.E.2d 551 (Ind. Ct. App. 1997).

28. 682 N.E.2d 827 (Ind. Ct. App. 1997).

29. *Id.* at 830-31.

30. *Id.*

31. *Id.* at 829.

32. *Id.*

33. *Id.* at 828.

34. *Id.*

Constitution.³⁵

In addressing the open courts provision, the *Johnson* court cited a number of cases which have interpreted the open courts provision in relation to various statutes of limitations, including the statute contained in the Malpractice Act, and noted that in each instance the statute was held constitutional.³⁶ The court reasoned that the open courts provision does not require that every plaintiff have a remedy for injuries suffered.³⁷ Although the Indiana Constitution prohibits the legislature from taking away vested property rights created by the common law,³⁸ the court reasoned that there were no vested rights or property rights at issue in the case.³⁹ As noted by the court, “[t]he right to bring a common law action is not a fundamental right.”⁴⁰ Instead, the legislature has the power to modify or restrict common law rights and remedies in cases involving personal injury.⁴¹ According to the court, the occurrence-based statute of limitations found in the Malpractice Act was simply one restriction which the Indiana legislature placed on medical malpractice claims to ensure the availability of malpractice insurance for Indiana physicians and, in turn, medical services for Indiana residents.⁴² In holding that the occurrence-based statute of limitations was constitutional under the open courts provision,⁴³ the court concluded that “[s]imply because the legislature has abolished or restricted a remedy does not render a statute unconstitutional.”⁴⁴

In reviewing the plaintiff’s equal privileges and immunities argument, the court acknowledged that medical malpractice claimants and health care providers are treated differently from other personal injury claimants.⁴⁵ The disparate treatment is based upon the claimant’s status as a patient and that the injuries arose from a breach of the duty owed by a health care provider.⁴⁶ Applying a two-prong test,⁴⁷ the *Johnson* court reached a conclusion different from that of

35. *Id.* at 829, 831.

36. *Id.* at 829 (citing *Bunker v. National Gypsum Co.*, 441 N.E.2d 8 (Ind. 1982) (statute of limitations for asbestos exposures); *Dague v. Piper Aircraft Corp.*, 418 N.E.2d 207 (1981) (products liability statute of limitations); *Johnson v. St. Vincent Hosp., Inc.*, 404 N.E.2d 585 (Ind. 1980) (medical malpractice statute of limitations); *Dillon v. Chicago S. Shore & N. Bend R.R. Co.*, 654 N.E.2d 1137 (Ind. Ct. App. 1995) (Indiana Tort Claims Act limitations on liability)).

37. *Id.*

38. *Id.* at 830 (quoting *Johnson v. St. Vincent Hosp., Inc.*, 404 N.E.2d 585, 594 (Ind. 1980)).

39. *Id.*

40. *Id.* (quoting *Dague*, 418 N.E.2d at 213).

41. *Id.*

42. *Id.*

43. *Id.*

44. *Id.*

45. *Id.* at 831.

46. *Id.*

47. The two-prong test, derived from *Collins v. Day*, 644 N.E.2d 72, 80 (Ind. 1994), considers (1) whether the disparate treatment accorded by the legislation is reasonably related to inherent characteristics which distinguish the unequally treated classes and (2) whether the

the court in *Martin*. The *Johnson* court found that a reasonable relationship existed between legislation limiting the time allowed to bring medical malpractice claims and the inherent characteristics which distinguish the class receiving the unequal treatment.⁴⁸ The court reasoned that the disparate treatment is based upon the claimant's status as a patient and the fact that the injuries arose from a breach of the duty owed by the health care provider.⁴⁹ In addition, the court acknowledged that health care providers are distinguished by the type of services they render and that the disparate treatment is "a response to the reduction in health care services available to Indiana residents and the financial uncertainties in the health care industry."⁵⁰

The court found that the Malpractice Act's occurrence-based statute of limitation also survived the second prong of the *Collins* analysis. The court stated that persons discovering their medical malpractice action within the two-year statute of limitations are not treated differently from those who discover the malpractice after the expiration of two years, since all malpractice claimants have two years from the date of the occurrence to file a claim.⁵¹ Although the court recognized that the occurrence-based statute of limitations may cause harsh and unequal results in certain cases, the court concluded that the statute was "reasonable in light of other policy considerations."⁵²

The Indiana Supreme Court was scheduled to hear oral arguments on May 4, 1998. Thus, the bench and bar must await the final disposition of this important issue.

2. *Limit on Recoverable Damages and Access to Patients' Compensation Fund.*—Two cases decided during the Survey period considered the Malpractice Act's limit on recoverable damages and access to the patients' compensation fund.

In *Miller v. Memorial Hospital of South Bend, Inc.*,⁵³ the parents of an infant brought a medical malpractice action against the delivering physician and the hospital for injuries allegedly sustained prior to and subsequent to the child's birth. The plaintiffs eventually settled their claim against the physician and received the statutory maximum recovery authorized by the Malpractice Act. The case was then dismissed as to the physician.⁵⁴

Thereafter, the hospital moved for summary judgment arguing that the

preferential treatment is uniformly applicable and equally available to all persons similarly situated.

48. *Johnson*, 682 N.E.2d at 831 (citing *Rohrbaugh v. Wagonor*, 413 N.E.2d 891, 893 (Ind. 1980)).

49. *Id.* (citing *Johnson v. St. Vincent Hosp., Inc.*, 404 N.E.2d 585, 597 (Ind. 1980)).

50. *Id.*

51. *Id.*

52. *Id.* (citing *Havens v. Ritchey*, 582 N.E.2d 792, 795 (Ind. 1991)). Judge Friedlander's dissenting opinion was based on his view that the occurrence-based statute of limitations in the Malpractice Act was unconstitutional under the open courts provision of the Indiana Constitution. *Id.*

53. 679 N.E.2d 1329 (Ind. 1997).

54. *Id.* at 1332.

Malpractice Act prohibited additional recovery since the injuries allegedly sustained by the infant as a result of the conduct of the physician and the hospital were identical.⁵⁵ The plaintiffs responded by asserting that the claim against the hospital was for *post natal* injuries that were separate and distinct from the claim for *prenatal* injuries against the delivering physician.⁵⁶ The hospital replied by pointing out that the plaintiffs had never raised any distinction between the alleged injuries in their proposed complaint, their submission of evidence to the medical review panel, or in their complaint filed in court.⁵⁷

The trial court granted the hospital's motion for summary judgment and the court of appeals affirmed.⁵⁸ On transfer, however, the Indiana Supreme Court reversed, finding that there existed a genuine issue of material fact whether the infant suffered separate injuries from two distinct acts of medical malpractice.⁵⁹

The supreme court first observed that "there is no dispute that, if there are two separate and distinct injuries caused by two separate occurrences of malpractice, the [Malpractice Act] does not preclude two separate recoveries (each separately limited in accordance with the Act)."⁶⁰ Finding a genuine issue of material fact, the supreme court relied primarily upon a physician's affidavit submitted by the plaintiffs in response to the hospital's motion for summary judgment. The affidavit stated that the injuries sustained by the infant as a result of the conduct of the physician were distinct from those injuries sustained as a result of the conduct of the hospital staff.⁶¹

The supreme court rejected the hospital's argument for summary judgment based on the plaintiffs' proposed and final complaints alleging only one cause of action and one injury for which the statutory maximum compensation had been received through the settlement with the physician.⁶² Under Indiana's notice pleading rules, a complaint need not state all elements of a cause of action; a plaintiff must only plead the operative facts involved in the dispute.⁶³ The court

55. *Id.* at 1331. The Malpractice Act's limitation on recoverable damages applies to "any injury or death of a patient" that results from "an occurrence of malpractice." IND. CODE § 27-12-14-3(a), (b) (1993). The Act authorizes only one recovery in those cases where a single injury exists, irrespective of the number of acts of malpractice causing the injury. *See Bova v. Roig*, 604 N.E.2d 1 (Ind. Ct. App. 1992).

56. *Miller*, 679 N.E.2d at 1331.

57. *Id.*

58. *Id.* at 1330 (citing *Miller v. Memorial Hosp.*, 645 N.E.2d 631, 634 (Ind. Ct. App. 1994)).

59. *Id.*

60. *Id.* at 1331.

61. *Id.* The expert witness' affidavit stated in pertinent part that:

The post natal injury caused by the hospital's breach of the appropriate standard of care is a different and separate injury from the prenatal injury caused by the obstetrician with different parts of the brain being affected by the prenatal hypotonic insult and the post natal metabolic insult . . . making the injuries distinct in character.

Id.

62. *Id.* at 1332.

63. *Id.* (citing *State v. Rankin*, 294 N.E.2d 604 (Ind. 1973)).

observed that the plaintiffs had described separate counts against the defendants in their complaints and alleged different dates for each of the defendants' alleged acts of malpractice. The court further declined to interpret the plaintiffs' general injury allegations as limiting the complaints to a claim for a single injury resulting from the conduct of both defendants.⁶⁴

The court also rejected the hospital's claim for summary judgment on the basis that the plaintiffs had not distinguished between the alleged prenatal and post natal injuries in their submission to the medical review panel.⁶⁵ The court reasoned that, although the Malpractice Act required that the plaintiffs' claim be presented to a duly formed medical review panel, there was nothing in the Act that required the plaintiffs to fully and explicitly define each and every aspect of their claim in the submission to the medical review panel.⁶⁶

In finding that a genuine issue of material fact existed regarding the injuries suffered and the acts of malpractice involved, the court noted the "rare factual circumstances of this case"⁶⁷ and cautioned that they did not intend its decision to "lead to any significant increase in the bifurcation of medical malpractice claims."⁶⁸

The second case to address the issue of damages under the Malpractice Act was *Smith v. Pancer*.⁶⁹ In *Smith*, Dr. Ronald Pancer and Dr. Richard Thompson were psychiatrists doing business as Pancer Psychiatric Services.⁷⁰ Terry Smith received psychiatric treatment from Dr. Pancer and Dr. Thompson during a four-month period of time.⁷¹ The patient subsequently filed a proposed complaint for medical malpractice with the Indiana Department of Insurance naming as defendants Dr. Pancer, Dr. Thompson, and Pancer Psychiatric Services.⁷² Dr. Pancer and Dr. Thompson were both qualified health care providers as defined in the Malpractice Act.⁷³ Pancer Psychiatric Services, however, was not a qualified health care provider.⁷⁴

The patient's claim was submitted to a medical review panel in accordance with the procedural requirements of the Malpractice Act.⁷⁵ The review panel issued a unanimous opinion that the defendant health care providers were negligent in rendering care to the patient and that the defendants' negligence was a factor in the resultant damages.⁷⁶ The patient then brought suit in the trial court

64. *Id.*

65. *Id.*

66. *Id.*

67. *Id.*

68. *Id.*

69. 679 N.E.2d 893 (Ind. 1997).

70. *Id.* at 894.

71. *Id.*

72. *Id.*

73. *Id.*

74. *Id.* at 895.

75. *Id.* at 894.

76. *Id.*

against the health care providers.⁷⁷

Shortly before the case was scheduled for trial, the parties entered into a settlement agreement.⁷⁸ The patient agreed as part of the settlement to substitute Summit Psychiatric Services, P.C., as the sole defendant in the case and to dismiss the three originally named defendants.⁷⁹ Summit Psychiatric Services was a professional corporation incorporated during the time that the patient was undergoing psychiatric treatment with Dr. Pancer and Dr. Thompson.⁸⁰ Dr. Pancer and Dr. Thompson initially were equal owners of Summit Psychiatric Services. At the time of settlement, however, the professional corporation was wholly owned by Dr. Pancer.⁸¹ Summit Psychiatric Services was not a qualified health care provider under the Malpractice Act.⁸² In consideration for the settlement, the patient received a payment which was the functional equivalent of the \$100,000 primary maximum recovery available under the Malpractice Act.⁸³

The patient filed a petition seeking additional compensation from the patients' compensation fund in accordance with the provisions of the Malpractice Act.⁸⁴ The insurance commissioner filed a motion for summary judgment arguing that, since Summit Psychiatric Services was not a qualified health care provider under the Malpractice Act, the patient was precluded from recovering payment from the patients' compensation fund.⁸⁵ The trial court granted the motion and entered summary judgment for the commissioner; the court of appeals affirmed.⁸⁶ The Indiana Supreme Court granted transfer and reversed.⁸⁷ The supreme court noted the requirement of the Malpractice Act that, in order to gain access to the patients' compensation fund for excess recovery, a plaintiff must demonstrate that a qualified health care provider or its insurer had "agreed to settle its liability on a claim by payment of its policy limits."⁸⁸ In denying the plaintiff access to the patient's compensation fund, the court of appeals had relied primarily upon the express language of the settlement document made between the plaintiff and Summit Psychiatric Services, which was not a qualified health care provider under the Malpractice Act.⁸⁹ According to the court of appeals, because Summit was not a qualified health care provider, the plaintiff

77. *Id.*

78. *Id.*

79. *Id.*

80. *Id.*

81. *Id.*

82. *Id.* at 895.

83. *Id.* See IND. CODE § 27-12-14-4(b) (1993) (provides for structured settlements that are deemed to satisfy the liability limitation under the Malpractice Act).

84. *Smith*, 679 N.E.2d at 895.

85. *Id.*

86. *Id.*

87. *Id.* at 898.

88. *Id.* (quoting IND. CODE § 27-12-15-3 (1993)).

89. *Id.*

had failed to demonstrate that a qualified health care provider or its insurer had agreed to settle its liability.⁹⁰ The Indiana Supreme Court, reviewing the provisions of the Malpractice Act, found nothing to preclude the parties from agreeing to an oral malpractice claim settlement or to one only partially written.⁹¹ According to the supreme court, though the settlement agreement was between a non-qualified health care provider and a patient, the settlement had the effect of releasing the plaintiff's claim against all four health care providers involved in the lawsuit, two of which were qualified health care providers.⁹² On that reasoning, the court concluded that a genuine issue of material fact existed as to whether either Dr. Pancer or Dr. Thompson, as qualified health care providers, were among those who had agreed to settle the plaintiff's claim. The court, therefore, reversed the judgment in favor of the commissioner on that issue.⁹³

The supreme court also found a question of fact as to whether the payment made to the plaintiff was attributable to one or more qualified health care providers in a sufficient amount to allow access to the patients' compensation fund.⁹⁴ According to the supreme court, the genuine issue of fact precluding summary judgment arose because the record failed to demonstrate the extent to which the liability alleged in the plaintiff's complaint was attributed to the qualified and unqualified health care providers in the lawsuit.⁹⁵ According to the court, the genuine issue of fact that precluded summary judgment was driven, in part, by the factual issue of whether the two physicians involved in the case were jointly or severally liable on the plaintiff's claim. Accordingly, the supreme court reversed the grant of summary judgment in favor of the commissioner on this issue as well.⁹⁶ The supreme court remanded the case to the trial court for further proceedings consistent with its opinion.⁹⁷

B. New "Wrongful Birth" Cause of Action Recognized

In 1997, the Indiana Court of Appeals recognized a cause of action in Indiana for wrongful birth.⁹⁸ In 1979, Connie Johnson gave birth to a daughter born with multiple birth defects. The infant required extensive medical care until she died four months later. Mrs. Johnson became pregnant again in 1982, and, because of

90. *Id.*

91. *Id.*

92. *Id.*

93. *Id.*

94. *Id.* Under the structured settlement provisions of the Medical Malpractice Act, when more than one qualified health care provider participates in the structured settlement, a single qualified health care provider must be liable for at least \$50,000 in order to satisfy the primary recovery limits and allow a patient access to the patient's compensation fund. *See* IND. CODE § 27-12-14-4(b) (1993).

95. *Smith*, 679 N.E.2d at 897.

96. *Id.*

97. *Id.*

98. *Bader v. Johnson*, 675 N.E.2d 1119 (Ind. Ct. App. 1997).

the birth defects of her first child, sought genetic counseling with Dr. Bader to confirm whether the pregnancy was affected by any birth defects.

Mrs. Johnson sought Dr. Bader's counseling in 1991 when she became pregnant with her third child. An amniocentesis performed at 19½ weeks gestation revealed no abnormalities, yet an ultrasound test performed on the same day indicated that the baby's head had an unusual shape and was larger than expected. Dr. Bader requested that Mrs. Johnson be scheduled for follow-up tests; due to an office error the tests were not scheduled. A second ultrasound was performed at 33 weeks gestation which indicated that the baby suffered from multiple defects. The pregnancy was too advanced to terminate; Mrs. Johnson gave birth to a baby girl on September 4, 1991. The infant suffered from hydrocephalus and multiple congenital defects and died from her condition less than four months later.⁹⁹

Mrs. Johnson and her husband brought suit against Dr. Bader alleging that had they been aware of the defects at the time of the first ultrasound, they would have terminated the pregnancy. The suit alleged a claim for wrongful birth and sought damages for the Johnsons' lost opportunity to terminate the pregnancy, physical pain of delivery, emotional pain and anguish of knowing that their child would suffer multiple congenital defects with little chance of survival, care and treatment provided for their child, medical expenses incurred, lost personal time and lost income, and for emotional anguish of watching their child suffer and die.¹⁰⁰

Dr. Bader moved for summary judgment, asserting that Indiana does not recognize a claim for wrongful birth.¹⁰¹ The trial court denied his motion and concluded that the Johnsons could recover damages if they could prove each element of the tort of negligence.¹⁰² The court of appeals affirmed the trial court's denial of Dr. Bader's summary judgment motion.¹⁰³ In doing so, the court differentiated the claims of wrongful birth and wrongful life.¹⁰⁴ Indiana has rejected claims for wrongful life¹⁰⁵ but had not previously addressed the viability of a claim for wrongful birth.

The court of appeals followed the majority of states who have found that parents may recover for the wrongful birth of a child.¹⁰⁶ The court rejected Dr.

99. *Id.* at 1121-22.

100. *Id.* at 1122.

101. *Id.*

102. *Id.*

103. *Id.* at 1127.

104. *Id.* at 1122. The court stated that "[w]rongful birth" refers to claims brought by parents of a child born with birth defects alleging that due to negligent medical advice or testing they were precluded from an informed decision about whether to conceive a potentially handicapped child or, in the event of a pregnancy, to terminate it." *Id.* at 1122 (citing *Cowe v. Forum Group, Inc.*, 575 N.E.2d 630, 633 (Ind. 1991)). The court defined "wrongful life" as the seeking of damages on behalf of the child rather than the parents. *Id.* at 1124.

105. *Cowe*, 575 N.E.2d at 633.

106. *Bader*, 675 N.E.2d at 1122-23 (The court noted that of the 31 states and the District of

Bader's argument that the court should defer to the legislature for creation of a cause of action for wrongful birth, stating that a claim for wrongful birth can be resolved through a traditional tort analysis.¹⁰⁷ The court also rejected Dr. Bader's argument that recognizing a wrongful birth action would give a parent the discretion to decide which defects would lead to the termination of the pregnancy; they held that this argument essentially goes to the measure of damages.¹⁰⁸ The court reasoned that parents have an unconditional right to abortion during the first trimester of a pregnancy; they held that being deprived of that right is an injury regardless of the reason for wanting to exercise the right.¹⁰⁹

In addition, the court was not persuaded that allowing damages for wrongful birth would increase the usage of pre-natal screening and would encourage physicians to advise abortions.¹¹⁰ The court further rejected Dr. Bader's argument that the element of proximate causation was not met.¹¹¹ The court reasoned that the defendant's negligence, the harm that proximately caused the effect on the parents, was the denial to the parents of their right to decide whether to bear a child with a genetic or other defect.¹¹²

With regard to the issue of damages, Dr. Bader argued the only damages that should be recoverable are the medical and other costs directly related to Mrs. Johnson carrying the child to term.¹¹³ The court noted that other courts addressing damages for wrongful birth agree that the mother should recover expenses for the continued pregnancy and birth, the mother's pain and suffering associated with the continued pregnancy and birth, and loss of consortium.¹¹⁴

Courts have diverged on the issue of recoverable damages when addressing extraordinary medical and related expenses for the child and emotional distress damages for the parent. The court in *Bader* agreed with the majority of other courts and held that the Johnsons could recover the extraordinary medical and related expenses due to the defects.¹¹⁵

The question of recovery for emotional distress caused the greatest problem

Columbia which have spoken to this issue, 22 states and the District of Columbia have recognized wrongful birth claims by judicial decision.).

107. *Id.* at 1124.

108. *Id.*

109. *Id.*

110. *Id.* In summary statements, the court indicated that they failed to see a reason for discouraging prenatal screening and that simply recognizing a claim for wrongful birth does not require physicians to counsel abortion. *Id.*

111. *Id.*

112. *Id.* (citations omitted).

113. *Id.* at 1125.

114. *Id.*

115. *Id.* While the court agreed that extraordinary medical and related expenses were recoverable, it left the factual question of whether any benefit from the birth of the child has been derived that would offset the associated expenses to the jury to evaluate on a case-by-case basis. *Id.*

for this court. Indiana courts apply the modified impact rule to determine whether damages for emotional distress may be recovered. The impact rule states that when:

[A] plaintiff sustains a direct impact by the negligence of another and, by virtue of that direct involvement sustains an emotional trauma which is serious in nature and of a kind and extent normally expected to occur in a reasonable person . . . [S]uch a plaintiff is entitled to maintain an action to recover for that emotional trauma without regard to whether the emotional trauma arises out of or accompanies any physical injury to the plaintiff.¹¹⁶

The majority in the *Bader* court found that the impact rule does not preclude recovery for emotional distress in a wrongful birth case because the court believed that the parents of the child were directly involved in the impact resulting from Dr. Bader's negligence and that the resulting trauma was of a kind and extent normally to be expected to occur in a reasonable person.¹¹⁷

Damages for emotional distress, however, were not allowed.¹¹⁸ Two judges in separate opinions used differing reasoning and disallowed recovery for emotional distress. One judge found that Indiana's modified impact rule applies to wrongful birth claims and thus disallowed emotional distress damages because the parents' injuries did not result from a direct impact.¹¹⁹ The second judge found that, while the impact rule does not preclude recovery, damages for emotional and mental anguish are too speculative and conjectural because it is impossible to separate the distress caused by the lost opportunity to abort the fetus from all the other distress attributable to carrying and bearing a child with defects.¹²⁰

Thus, the court held that damages were recoverable for extraordinary medical and other expenses relating to the child's defects, pain and suffering, the medical and other expenses related to the continued pregnancy and birth, and loss of consortium.¹²¹ The court did not, however, allow recovery for emotional distress for the reasons set out above.¹²²

C. Attorney/Client Relationships and Scope of Discovery

In a dispute concerning production of discovery, the Federal District Court for the Southern District of Indiana clarified the relationship between an attorney representing a hospital and the hospital's board of trustees. In *Draus v.*

116. *Id.* at 1126 (citing *Shuamber v. Henderson*, 579 N.E.2d 452, 456 (Ind. 1991)).

117. *Id.*

118. *Id.*

119. *Id.* at 1127 (Friedlander, J., concurring).

120. *Id.* at 1128 (Garrad, J., dissenting in part and concurring in part).

121. *Id.* at 1127.

122. *Id.*

Healthtrust, Inc.,¹²³ the attorney for the defendant inadvertently produced a letter she had written to the board of trustees of the hospital concerning the board's peer review of the plaintiff, Draus. The defendant sought return of the letter claiming that it was protected by the attorney-client privilege.¹²⁴ In opposing the motion to compel return of the letter, Draus argued that there was no attorney-client relationship between the attorney and the hospital's board of trustees, because the attorney represented only Healthtrust or the hospital, not the board of trustees; thus, the document was properly produced.¹²⁵

Finding that the letter was protected by the attorney-client privilege, the court noted that the attorney believed she was providing privileged legal advice to the client as was evidenced by the bolded and capitalized letters on the top of the letter which stated "PRIVILEGED AND CONFIDENTIAL/ATTORNEY-CLIENT PRIVILEGED."¹²⁶ The court was further persuaded by the fact that the attorney testified in an affidavit that she viewed the board of trustees as a client because she had been asked to represent the hospital in the peer review process and because she knew that hospital boards of directors in the Healthtrust corporate family delegated peer review authority to the boards of trustees of the hospitals involved.¹²⁷ Although the court did find that the letter was protected by attorney-client privilege, it found that the privilege was waived under both the of strict accountability tests and the balancing approach.¹²⁸

Other documents to which the defendant claimed a privilege included communications between American Medtrust and Healthtrust. After the hospital imposed limitations on Dr. Draus' privileges, the hospital sent three reports to the National Practitioners Data Bank.¹²⁹ After the reports were sent, control of the hospital changed from Healthtrust to American Medtrust, Inc. Dr. Draus then protested the reports with the Data Bank and the Data Bank asked the hospital, now under control of American Medtrust, for a response to the protest. Because American Medtrust no longer owned the hospital when the reports were filed with the Data Bank, American Medtrust looked to Healthtrust for information

123. 172 F.R.D. 384 (S.D. Ind. 1997).

124. *Id.* at 385.

125. *Id.* at 386.

126. *Id.*

127. *Id.*

128. *Id.* at 387-88. The test of strict accountability holds that nearly any disclosure of the communication waives the privilege. *See, e.g., In re Sealed Case*, 877 F.2d 976, 980 (D.C. Cir. 1989). The balancing approach considers the following five factors in deciding whether the privilege has been waived as to a particular communication: (1) the reasonableness of the precautions taken to prevent inadvertent disclosures; (2) the time taken to rectify the error; (3) the scope of the discovery; (4) the extent of the disclosure; and (5) the "overriding issue of fairness." *Draus*, 172 F.R.D. at 387 (citing *Bud Antle, Inc. v. Grow-Tech, Inc.*, 131 F.R.D. 179, 183 (N.D. Cal. 1990)).

129. The National Practitioners Data Bank, administered by the federal government, serves as a central repository for information regarding actions taken against physicians due to poor quality of care issues.

and guidance. In response to American Medtrust's request for information and guidance, attorneys for each of the companies communicated with one another concerning the response to the protests, and non-lawyer executives of both companies were advised of the circumstances.¹³⁰

In response to the plaintiff's motion to compel, Healthtrust asserted that the communications were protected because the two separate clients shared a community of interest with respect to the potential litigation.¹³¹ The court denied the plaintiff's motion to compel and followed the reasoning of the Seventh Circuit and other federal courts which have recognized that the attorney-client and work-product privileges may extend to communications among persons who share a joint legal interest in the subject matter of the communications.¹³² The key consideration examined by the court was whether the nature of the interest is identical, not similar, and whether the representation is legal, not solely commercial.¹³³

Finally, the court found that communication between the attorney hired to represent the hospital and the attorney hired by the hospital to represent the hearing committee in the Draus matter was not protected by the attorney-client privilege.¹³⁴ The court analogized the hearing committee to administrative agencies that employ both administrative law judges and attorneys who represent the agency in enforcement actions and hearings before those administrative law judges.¹³⁵

D. The Scope and Extent of the Health Care Provider's Duty

The Indiana Supreme Court decided a case during the survey period that questioned the extent of the duty owed by a health care provider to an unknown non-patient who was allegedly injured by the health care provider's treatment of a patient. In *Cram v. Howell*,¹³⁶ a patient visited Dr. Howell's office where he

130. *Draus*, 172 F.R.D. at 391.

131. *Id.* The court noted that a community of interest exists among different persons or separate corporations where they have an identical legal interest with respect to the subject matter of the communication between an attorney and a client concerning legal advice. *Id.*

132. *Id.* See *United States v. McPartlin*, 595 F.2d 1321, 1336 (7th Cir. 1979); *Anderson v. Torrington Co.*, 120 F.R.D. 82, 86 (N.D. Ind. 1987); *Schachar v. American Academy of Ophthalmology, Inc.*, 106 F.R.D. 187, 191 (N.D. Ill. 1985). The court also noted that Indiana courts appear to recognize the extension of the attorney-client and work-product privileges to communications within a group with a community of legal interest in the context of potential litigation. *Draus*, 172 F.R.D. at 391 (citing *Corll v. Edward D. Jones & Co.*, 646 N.E.2d 721, 725 (Ind. Ct. App. 1995)).

133. *Draus*, 172 F.R.D. at 391.

134. *Id.* at 392. A hearing committee presides over an adversary hearing where opposing parties (who may be represented by counsel) present evidence, cross examine witnesses and argue their cases. *Id.*

135. *Id.*

136. 680 N.E.2d 1096 (Ind. 1997).

was administered various immunizations and vaccinations.¹³⁷ Subsequent to being vaccinated, the patient experienced two episodes of loss of consciousness while still at Dr. Howell's office.¹³⁸ Later, while driving himself home from the physician's office, the patient again lost consciousness, resulting in his collision with the plaintiff, Gregory Cram.¹³⁹ Cram sustained severe injuries in the collision that subsequently resulted in Cram's death.¹⁴⁰

Cram's personal representative filed a medical malpractice action against Dr. Howell before the Indiana Department of Insurance pursuant to the provisions of the Indiana Medical Malpractice Act.¹⁴¹ Thereafter, Cram's personal representative filed a motion for preliminary determination of law and a proposed wrongful death complaint with the trial court¹⁴² alleging that Dr. Howell failed to properly monitor the patient and failed to warn the patient of the dangers of driving a vehicle in his apparent condition.¹⁴³ The personal representative further alleged that Dr. Howell owed a duty of care to Cram that was breached through Dr. Howell's negligent treatment of the patient.¹⁴⁴ By his motion, the personal representative requested that the trial court find, as a matter of law, that Dr. Howell owed a duty to Cram.¹⁴⁵

The trial court dismissed the proposed complaint pursuant to Trial Rule 12(B)(6) finding that the proposed complaint did not state a cause of action upon which relief could be granted for the reason that, as a matter of law, Dr. Howell did not owe a duty to Cram.¹⁴⁶ The trial court's dismissal of the proposed complaint was affirmed by the Indiana Court of Appeals.¹⁴⁷

In reversing the trial court's dismissal, the Indiana Supreme Court noted its prior decision in *Webb v. Jarvis*,¹⁴⁸ which also involved the determination of a physician's duty to a third party who was not a patient of the physician.¹⁴⁹ In *Webb*, the supreme court balanced three factors in determining whether the physician owed a duty to the victim of his patient's subsequent violent acts which

137. *Id.* at 1097.

138. *Id.*

139. *Id.*

140. *Id.*

141. *Id.* at 1096-97.

142. Under the provisions of the Malpractice Act, a trial court has limited jurisdiction to make preliminary determination on certain issues of law prior to the issuance of an opinion by a medical review panel. IND. CODE § 27-12-11-1 (1993).

143. *Cram*, 680 N.E.2d at 1097.

144. *Id.*

145. *Id.*

146. *Id.*

147. *Cram v. Howell*, 662 N.E.2d 678 (Ind. Ct. App. 1996).

148. 575 N.E.2d 992 (Ind. 1991).

149. *Cram*, 680 N.E.2d at 1097. In *Webb*, a physician allegedly overprescribed a medication that caused the patient to become a toxic psychotic and to be unable to control his rage. *Webb*, 575 N.E.2d at 994. During one of the toxic episodes, the patient shot a third person who then sued the physician claiming that the physician owed him a duty. *Id.*

included: “(1) the relationship between the parties; (2) the reasonable foreseeability of harm to the person who was injured; and (3) public policy concerns.”¹⁵⁰ Applying the balancing test, the court in *Webb* affirmed summary judgment in favor of the defendant physician and stated that “generally physicians do not owe a duty to unknown nonpatients who may be injured by the physician’s treatment of a patient.”¹⁵¹

In *Cram*, the supreme court observed that the application of the balancing test established in *Webb* was necessarily case specific.¹⁵² The supreme court then distinguished the facts of *Cram* on both the foreseeability and the public policy issues embodied in the second and third factors of the *Webb* balancing test.¹⁵³

With respect to foreseeability, the court noted that Dr. Howell allegedly had actual knowledge that the medication administered to his patient caused two episodes of loss of consciousness.¹⁵⁴ Thus, the court determined that it was reasonably foreseeable that injury would result to third persons if the patient operated a motor vehicle.¹⁵⁵

As to public policy concerns, the court stated that the complaint in *Cram* did not assert that Dr. Howell should not have administered the medication to his patient. Rather, the plaintiff merely alleged that Dr. Howell should have monitored the patient for a longer period of time before allowing him to leave the office and should have warned the patient of the potential dangers of operating a motor vehicle.¹⁵⁶ Therefore, in the court’s view, the imposition of a legal duty on Dr. Howell relative to the plaintiff did not infringe upon Dr. Howell’s professional obligation to treat his patient as was determined to be the case in *Webb*.¹⁵⁷

Applying the *Webb* analysis to the facts alleged in the complaint, the court concluded that “the defendant physician here owed a duty of care to take reasonable precautions in monitoring, releasing, and warning his patient for the protection of unknown third persons potentially jeopardized by the patient’s driving upon leaving the physician’s office.”¹⁵⁸ The supreme court remanded the

150. *Cram*, 680 N.E.2d at 1097. The court specifically noted that the three factors employed in the *Webb* analysis are used in a balancing approach rather than as three distinct and necessary elements. *Id.*

151. *Id.* (quoting *Webb*, 575 N.E.2d at 998).

152. *Cram*, 680 N.E.2d at 1097.

153. *Id.* at 1098. The court noted initially that the relationship between *Cram* and Dr. Howell was similar to the relationship between the defendant physician and the injured plaintiff in *Webb*.

154. *Id.*

155. *Id.*

156. *Id.*

157. *Id.*

158. *Id.* The court also noted the procedural distinction between the case at bar and *Webb*. *Webb* came on appeal from the grant of a motion for summary judgment. *Cram* came to the court on a dismissal under Trial Rule 12(B)(6) for failure to state a claim upon which relief could be granted. The court observed that dismissals under Trial Rule 12(B)(6) are “improper unless it appears to a certainty that the plaintiff would not be entitled to relief under any set of facts.” *Id.*

case to the trial court for further proceedings consistent with its opinion.

*E. Requirements for Recovery of Emotional Damages
in a Medical Malpractice Case*

In *Etienne v. Caputi*,¹⁵⁹ the Indiana Court of Appeals considered a unique claim for damages in a medical malpractice case. Ms. Etienne brought a claim for medical malpractice against several of her treating physicians, including Dr. Caputi, for failure to diagnose and recommend appropriate follow-up care for her subsequently diagnosed breast cancer.¹⁶⁰ Upon diagnosis of the breast cancer, Ms. Etienne was required to undergo chemotherapy as well as a modified left radical mastectomy.¹⁶¹ According to the proposed complaint filed under the Malpractice Act, Dr. Caputi allegedly failed to properly interpret a mammogram ordered by Ms. Etienne's primary care physician.¹⁶²

In accordance with the requirements of the Malpractice Act, Ms. Etienne's claim was submitted to a duly constituted medical review panel.¹⁶³ The panel issued an expert opinion finding that, although Dr. Caputi's reading of the mammogram did not meet the applicable standard of care, his medical negligence was not a causative factor of the alleged injuries.¹⁶⁴

Ms. Etienne thereafter filed a complaint in court that included Dr. Caputi as a named defendant.¹⁶⁵ The complaint alleged a claim for medical negligence as well as a claim for negligent infliction of emotional distress.¹⁶⁶ Dr. Caputi filed a motion for summary judgment asserting that, even assuming he had negligently read or interpreted Ms. Etienne's mammogram, his negligence did not cause the alleged injuries.¹⁶⁷ The trial court ultimately granted Dr. Caputi's motion for summary judgment and dismissed the complaint on all claims presented on the basis that Ms. Etienne had failed to present a genuine issue of material fact on the issue of causation.¹⁶⁸

On appeal, Ms. Etienne contended, among other things, that the trial court erred in granting summary judgment on her claim for negligent infliction of emotional distress for the reason that Indiana's modified impact rule allows pursuit of a distinct claim for negligent infliction of emotional distress despite the outcome on the claim for medical negligence.¹⁶⁹

(quoting *Obremski v. Henderson*, 497 N.E.2d 909, 910 (Ind. 1986)).

159. 679 N.E.2d 922 (Ind. Ct. App. 1997).

160. *Id.* at 923.

161. *Id.*

162. *Id.*

163. *Id.*

164. *Id.*

165. *Id.*

166. *Id.* at 925.

167. *Id.* at 923.

168. *Id.*

169. *Id.* at 925.

In approaching the issue, the Indiana Court of Appeals opined that the proper analysis of the plaintiff's claim for negligent infliction of emotional distress was governed by *Shuamber v. Henderson*,¹⁷⁰ in which the Indiana Supreme Court modified the traditional requirement that a plaintiff's alleged claim for emotional damages be accompanied by and result from physical injury caused by an impact to the person seeking recovery.¹⁷¹

The court noted that the Etiennes were not seeking emotional damages as a result of physical injury.¹⁷² The emotional damages sought were, rather, based upon Ms. Etienne's assertion that she suffered emotional distress and turmoil associated with a continuing fear of misdiagnosis and the potential reoccurrence of her cancer.¹⁷³

Although *Shuamber* dispensed with the requirement that a plaintiff's emotional damages arise out of or be accompanied by physical injury, the court in *Etienne* observed that the modified rule continues the requirement of a direct physical impact upon the plaintiff seeking recovery of emotional damages.¹⁷⁴ Applying the modified impact rule of *Shuamber*, the court stated:

In Etienne's case, no physical touching occurred. Instead, the alleged emotional damages arose as a result of Dr. Caputi's incorrect reading of Nancy's mammogram. . . . We do not see the direct physical impact or direct involvement necessary for the application of the modified impact rule. We can deny summary judgment on this issue only by ignoring the direct physical impact requirement of the modified impact rule. As our supreme court established this rule, we are not free to ignore it.¹⁷⁵

Accordingly, the court affirmed the trial court's entry of summary judgment in favor of Dr. Caputi on the plaintiffs' claim for negligent infliction of emotional distress.

170. 579 N.E.2d 452 (Ind. 1991).

171. *Id.* at 455. In *Shuamber*, the Indiana Supreme Court stated the modified impact rule as follows:

When, as here, a plaintiff sustains a direct impact by the negligence of another and, by virtue of that direct involvement sustains an emotional trauma which is serious in nature and of a kind and extent normally expected to occur in a reasonable person, we hold that such a plaintiff is entitled to maintain an action to recover for that emotional trauma without regard to whether the emotional trauma arises out of or accompanies any physical injury to the plaintiff.

Id. at 456.

172. *Etienne*, 679 N.E.2d at 926. The emotional damages sought by the Etiennes were apparently not based upon Ms. Etienne's chemotherapy or the mastectomy. *Id.*

173. *Id.*

174. *Id.*

175. *Id.*

F. Informed Consent

In *Auler v. Van Natta*,¹⁷⁶ a case of first impression in Indiana, the court of appeals evaluated the extent of a hospital's duty to obtain a patient's informed consent to surgery. In *Auler*, the patient was admitted to the hospital for removal of her breast and reconstructive surgery, following her advising the surgeon that she did not want a breast implant.¹⁷⁷ Upon admission to the hospital, the patient signed a general consent form¹⁷⁸ that included the name of the hospital in bold print in the top right portion of the form.¹⁷⁹ The body of the general consent form provided that "[t]he explanation of the operation or special procedure must be given to the patient by the named physician since only he is competent to do so."¹⁸⁰ The patient's signature on the consent form, directly under a bold print acknowledgment that she had read and understood its content,¹⁸¹ was witnessed by a registered nurse.¹⁸² Nowhere in the consent form did it indicate that a saline breast implant was authorized or contemplated during the surgical procedures.¹⁸³

The surgical procedures were performed on the day the patient signed the general consent form and included the insertion of a saline-filled breast implant.¹⁸⁴ The patient first became aware of the implant the following year when it was discovered during a sonogram examination.¹⁸⁵ The Aulers filed a proposed complaint with the Indiana Department of Insurance against the hospital and the surgeon that resulted in a unanimous opinion from a medical review panel that the hospital had complied with the applicable standard of medical care.¹⁸⁶

Thereafter, the Aulers filed a complaint for medical malpractice in the trial court alleging that the hospital failed to obtain Ms. Auler's informed consent to the breast implant procedure.¹⁸⁷ The hospital moved for summary judgment based upon the uncontroverted opinion in its favor issued by the medical review panel.¹⁸⁸ The trial court granted the hospital's motion and the plaintiffs

176. 686 N.E.2d 172 (Ind. Ct. App. 1997).

177. *Id.* at 173.

178. *Id.* The consent form signed by the patient was titled "Consent to Operation or Other Special Procedure." *Id.*

179. *Id.*

180. *Id.*

181. *Id.*

182. *Id.*

183. *Id.* The procedures indicated in the consent form were described as "Left Modified Radical Mastectomy, Immediate Reconstruction[,] Left Latissimus Dorsi Flap." *Id.*

184. *Id.*

185. *Id.*

186. *Id.* With respect to the surgeon, the panel concluded that there was a material issue of fact, not requiring expert opinion, concerning the issue of informed consent.

187. *Id.* The surgeon was also named as a defendant in the malpractice complaint but was not a party to the appeal.

188. *Id.*

appealed.¹⁸⁹

The court of appeals observed that, although the duty to obtain the patient's informed consent to medical treatment generally rests with the patient's treating physician,¹⁹⁰ other jurisdictions have held hospitals vicariously liable for a physician's failure to obtain the patient's informed consent.¹⁹¹ Noting that the plaintiffs made no claim of vicarious liability on the part of the hospital for the acts of the surgeon,¹⁹² the court was left to consider two issues: (1) whether the hospital had an independent duty to obtain the patient's informed consent to the implant procedure; and (2) whether the hospital had gratuitously assumed such a duty through its general consent form.¹⁹³

The court rejected the plaintiffs' claim that the hospital possessed a legal duty, separate and distinct from that of the physician, to obtain a patient's informed consent to medical treatment observing:

Typically, courts reach this conclusion after determining that it is the treating physician who has the education, expertise, skill, and training necessary to treat a patient and determine what information a patient must have in order to give informed consent. These courts recognize that nurses and other nonphysician hospital employees do not normally possess knowledge of "a particular patient's medical history, diagnosis, or other circumstances which would enable the employee to fully disclose all pertinent information to the patient."¹⁹⁴

Following the majority position on this issue, the court of appeals concluded that "in the absence of circumstances supporting a claim for vicarious liability or other special circumstances, a hospital has no independent duty to obtain a patient's informed consent."¹⁹⁵ The court of appeals also rejected the plaintiffs' alternative argument that the hospital had assumed the duty to obtain the patient's informed consent to surgery by providing the written consent form and obtaining

189. *Id.*

190. *Id.* at 174. The court of appeals noted that the physician's duty to obtain informed consent arises as a matter of law from the relationship between the physician and the patient and "is based upon the patient's right 'to intelligently reject or accept treatment.'" *Id.* (quoting *Revord v. Russell*, 401 N.E.2d 763, 767 (Ind. Ct. App. 1980)). As such, the doctrine of informed consent mandates that the physician "make a reasonable disclosure of material facts relevant to the decision the patient is required to make." *Auler*, 686 N.E.2d at 174 (citing *Culbertson v. Mernitz*, 602 N.E.2d 98, 101 (Ind. 1992)).

191. *Auler*, 686 N.E.2d at 174.

192. *Id.* The plaintiffs did not allege that the surgeon was an employee or agent of the hospital or that the hospital controlled the surgeon's practice. In addition, there was no allegation in the complaint that the hospital was aware of any propensity on the part of the surgeon for not obtaining patients' informed consent. *Id.*

193. *Id.*

194. *Id.* at 175 (quoting *Giese v. Stice*, 567 N.W.2d 156, 163 (1997)).

195. *Id.*

the patient's signature thereon.¹⁹⁶

The court acknowledged that under the Restatement of Torts¹⁹⁷ and the parallel doctrine in Indiana of assumed duty, "[a] party may gratuitously place himself in such a position that the law imposes a duty to perform an undertaking in a manner which will not jeopardize the safety of others, including third parties."¹⁹⁸ On the facts presented, however, the court concluded that the hospital did not undertake to secure the patient's informed consent and, therefore, did not assume the physician's duty in that regard.¹⁹⁹ In so holding, the court relied upon the specific language of the written consent form which indicated that the explanation of the medical treatment was the responsibility of the physician since only the physician is competent to give that explanation.²⁰⁰ The court found further support for its conclusion in the fact that the patient had specifically acknowledged in the consent form that the risks and complications had been explained to the patient.²⁰¹ In the court's view, these facts led to the conclusion that the hospital's general consent form was not constructed to replace the informed consent required to be given by the surgeon.²⁰² The court of appeals, therefore, affirmed the trial court's entry of summary judgment in favor of the hospital.²⁰³

G. The Requirement of Expert Testimony in Malpractice Actions

The Indiana Court of Appeals examined the need for expert testimony in medical malpractice cases in *Slease v. Hughbanks*.²⁰⁴ In *Slease*, the plaintiff underwent ankle surgery following a work-related injury.²⁰⁵ The day following surgery, a nurse at the hospital noticed a burn on the patient's left thigh which

196. *Id.* at 176.

197. RESTATEMENT (SECOND) OF TORTS § 324A (1965). Section 324A provides:

One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of a third person or his things, is subject to liability to the third person for physical harm resulting from his failure to exercise reasonable care to protect his undertaking, if

- (a) his failure to exercise reasonable care increases the risk of such harm, or
- (b) he has undertaken to perform a duty owed by the other to the third person, or
- (c) the harm is suffered because of reliance of the other or the third person upon the undertaking.

198. *Auler*, 686 N.E.2d at 175 (citing *Harper v. Guarantee Auto Stores*, 533 N.E.2d 1258, 1263 n.4 (Ind. Ct. App. 1989)).

199. *Id.* at 176.

200. *Id.* at 175.

201. *Id.* at 176.

202. *Id.*

203. *Id.*

204. 684 N.E.2d 496 (Ind. Ct. App. 1997).

205. *Id.* at 498.

she attributed to the occurrence of the work-related injury and which the patient attributed to the course of his ankle surgery. The patient filed a proposed complaint against the hospital alleging medical malpractice. Following submission of the case to a medical review panel, the panel issued a unanimous decision that the hospital had properly complied with the applicable standard of care.²⁰⁶ Nonetheless, the plaintiff pursued his action in the trial court, and the hospital moved for summary judgment asserting that the patient had failed to present expert testimony controverting the unanimous opinion of the medical review panel the hospital's favor.²⁰⁷ The trial court denied the hospital's motion and the matter was taken on interlocutory appeal to the Indiana Court of Appeals.²⁰⁸ The court of appeals observed that, when a medical review panel issues a unanimous opinion in favor of the health care provider, that is generally sufficient to show that there is no genuine issue of material fact with respect to the claim of medical malpractice.²⁰⁹ Therefore, to successfully oppose a motion for summary judgment, the patient must present expert testimony to show that there is a dispute regarding the appropriate standard of care and the health care provider's compliance with the standard of care.²¹⁰ In the absence of such testimony, the patient generally cannot establish a genuine issue of material fact to survive a motion for summary judgment.²¹¹

The court of appeals, however, noted that there are two exceptions to the expert testimony requirement in medical malpractice cases.²¹² The two exceptions are the common knowledge exception and the theory of *res ipsa loquitur*.²¹³ The court of appeals refused to apply either exception to the facts before it. The court observed that the common knowledge exception to the expert testimony requirement generally applies when a jury can fully understand the conduct and the breach of duty without technical explanation.²¹⁴ The court further observed, however, that the application of the common knowledge exception has traditionally been limited to cases that involve foreign objects being left in the body following surgery.²¹⁵ Such incidents are not the intended results of the operative procedure and do not require expert testimony to establish a breach of the health care provider's duty.²¹⁶

The patient argued that a jury did not require expert testimony to understand that a patient should not sustain a burn during ankle surgery. The court of appeals, however, viewed the issue as framed by the patient to be an

206. *Id.*

207. *Id.* at 500.

208. *Id.* at 498.

209. *Id.* at 499.

210. *Id.*

211. *Id.*

212. *Id.*

213. *Id.*

214. *Id.*

215. *Id.*

216. *Id.*

oversimplification. According to the court of appeals, the real issues presented were “whether the burn was caused by an instrument or technique used during the surgery and whether the instrument or technique was misused or whether burns are a common and expected result.”²¹⁷ Under this formulation of the issues, the court concluded that a jury was incapable of understanding the proper tools and techniques to be used during surgery without expert testimony.²¹⁸

The court also rejected the plaintiff’s claim that the facts of his case fell within the doctrine of *res ipsa loquitur*.²¹⁹ The rule of *res ipsa loquitur* is evidentiary in nature and allows an inference of negligence to be drawn from the facts surrounding the particular injury.²²⁰ The elements for application of the doctrine include: “(1) that the injury is one which does not ordinarily occur in the absence of negligence; (2) the injury was caused by an instrumentality over which the defendant had exclusive control; and (3) the injury was not due to any voluntary act of the plaintiff.”²²¹ The court observed that it is not necessary for a plaintiff to demonstrate actual control over a particular instrumentality or that the plaintiff eliminate all possible causes of the injury for the application of the doctrine of *res ipsa loquitur*. Rather, it is the right of control and the opportunity to exercise control that governs; the patient is merely required to demonstrate that any reasonably probable causes for the injury were under the control of the defendant.²²² It is then left with the jury to determine which, if any, instrumentality actually caused the injury. The court observed, however, that “if the plaintiff cannot specifically identify any potential causes and show that they were within the exclusive control of the defendant his *res ipsa loquitur* claim must fail.”²²³

Applying the doctrine to the facts then before it, the court of appeals concluded that the patient had failed to present any evidence concerning possible causes of the burn.²²⁴ Although the patient argued that a “bovie pad” used during his operation was the cause of the burn, the court noted that there was nothing in the patient’s designated evidence to show that the bovie pad had the potential to cause a burn like he allegedly received during surgery.²²⁵ Having failed to present any evidence regarding the cause of the burn, the court concluded that the patient had failed to sustain his burden of proving the application of the doctrine of *res ipsa loquitur*.²²⁶ As such, the patient had failed to demonstrate the existence of a genuine issue of material fact to preclude summary judgment.²²⁷

217. *Id.*

218. *Id.*

219. *Id.*

220. *Id.*

221. *Id.* (citing *Widmeyer v. Faulk*, 612 N.E.2d 1119 (Ind.Ct.App. 1993)).

222. *Id.*

223. *Id.*

224. *Id.* at 500.

225. *Id.*

226. *Id.*

227. *Id.*

The court of appeals reversed the trial court and directed entry of summary judgment in favor of the hospital.²²⁸

II. LABOR/EMPLOYMENT

The Seventh Circuit Court of Appeals has recently narrowed the reach of federal employment discrimination laws by ruling that an independent contractor physician with staff privileges could not bring an employment discrimination claim against the hospital at which he worked.²²⁹ In *Alexander*, the court ruled that an independent contractor physician who had staff privileges at a hospital could not bring a discrimination claim against the hospital under Title VII of the Civil Rights Act of 1964²³⁰ by noting that Title VII protects only individuals who are “employees” and does not extend to independent contractors.²³¹

Alexander involved Dr. Mark Alexander, an Egyptian-born Muslim anesthesiologist, who had staff privileges at Rush North Shore Medical Center in Chicago, Illinois.²³² As a condition of his privileges, Dr. Alexander was required to spend a specified number of hours per week “on call” in the hospital’s emergency room.²³³ According to the hospital’s policy, a physician on call was required to be available by pager or phone, to call the hospital within twenty minutes of being paged, and to come to the hospital if requested to do so by the emergency room physician on duty.²³⁴ Following one of Dr. Alexander’s on-call rotations, an emergency room physician filed a complaint alleging that Dr. Alexander had refused to come to the hospital after having been requested to do so by the emergency room physician.²³⁵ Following its investigation of the incident, the hospital’s board of trustees informed Dr. Alexander that his staff privileges had been revoked for violation of the hospital’s on-call policy.²³⁶ Dr. Alexander filed a discrimination complaint alleging that the hospital had revoked his staff privileges not because he had violated the hospital’s on-call policy, but because of his religion and national origin.²³⁷

The court noted that Title VII applies only to “employees,” not independent

228. *Id.*

229. *Alexander v. Rush North Shore Medical Center*, 101 F.3d 487 (7th Cir. 1996).

230. 42 U.S.C. § 2000e (1994).

231. *Alexander*, 101 F.3d at 492; *see also* *Knight v. United Farm Bureau Mut. Ins. Co.*, 950 F.2d 377 (7th Cir. 1991); *Ost v. West Suburban Travelers Limousine, Inc.*, 88 F.3d 435 (7th Cir. 1996). These decisions held that a plaintiff must prove the existence of an employment relationship in order to maintain a Title VII action against the defendant and that independent contractors are not protected by Title VII. *Knight*, 950 F.2d at 380; *accord Ost*, 88 F.3d at 440.

232. *Alexander*, 101 F.3d at 488, 489.

233. *Id.* at 489.

234. *Id.*

235. *Id.*

236. *Id.*

237. *Id.*

contractors of the employer.²³⁸ Because Title VII's definition of "employee" was vague, the court applied the five-part test which was used in both the *Ost* and *Knight* cases to determine whether an individual is an employee for purposes of the Act.²³⁹ While noting that all five factors are to be considered in the determination of whether an individual is an employee or an independent contractor, the court considered the employer's right to control as the most important.²⁴⁰

In applying the five-part test to Dr. Alexander's relationship with the hospital, the court found that Dr. Alexander was an independent contractor rather than an employee.²⁴¹ Specifically, the court looked to the following factors in its determination that Dr. Alexander was an independent contractor: he possessed significant specialized skills; he listed as his employer on his income tax return his personal, wholly-owned professional corporation that was responsible for paying his malpractice insurance premiums, employment benefits and income and social security taxes; he was responsible for billing his patients and collecting his fees directly from them; he never received compensation, paid vacation, private office space, or other paid benefits from the hospital; he had the authority to exercise his own independent discretion concerning the care he delivered to his patients; he was not required to admit his patients to the hospital; and he was free to associate himself with other hospitals if he wished to do so.²⁴² The court rejected Dr. Alexander's argument that he was an employee because he was required to spend a specified amount of time per week on call and because, by virtue of the nature of being an anesthesiologist, most of his operating room patients were assigned to him on a daily basis by the hospital.²⁴³

III. HEALTH CARE PROVIDER/PATIENT'S RIGHTS

A. Contract Law: Unenforceability Based Upon Public Policy

During this Survey period, Indiana courts have demonstrated that contracts will not be enforceable if lacking essential formation elements or if they are clearly contrary to public policy. This is of particular note since contracts involving health care entities often present considerable complexities and

238. *Id.* at 494.

239. *Id.* at 492. The five-part test includes a consideration of the following factors: (1) the extent of the employer's control and supervision over the worker, including directions on scheduling and performance of work; (2) the kind of occupation and nature of skill required, including whether skills are obtained in the workplace; (3) responsibility for the costs of operation, such as equipment, supplies, fees, licenses, workplace and maintenance of operations; (4) method and form of payment and benefits; and (5) length of job commitment and/or expectations. *Id.* (citing *Ost*, 88 F.3d at 438 (quoting *Knight*, 950 F.2d at 378-79)).

240. *Id.* at 493.

241. *Id.*

242. *Id.*

243. *Id.*

opportunities to be at variance with federal or state law or regulation especially in areas of fraud and abuse.

A recent Indiana Court of Appeals decision reflects the willingness of Indiana courts to depart from the well-settled principle of freedom to contract in light of public policy considerations. The Fifth Circuit Court of Appeals, in *DeKalb Chiropractic Center, Inc. v. Bio-Testing Innovation, Inc.*,²⁴⁴ refused to enforce the terms of a medical equipment lease between a medical equipment company and a chiropractor because the terms of the contract violated public policy. The Fifth Circuit's decision indicates that courts are willing to limit or strictly construe contracting rights when contractual terms tend to impugn the integrity of the physician/patient relationship.

In *DeKalb Chiropractic Center*, an Indiana corporation that leases medical equipment entered into a contract with DeKalb Chiropractic Center, Inc. ("Center"). The contract provided for the lease of two strength-testing units to the Center and required the Center to perform a minimum number of billable examinations per week using the equipment, without regard to patient need for such testing. The Center failed to perform the minimum billable examinations required by the contract, and Bio-Testing sued for breach of contract. The trial court awarded Bio-Testing \$11,975 in damages for breach of the minimum testing requirements and \$2,552.25 in attorneys' fees.²⁴⁵

The Center appealed, claiming that the leasing arrangement requiring the Center to perform a minimum number of billable tests per week whether or not such tests were necessary, was contrary to public policy and therefore unenforceable.²⁴⁶ The Indiana Court of Appeals reversed the trial court's decision.²⁴⁷

The Fifth Circuit noted that courts have generally declined to unnecessarily restrict a person's freedom to contract.²⁴⁸ However, despite this "very strong presumption of enforceability,"²⁴⁹ courts have refused to enforce contracts that contravene statute, injure the public in some way, or are otherwise contrary to the public policy of Indiana.²⁵⁰ In reviewing the contract between Bio-Testing and the Center, the Fifth Circuit held that the minimum testing requirements contained in the contract violated public policy in two important respects.²⁵¹

First, the minimum testing requirements violated the integrity of the physician/patient relationship as the agreement required the Center to conduct a minimum number of tests each week without regard to the actual needs of the Center's patients.²⁵² In requiring the doctors to either perform a prescribed

244. 678 N.E.2d 412 (Ind. Ct. App. 1997).

245. *Id.* at 414.

246. *Id.*

247. *Id.* at 415.

248. *Id.* at 414.

249. *Id.*

250. *Id.*

251. *Id.* at 414-15.

252. *Id.* at 415.

number of tests each week or risk breaching the contract, the agreement prevented the Center's doctors from using their own professional judgment and discretion in treating their patients. Because the contract intruded upon the doctor/patient relationship, the Fifth Circuit determined it was in violation of public policy, and therefore, unenforceable.²⁵³

Finally, the court held that the minimum testing requirements contained in the contract also conflicted with Indiana's policy of containing health care costs.²⁵⁴ Under the terms of the contract, the Center was required to conduct a certain number of tests and provide the billing information to Bio-Testing, and would then receive a share of the insurance proceeds following Bio-Testing's submission to the insurance company. Bio-Testing was expected to receive between \$250,000 and \$300,000 for tests performed on equipment that cost Bio-Testing only \$12,000. The Court found that the fees contemplated by the contract more than covered the cost of Bio-Testing's original purchase and chiropractic center's use of the medical equipment.²⁵⁵ As such, the court noted that the terms of the contract contravene Indiana's public policy of containing health care costs because the terms exploit the health insurance industry by unnecessarily charging insurers, thereby increasing the cost of health care and jeopardizing equal access to health care.²⁵⁶ Because the court determined that the lease agreement violated important public policy, it was held to be unenforceable.²⁵⁷

B. Determining Parties Responsible for Reimbursement

In *Porter Memorial Hospital. v. Wozniak*,²⁵⁸ the Indiana Court of Appeals held that a spouse may be secondarily liable for medical expenses under the doctrine of necessities.²⁵⁹ In *Wozniak*, Mrs. Wozniak required medical care that resulted in a hospital bill of \$44,301.12. Subsequent to her discharge and prior to paying her hospital bill, Mrs. Wozniak filed bankruptcy. The Hospital filed suit against Mr. Wozniak for the hospital bill claiming that he was responsible for his wife's medical expenses under the doctrine of necessities.²⁶⁰

The trial court entered judgment in favor of Mr. Wozniak, holding that because Mrs. Wozniak's debt had been extinguished by her bankruptcy, there was no debt for which Mr. Wozniak could be secondarily liable.²⁶¹ The trial court relied on *In re Lundberg*²⁶² in granting Mr. Wozniak's summary judgment.

253. *Id.*

254. *Id.*

255. *Id.*

256. *Id.*

257. *Id.*

258. 680 N.E.2d 13 (Ind. Ct. App. 1997).

259. *Id.* at 16.

260. *Id.* at 14.

261. *Id.* at 15.

262. 152 B.R. 316 (Bankr. E.D. Okla. 1993).

Lundberg involved a creditor attempting to sue the debtor's insurer. Under Tennessee law, the creditor was required to first obtain a judgment of liability against the insured before the creditor could sue the insurer. The creditor in *Lundberg* was attempting to reopen the debtor's bankruptcy proceedings in order to obtain a judgment of liability against the debtor. The *Lundberg* court ruled that because the debtor's liability had not already been established prior to the closing of the bankruptcy proceedings, the insurer could not be deemed liable.²⁶³ Relying upon the *Lundberg* court's reasoning, the trial court ruled that the bankruptcy proceedings extinguished Mrs. Wozniak's debt, and therefore, like the insurer in *Lundberg*, Mr. Wozniak was not liable for his wife's medical expenses.²⁶⁴

The appellate court disagreed with the trial court's decision, and held that Mr. Wozniak may be secondarily liable for his wife's medical expenses under the doctrine of necessities, even though his wife's debt had been discharged in bankruptcy.²⁶⁵ The appellate court rejected the trial court's analysis, and held that *Lundberg* was inapplicable to the facts in *Wozniak*.²⁶⁶ *Lundberg* stands for the rule that a bankruptcy proceeding need not be reopened to allow a creditor to obtain a judgment against the debtor in order to then pursue a separate suit against the debtor's insurance carrier.²⁶⁷ In the present case, the Hospital was not attempting to reopen a bankruptcy proceeding to establish Mrs. Wozniak's liability; rather, it was attempting to collect a pre-existing debt from Mr. Wozniak.²⁶⁸ Thus, although Mrs. Wozniak's debt was discharged in bankruptcy, it does not cancel Mr. Wozniak's obligation.²⁶⁹

However, because Mr. Wozniak did not agree to be primarily liable for his wife's medical expenses, the appellate court used the doctrine of necessities to determine whether Mr. Wozniak was secondarily liable. The court found that the expenses medically necessary were "necessary expenses" under the doctrine of necessities.²⁷⁰ Further, because there was a shortfall in Mrs. Wozniak's funds due to her bankruptcy, Mr. Wozniak was potentially secondarily liable for the medical expenses under the doctrine of necessities.²⁷¹ A factual question remained as to the extent of Mr. Wozniak's liability. The appellate court remanded the issue to the trial court for further proceedings.²⁷²

263. *Id.* at 319.

264. *Wozniak*, 680 N.E.2d at 14.

265. *Id.* at 16.

266. *Id.* at 15.

267. *Id.*

268. *Id.*

269. *Id.*

270. *Id.* at 16.

271. *Id.*

272. *Id.*

IV. LEGISLATION—STATE

A. *Modification of County Hospital Statutes*

The Indiana General Assembly continues to consider health care issues worthy of increasing legislative and regulatory oversight and guidance. Several laws provided protection for patients as managed care enrollees and in health care settings by requiring grievance procedures for patient complaints and criminal background checks for certain health care employees. Other laws mandated health insurance availability for persons suffering from certain illnesses or diseases and provided protections for release of medical records and informed consents for mental health treatment. These changes appear to reflect public input into the legislative process regarding the importance of health care to the public and the increasing willingness of elected officials to seek to improve the system by intervention.

Effective July 1, 1997, House Enrolled Act 1826²⁷³ made several significant changes affecting the organization and operation of county-owned hospitals. The newly revised statute provides that county hospitals proposing leases in conjunction with publicly-financed projects are not subject to remonstrance procedures under current law²⁷⁴ if they comport with the public notice requirements of sections 6-1.1-20-3.1 to 3.2 of the Indiana Code.²⁷⁵

County hospitals organized under the Acts of 1917, with the approval of the county executive, are now permitted to increase or decrease the size of the governing board from a range of four members to nine members.²⁷⁶ A decrease in board size may occur only when there exists a vacancy on the board.²⁷⁷ Boards of county hospitals now must meet a minimum of ten times a year rather than monthly as previously required.²⁷⁸ A county hospital board may now include productivity bonuses as a part of compensation arrangements for employees and the amounts are not subject to existing limits on amounts expended for productivity or morale of personnel, volunteers or physicians.²⁷⁹ The statute also authorizes county hospitals to conduct business in states adjacent to Indiana²⁸⁰ and affords hospital board members and county officials immunity from liability with regard to the sale or lease of county hospitals subject to prior conformance with applicable statutes regarding sales and leases.²⁸¹ County hospital boards may conduct executive sessions under the "Indiana Open Door Law"²⁸² and

273. Act of May 13, 1997, 1997 Ind. Acts 1399, 1399-1414 (effective July 1, 1997).

274. 1997 Ind. Acts at 1414 (amending IND. CODE § 16-22-6-20(b)).

275. *Id.*

276. *Id.* at 1402 (amending IND. CODE § 16-22-2-7(a)).

277. *Id.* at 1404 (amending IND. CODE § 16-22-2-7(b)).

278. *Id.* at 1406 (amending IND. CODE § 16-22-2-9(f)).

279. *Id.* at 1407 (amending IND. CODE § 16-22-3-11(3)(B)).

280. *Id.* at 1408 (amending IND. CODE § 16-22-3-11(12)).

281. *Id.* at 1409 (amending IND. CODE § 16-22-3-17(f), (g)).

282. IND. CODE § 16-22-3-28(d) (1993 & Supp. 1997).

permissible activities and deliberations may include strategic planning and motivational retreats provided official action is not taken during the meetings.²⁸³

B. Grievance Procedures for HMO Enrollees

House Enrolled Act 1663,²⁸⁴ effective July 1, 1997, made several important additions to existing law regarding health maintenance organizations (“HMOs”). Most notably, the Indiana Department of Insurance, which regulates HMOs, is now empowered to ensure that providers of services offered to enrollees of an HMO, post in conspicuous public locations, a written description or notice of the enrollee’s right to pursue grievance procedures against the HMO.²⁸⁵ The HMO is also required to inform its enrollees of its grievance procedures.²⁸⁶ These grievance procedures include a requirement that every HMO have a toll free number which is available and staffed a minimum of forty business hours a week for enrollee use.²⁸⁷ Further, the HMO, except in unusual circumstances, must resolve grievances within twenty calendar days from the enrollee’s grievance filing date.²⁸⁸ The HMO must also afford the enrollee appeal rights in the event of an adverse determination.²⁸⁹ The HMO must establish an appeals panel which must make a final determination regarding the enrollee’s grievance not later than forty-five days after the appeal is filed.²⁹⁰ The Department is required to file an annual report listing the grievance procedures of all certified HMO’s as well as the number of grievances filed with each HMO.²⁹¹

C. Drug Testing for Newborns

Senate Enrolled Act 6(ss) passed during the special session of the 1997 Indiana General Assembly.²⁹² It provides in part that the Indiana State Department of Health oversee testing of newborns for drugs by a contract with an independent laboratory.²⁹³ The laboratory will test meconium samples obtained from certain newborns. Meconium accumulates in the bowel of the fetus and is discharged shortly after birth. The infants will be tested for the presence of controlled substances in the child’s meconium if the birth rate of the child is less than 2,500 grams and the infant’s head are smaller than the third percentile for that infant’s normal gestational age and there are no medical

283. 1997 Ind. Acts at 1413 (amending IND. CODE § 16-22-3-28(c)(4), (5)).

284. Act of May 12, 1997, 1997 Ind. Acts 2782, 2782-89 (effective July 1, 1997).

285. 1997 Ind. Acts at 2784 (amending IND. CODE § 27-13-10-4(c)).

286. *Id.* at 2783 (amending IND. CODE § 27-13-10-4(a)).

287. *Id.* at 2784 (amending IND. CODE § 27-13-10-5(b)(1)-(3)).

288. *Id.* at 2785 (amending IND. CODE § 27-13-10-7(c)).

289. *Id.* (amending IND. CODE § 27-13-10-7(d)(3)).

290. *Id.* at 2786-87 (amending IND. CODE § 27-13-10-8(b), (c)).

291. *Id.* at 2782-83 (amending IND. CODE § 27-13-8-2(b)(1)-(2)).

292. Act of May 28, 1997, 1997 Ind. Acts 3324, 3324-3581 (effective July 1, 1997).

293. *Id.*

explanations for such conditions.²⁹⁴ Hospitals and physicians are required to take meconium samples from infants born under their care that meet the parameters of the statute and forward the samples to a laboratory designated by the Indiana State Department of Health.²⁹⁵

D. Requirements for Alzheimer and Dementia Specialty Care

House Enrolled Act 1300,²⁹⁶ effective July 1, 1997, requires that those health facilities providing special services for residents with Alzheimer's Disease or dementia must make specific reports to the Division of Mental Health of the Indiana Family and Social Services Administration.²⁹⁷ The reports are required of those health facilities providing specialized care to these patients if the facility locks, secures, segregates, or otherwise provides a special program or unit for services to such residents and advertise, market or promote the facility as providing such services.²⁹⁸

A health facility subject to the Act is required to submit written reports on forms provided by the Division of Mental Health detailing the health facility's mission or philosophy, the process and criteria used to place, transfer, or discharge such patients, and the process for the assessment, establishment, and implementation of plans of care.²⁹⁹ A facility is also required to provide information regarding staffing ratios, qualifications, and required training of staff.³⁰⁰

The facility is also required to detail other specific policies regarding restraints, charges and fees, activities and services available, and the characteristics that the facility identifies as distinguishing it from other health facilities.³⁰¹

E. Various Health Insurance Provisions

Effective January 1, 1998, persons diagnosed with diabetes are required to be covered under health insurance policies pursuant to Senate Enrolled Act 184.³⁰² Specifically, a health insurance plan must provide coverage to an insured for medically-necessary treatment for diabetes³⁰³ and the insured may not be required to pay an annual deductible or co-payment that is greater than that normally associated with similar benefits under the plan.³⁰⁴ The statute also

294. *Id.*

295. *Id.*

296. Act of May 13, 1997, 1997 Ind. Acts 2058, 2058-60 (effective July 1, 1997).

297. *Id.*

298. 1997 Ind. Acts at 2059 (amending IND. CODE § 12-10-5.5-1(1)-(2)).

299. *Id.* (amending IND. CODE § 12-10-5.5-3(1)-(3)).

300. *Id.* at 2059-60 (amending IND. CODE § 12-10-5.5-3(4)).

301. *Id.* at 2060 (amending IND. CODE § 12-10-5.5-3(6)-(10)).

302. Act of April 16, 1997, 1997 Ind. Acts 2779, 2779-81 (effective January 1, 1998).

303. 1997 Ind. Acts at 2780 (amending IND. CODE § 27-8-14.5-4).

304. *Id.* (amending IND. CODE § 27-8-14.5-5(a)).

requires that health insurance must provide coverage for diabetes self-management training subject to certain limitations relating to the number of visits and comparable coverage in a health insurance plan which limits the use of participating providers of service.³⁰⁵ House Enrolled Act 1684³⁰⁶ obligates entities issuing policies of accident or sickness insurance to cover items and services incident to mastectomy procedures.³⁰⁷ This Act also proscribes the use of genetic testing by such entities in processing applications for coverage or in determining the insurability of an applicant.³⁰⁸

Effective July 1, 1997, Senate Enrolled Act 225³⁰⁹ specifies that an insurer need not provide coverage for a newly born child of an insured if the pregnancy resulting in the birth commenced prior to the issuance of the insurance policy.³¹⁰

F. Informed Consent Required for Certain Mental Health Services

Effective July 1, 1997, Senate Enrolled Act 309³¹¹ specifies informed consent requirements prior to the provision of mental health services. Before such services are rendered, a mental health provider³¹² must obtain a consent from each patient.³¹³

A mental health provider is only required to obtain one consent for mental health services from a patient even if the services are provided in several locations.³¹⁴ The mental health provider must inform each patient about the provider's training and credentials, the reasonably foreseeable risks and relative benefits of the proposed treatments and alternative treatments available if any.³¹⁵ Further, the patient must be informed of the right to withdraw consent for treatment at any time.³¹⁶ A physician licensed under section 25-22.5 of the Indiana Code must obtain a written consent signed by the patient or the patient's authorized representative prior to treatment being undertaken.³¹⁷

G. Release of Mental Health Records

House Enrolled Act 1700 ("Act"),³¹⁸ which was effective July 1, 1997,

305. *Id.* at 2780-81 (amending IND. CODE § 27-8-14.5-6(a)-(c)).

306. Act of May 12, 1997, 1997 Ind. Acts 2451, 2451-2464 (effective January 1, 1998).

307. 1997 Ind. Acts at 2460 (amending IND. CODE § 22-8-5-26(d)).

308. *Id.* at 2462 (amending IND. CODE § 27-8-26-5).

309. Act of May 6, 1997, 1997 Ind. Acts 2777, 2777-78 (effective July 1, 1997).

310. 1997 Ind. Acts at 2778 (amending IND. CODE § 27-8-5.6-2(b)).

311. Act of April 17, 1997, 1997 Ind. Acts 2448, 2448-51 (effective July 1, 1997).

312. 1997 Ind. Acts at 2448 (amending IND. CODE § 16-36-1.5-2).

313. *Id.* at 2448-49 (amending IND. CODE § 16-36-1.5-4).

314. *Id.* at 2449 (amending IND. CODE § 16-36-1.5-6).

315. *Id.* at 2449-50 (amending IND. CODE § 16-36-1.5-10).

316. *Id.*

317. *Id.* at 2449 (amending IND. CODE § 16-36-1.5-4.5).

318. Act of May 13, 1997, 1997 Ind. Acts 908, 908-19 (effective July 1, 1997).

amends various provisions regarding the release of mental health records.³¹⁹ Section 16-39-5-1 of the Indiana Code provides that health care providers may obtain a patient's mental health records³²⁰ from another provider without the patient's consent if the records are required to provide health services to the patient.³²¹ Since a health record includes alcohol and drug abuse records,³²² providers are permitted to exchange a patient's alcohol and drug abuse records provided that the records do not meet the definition or requirements of a federal law which has additional disclosure requirements.³²³

The Act also specifies circumstances that permit disclosure of a patient's mental health records without the patient's consent.³²⁴ The Act permits disclosure of a patient's mental health records to law enforcement agencies without the patient's consent if the patient is in the custody of a law enforcement officer or agency and the information be released is limited to medications currently prescribed for the patient or the patient's history of adverse medication reactions and the disclosing provider determines that the release of the information will assist in the protection and well being of the patient.³²⁵ Law enforcement agencies receiving such records must maintain their confidentiality.³²⁶

H. Provisions Relating to Various Health Professions and Occupations

Effective July 1, 1997, Senate Enrolled Act 74³²⁷ requires that hypnotists be certified and provides for exclusion from certification requirements various licensed health care providers.³²⁸

House Enrolled Act 1961 ("Act"),³²⁹ effective July 1, 1997, contains numerous provisions concerning licensure for social workers, clinical social workers, marriage and family therapists and certain mental health counselors. The major provisions include a requirement that individuals who practice social work, clinical social work, marriage and family therapy and mental health counseling must be licensed by January 1, 1999.³³⁰ There is a provision for previously certified individuals to be "grandfathered."³³¹ The Act further permits social workers, clinical social workers and marriage and family therapists to

319. *Id.*

320. 1997 Ind. Acts at 910 (amending IND. CODE § 16-18-2-226).

321. *Id.* at 912 (amending IND. CODE § 16-39-2-6-(1)).

322. *Id.* at 909 (amending IND. CODE § 1-1-4-5(5)).

323. *Id.* at 910-11, 914 (amending IND. CODE §§ 16-39-2-6(a)(15)(A), 16-39-1-9).

324. *Id.* at 912 (amending IND. CODE § 16-39-2-6).

325. *Id.* at 913 (amending IND. CODE § 16-39-2-6(a)(7)(D)).

326. *Id.*

327. Act of May 14, 1997, 1997 Ind. Acts 2616, 2616-32 (effective July 1, 1997).

328. 1997 Ind. Acts at 2623-24 (adding IND. CODE § 25-20.5-1-1).

329. Act of May 13, 1997, 1997 Ind. Acts 2391, 2391-2446 (effective July 1, 1997).

330. 1997 Ind. Acts at 2413 (amending IND. CODE § 25-23.6-3-3).

331. 1997 Ind. Acts at 2458.

utilize certain appraisal instruments incident to their work with clients and patients.³³² The Act also specifies that certain acts of such professionals are proscribed and will subject the individual engaging in such activity to disciplinary action by a licensure board.³³³

I. Certificate of Need

House Enrolled Act 1597³³⁴ became effective on July 1, 1997 and re-established Indiana's certificate of need ("CON") program until June 30, 1998.³³⁵ The program requires approval for the construction, addition or conversion of beds for use as comprehensive care beds in a comprehensive care facility.³³⁶ Licensed hospitals³³⁷ are permitted to convert up to 50 acute care beds to comprehensive care beds without the necessity of a CON. The Act also address the period of time between July 1, 1996 and June 30, 1997, during which period the certificate of need was not in effect in Indiana. Specifically, the Act provides that projects otherwise subject to the certificate of need program are exempt from CON requirements if a notice of intent to build a facility at a specific location within a specific county was submitted to the Indiana State Department of Health after July 1, 1996 but before July 1, 1997.³³⁸ In addition, to receive exempt status, construction plans for the project are to have been approved by the Indiana State Department of Health and the Indiana Department of Fire and Building Safety before July 1, 1997, and the foundation for the project is to have been constructed in conformity with the aforesaid approved plans before July 1, 1997, as certified by an architect licensed under section 25-4 of the Indiana Code or a professional engineer licensed under section 25-31 of the Indiana Code.³³⁹

J. Home Health Agency Criminal Background Checks

Effective July 1, 1997, House Enrolled Act 1051³⁴⁰ requires that a home health agency³⁴¹ may not employ persons to work in a patient's or client's home for more than three business days unless the operator of the home health agency has first applied for a copy of the employee's limited criminal history.³⁴²

In addition, a home health agency is prohibited from employing a person a person for more than twenty-one calendar days unless the agency receives a copy of the person's limited criminal history except where the applicable state agency

332. 1997 Ind. Acts 2391, 2391-2446.

333. *Id.*

334. Act of May 13, 1997, 1997 Ind. Acts 2088, 2088-2090 (effective July 1, 1997).

335. 1997 Ind. Acts at 2089.

336. *Id.* at 2089-90.

337. Hospitals are licensed by the ISDH. IND. CODE § 16-27-2.

338. 1997 Ind. Acts at 2090.

339. *Id.*

340. Act of May 12, 1997, 1997 Ind. Acts 2446, 2446-47 (effective July 1, 1997).

341. Home Health Agencies are regulated by the ISDH.

342. 1997 Ind. Acts at 2446 (amending IND. CODE § 16-27-2-4).

has failed to timely provide the agency with a limited criminal history.³⁴³

K. Foreign Domiciled Pharmacies

Effective July 1, 1997, House Enrolled Act 1087³⁴⁴ requires out-of-state pharmacies that dispense drugs or health care devices through the mail or other delivery methods to Indiana patients to register with the Indiana Board of Pharmacy.³⁴⁵

L. Prohibition On Sale of Fetal Tissue

Senate Enrolled Act 61³⁴⁶ provides that a person who intentionally acquires, receives, sells or transfers "fetal tissue"³⁴⁷ in exchange for an item of value commits a Class C felony. This Act was effective July 1, 1997.³⁴⁸

M. Treatment of Sex Crime Victims

Effective July 1, 1997, Senate Enrolled Act 144³⁴⁹ requires licensed medical service providers³⁵⁰ that provide emergency services to victims of sex crimes to do so without charge to the victim. Under certain circumstances, some reimbursement is available to providers for such services from a state agency.³⁵¹

V. TAX ISSUES

A. Judicial Developments

Both the courts and the Internal Revenue Service have provided needed clarification during the Survey period regarding the appropriate use of tax-exempt assets by exempt health care entities in furtherance of their exempt status.

During the survey period, the Indiana Tax Court further defined the requirements for nonprofit corporations to retain exemption from property taxation and state gross income and sales taxation. In *Sangrilea Boys Fund, Inc. v. State Board of Tax Commissioners*,³⁵² the court reversed the State Board's final determination denying Sangrilea property tax exemption on the basis that the statute³⁵³ requires a complete unity of ownership, occupation, and use of property

343. *Id.* at 2447 (amending IND. CODE § 16-27-2-5).

344. Act of May 13, 1997, 1997 Ind. Acts 2664, 2664-66 (effective July 1, 1997).

345. 1997 Ind. Acts at 2664 (adding IND. CODE § 25-26-17).

346. Act of May 13, 1997, 1997 Ind. Acts 2949, 2949-50 (effective July 1, 1997).

347. 1997 Ind. Acts at 2949 (amending IND. CODE § 35-46-5-1).

348. *Id.*

349. Act of April 28, 1997, 1997 Ind. Acts 1414, 1414-22 (effective July 1, 1997).

350. 1997 Ind. Acts at 1418-20 (amending IND. CODE § 5-2-6.1-39).

351. *Id.*

352. 686 N.E.2d 954 (Ind. T.C. 1997).

353. IND. CODE § 6-1.1-10-16 (1993 & Supp. 1997).

by the party seeking the exemption.³⁵⁴ Sangralea is a nonprofit corporation that was admitted to transact business in Indiana as a nonprofit corporation in 1963. Sangralea provides guidance and education for troubled youth in its facilities consistent with its organizational documents and with the requirements of the state to maintain exempt status. However, in 1987, Sangralea sought to carry out its activities by leasing a part of its property to three nonprofit entities. The rent-free leases required the lessee to engage in activities wholly consistent with Sangralea's operating purposes. Sangralea also continued to maintain oversight of the functions of the lessee.

The County Board of Review denied Sangralea a property tax exemption in 1992 and 1993. The State Board, upon appeal by Sangralea, denied the exemption for a majority of the property Sangralea owned excepting only the property occupied and used by Sangralea directly. Sangralea filed an original tax appeal and both parties filed motions for summary judgment. The court, in granting Sangralea's motion for summary judgment, held that an examination of the history of the Act showed that the legislature had until recent times, required that buildings be exempt from taxation if owned and *actually* occupied for charitable purposes.³⁵⁵ In 1975, the Act was recodified and the word "actually" was removed thus recognizing several judicial interpretations which focused on a liberal construction of the prior statute to accomplish overall charitable purposes.³⁵⁶

The court also indicated that its decision did not rest entirely on the 1975 statutory change given that prior judicial interpretation did not require strict adherence to the literal language but rather to the full intent of the statute. Further, the court found that other statutes affecting the Act supported its position that a lease of exempt property to an exempt lessee does not make the property taxable.³⁵⁷ The court concluded the relevant test is that a piece of property must be owned for charitable purposes, occupied for charitable purposes, and used for charitable purposes.³⁵⁸

In *Raintree Friends Housing, Inc. v. Indiana Department of State Revenue*,³⁵⁹ the tax court reversed the decision of the Department of State Revenue ("Departmental") denying the petitioners exemption from state gross income tax, sales tax and county food and beverage tax. The Department denied such exemptions after conducting an audit of two nonprofit housing corporations which operated homes for aged citizens. The Department found that the homes were not operated exclusively for charitable purposes and did not qualify for exemption.³⁶⁰

While both housing corporations were organized as nonprofit corporations

354. *Sangralea*, 686 N.E.2d at 954.

355. *Id.* at 956.

356. *Id.* at 957.

357. *Id.* at 958.

358. *Id.*

359. 667 N.E.2d 810 (Ind. T.C. 1996).

360. *Id.* at 812-13.

under Indiana law, the court did not find that determinative. Instead, applicants must show that they are charitable organizations specifically eligible for Indiana state tax exemption.³⁶¹ The court found that the term charitable had been broadly construed by Indiana courts and that public policy supports such a construction of the term.³⁶² The court further concluded that meeting the needs of the aged, while promoting decent housing, relief of loneliness, emotional stability, safety and related desirable goals confers a benefit upon society and accomplishes a charitable purpose.³⁶³

Although the services provided by petitioners were restricted to those beneficiaries paying fees, the court held that charitable organizations could limit services provided without impairing their exempt status.³⁶⁴ *Raintree*, in following a similar line of cases, reaffirms that exemption under Indiana law is based on broad principles and is not dependent solely on federal principles of exemption nor rigid state requirements.

B. Revised Model for Conflicts of Interest

The Internal Revenue Service ("IRS") has made public the latest revision of its Model Conflicts of Interest Policy applicable to exempt organizations.³⁶⁵ This recent version has several significant changes to that published in late 1996. By way of background, the IRS has suggested that tax exempt health care entities that have business relationships with members of their boards of directors risk violating the inurement prohibition and private benefit restrictions of section 501(c)(3) of the Internal Revenue Code.³⁶⁶

The IRS's current modifications of policy require that in addition to disclosing a financial interest in a matter, an interested person must provide all material facts and must leave the meeting while the determination of a conflict is discussed and decided.³⁶⁷ An interested person may make a presentation or provide information at a board or committee meeting, but upon the meeting's conclusion, the person must leave the meeting during the discussion and vote on any transaction that is the subject of the conflict of interest.³⁶⁸

The revised policy permits physicians who receive compensation from an exempt entity to provide information to a board or committee setting compensation. However, such physicians are still precluded from service on any compensation committee based on the prior policy.³⁶⁹

361. *Id.* at 813-14.

362. *Id.* at 814.

363. *Id.* at 814-15.

364. *Id.* at 816.

365. MODEL CONFLICTS OF INTEREST POLICY (IRS rev. version, May 22, 1997).

366. I.R.C. § 501(c)(3) (1994).

367. MODEL CONFLICTS OF INTEREST POLICY § 3-1(6) (IRS rev. version, May 22, 1997).

368. *Id.*

369. *Id.* § 5-1.

C. Taxation of Exempt Organization Transaction

Among the more interesting provisions of the Taxpayer Relief Act of 1997 (“Act”),³⁷⁰ which became effective August 5, 1997, is a provision which broadens the scope of defined relationship between affiliated entities.

Generally, tax-exempt organizations do not pay unrelated business income (“UBI”) tax on rents, interest or royalties received unless the source is a controlled affiliate, in which instance the revenue is partially taxable unless the affiliate is tax-exempt and has no revenue from an unrelated trade or business.³⁷¹

The Act defines “control” to bring more affiliates within the ambit of section 512(b)(13) of the Internal Revenue Code and to close possible loopholes when exempt organizations do not have complete ownership of an affiliate.³⁷² The IRS, prior to this change, required an exempt organization to own eighty percent or more of the affiliate before this section applied. The amendment now requires only fifty percent control and also expands certain attribution methodology, further extending the reach of the section.³⁷³ While the Act became effective August 5, 1997, payments pursuant to written agreements in effect on June 8, 1997, are permitted a two year transition period.³⁷⁴

D. Participation in a Provider-Sponsored Organization

The Balanced Budget Act of 1997 (“BBA”)³⁷⁵ contains a section providing that a tax-exempt organization will not jeopardize its exemption solely because a hospital owned and operated by the organization participates in a provider-sponsored organization (“PSO”).³⁷⁶

Further, the BBA authorizes PSOs as a type of managed care entity that may enter into contracts with the Medicare Program to provide services to its beneficiaries.³⁷⁷ The BBA defines a PSO as an entity established and operated by a health care provider or providers which directly or indirectly, through affiliated providers who are at financial risk, provides most of the health services required of Medicare enrollees.³⁷⁸

VI. LEGISLATION—FEDERAL: BALANCED BUDGET ACT OF 1997

On August 5, 1997, Congress passed the Balanced Budget Act of 1997,³⁷⁹ a

370. Pub. L. No. 105-34, 111 Stat. 788.

371. I.R.C. § 512(b) (1997).

372. 26 U.S.C. § 512(b)(13)(D) (Supp. 1998).

373. *Id.*

374. *Id.* § 512(b).

375. Pub. L. No. 105-33, 111 Stat. 251 (codified as amended in scattered titles and sections of U.S.C., predominantly 42 U.S.C. for the purposes herein).

376. I.R.C. § 501(o) (1994).

377. Pub. L. No. 105-33, 111 Stat. 251.

378. *Id.*

379. *Id.*

comprehensive act that is expected to produce substantial savings in Medicare and Medicaid over the next five years.³⁸⁰ The comprehensiveness of the Act precludes a detailed discussion of all the provisions; therefore, this brief overview attempts to highlight only some of the provisions.³⁸¹

A. Medicare+Choice

Section 4001 of the BBA created a new Part C in Medicare³⁸² entitled the Medicare+Choice Program. Types of Medicare+Choice plans include: private fee for service plans, coordinated care plans (which includes health maintenance organizations, provider sponsored organizations ("PSOs"),³⁸³ religious fraternal benefit plans and other coordinated care plans that meet the Medicare+Choice standards), and medical savings accounts ("MSAs").³⁸⁴

All Medicare beneficiaries will be eligible for the Medicare+Choice plan except those with end-stage renal disease who are not already enrolled at the time of diagnosis.³⁸⁵ Eligible beneficiaries may enroll in or disenroll from the new plans on a monthly basis from 1998 through 2001.³⁸⁶ The Medicare+Choice plans are required to provide the current Medicare benefit package, with the exception of hospice services.³⁸⁷ In addition, the plans must provide access to emergency services and must maintain meaningful procedures for hearing and resolving beneficiary grievances.³⁸⁸ Standards that Medicare+Choice organizations must meet in order to contract to enroll Medicare beneficiaries are scheduled to be published June 1, 1998. The BBA also provides for the

380. Donna Clark et al., *Providers Face Multitude of Payment Reductions*, HEALTH L. DIG., Nov. 1997, at 3. Projected savings include \$115 billion for Medicare and \$13 billion for Medicaid. *Id.*

381. *See id.*; BALANCED BUDGET ACT OF 1997, MEDICARE AND MEDICAID PROVISIONS GOVERNMENT PRINTING OFFICE (for a more comprehensive overview of the Act).

382. Before the BBA was enacted, Medicare consisted of Part A, inpatient facility services, and Part B, physician services.

383. PSOs are defined as public or private entities established by or organized by health care providers or a group of affiliated providers that provide a substantial portion of health care items and services directly through providers or affiliated groups of providers. Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (to be codified at 42 U.S.C. § 1395w-25) [hereinafter Budget Act].

384. An MSA is a pilot project covering 390,000 beneficiaries who will take out a high-deductible catastrophic policy and get Medicare contributions to their own tax-free account to help pay smaller medical expenses. *See* NHLA HEALTH LAW. NEWS, Sept. 1997.

385. *See* Budget Act, *supra* note 380, § 1395w-21.

386. *Id.* For the first six months of 2002, beneficiaries may enroll or disenroll from the plans, but may only change plans one time during this six-month period. After 2002, the same process applies, except the six-month time frame becomes a three-month time frame.

387. *Id.* § 1395w-23.

388. *Id.* § 1395w-22.

development of solvency standards for PSOs.³⁸⁹

B. Medical Savings Accounts

Section 4006 of the BBA sets out guidance concerning medical savings accounts (“MSAs”).³⁹⁰ Pursuant to the Act, Medicare’s contributions to a Medicare+Choice MSA account and the interest income earned on amounts in the account are not included in the gross income of the MSA holder.³⁹¹ However, only the Secretary can make direct contributions to the MSA account.³⁹² Withdrawals that a beneficiary makes for qualified medical expenses are not included in the taxable income of the beneficiary yet withdrawals for non-medical expenses are included in taxable income and are subject to a penalty if the medical savings account funds are used for non-medical expenses and a minimum balance is not maintained.³⁹³ Upon the death of the MSA holder, the surviving spouse may continue the MSA but no new contributions can be made.³⁹⁴ In addition, withdrawals for non-medical expenses are taxable and are subject to a fifteen percent excise tax unless the withdrawal is made after the surviving spouse reaches age sixty-five or becomes disabled.³⁹⁵

C. Anti-Fraud and Abuse Provisions and Improvements in Protecting Program Integrity

The BBA includes several new provisions to help curb fraud and abuse in health care. The Secretary of the Department of Health and Human Services, Donna E. Shalala, in a statement given on the day the BBA was enacted, stated that “[p]erhaps most importantly, the BBA includes many of the tools that the President repeatedly requested to continue our fight to eliminate waste, fraud and abuse in health care.”³⁹⁶

To help curb fraud and abuse, the BBA provides for permanent exclusion from Medicare or any state-related health care program for any person or entity who has been convicted on two or more previous occasions of one or more health-related crimes for which mandatory exclusion could be imposed.³⁹⁷ In addition, the Secretary may exclude an individual or entity from participation in

389. *Id.* § 1395w-26. The minimum enrollment requirements can be waived the first three contract years. *Id.*

390. *See generally* 26 U.S.C.A. § 138 (Supp. 1998).

391. *Id.* § 138(a).

392. *Id.* § 138(b).

393. *Id.* § 138(c).

394. *Id.* § 138(d).

395. *Id.* § 220(f).

396. Donna E. Shalala, Statement, NHLA HEALTH LAWYERS NEWS, Sept. 1997.

397. 42 U.S.C.A. § 1320a-7 (Supp. 1998). These crimes include Medicare and state health care program-related crimes, patient abuse or felonies related to health care fraud or controlled substances. *Id.*

any federal health care program for numerous other violations.³⁹⁸ If the first violation occurred on or after August 5, 1997, the individual will be excluded from participation in Medicare or any state-related health care program for at least ten years.³⁹⁹ After the second violation, the period of exclusion will be permanent.⁴⁰⁰ In addition, the Secretary may refuse to enter into or renew an agreement with a provider if the provider has been convicted of a felony under federal or state law for an offense which the Secretary determines is inconsistent with the best interests of the program or program beneficiaries.⁴⁰¹

Other anti-fraud provisions authorize the Secretary to exclude from Medicare or any state health care program an entity controlled by a family member of a sanctioned individual.⁴⁰² In addition, civil monetary penalties of up to \$10,000 could be assessed against a person when the individual arranges or contracts with an individual or entity for the provision of items or services when it knows or should know that the individual or entity has been excluded from a federal health care program.⁴⁰³ A civil monetary penalty of up to \$50,000 plus up to three times the amount of the remuneration offered, paid, solicited or received could be levied for each violation of the anti-kickback provisions of Title XI of the Social Security Act.⁴⁰⁴

To assist providers in determining whether certain activities constitute self-referral, the BBA provides that the Secretary must issue binding advisory opinions as to whether a physician referral for certain designated health services (other than clinical laboratory services) is prohibited by law.⁴⁰⁵ Each advisory opinion is binding on the Department of Health and Human Services Secretary and the party or parties requesting the opinion.⁴⁰⁶

In addition, section 4707 of the BBA includes provisions relating to fraud

398. These violations include: convictions relating to fraud, obstruction of an investigation, misdemeanor convictions relating to controlled substances, license revocation or suspension, exclusion or suspension under federal or state health care program, claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services, fraud, kickbacks and other prohibited activities, entities controlled by a sanctioned individual, failure to disclose required information, failure to supply requested information on subcontractors and suppliers, failure to supply payment information, failure to grant immediate access, failure to take corrective action, default on health education loan or scholarship obligations, and, finally, controlling a sanctioned entity. *Id.* § 1320a-7b.

399. *Id.*

400. *Id.*

401. *Id.*

402. *Id.* § 1320a-7b(8).

403. *See* Budget Act, *supra* note 380, § 1395w-27.

404. *Id.* The anti-kickback statute is a criminal law, the general premise of which is that it is a felony to offer, pay, solicit or receive remuneration in order to induce referrals or otherwise generate business that may be paid by Medicare, Medicaid or other governmental health care programs. 42 U.S.C.A. § 1320a-7(b) (Supp. 1998).

405. *Id.* § 1320a-7(d).

406. *Id.*

and abuse in managed care.⁴⁰⁷ This section prohibits a managed care entity from knowingly having a director, officer, partner, or person with more than five percent of the entity's equity, or having an employment, consulting, or other agreement with such a person for the provision of items and services that are significant and material to the entity's contractual obligation with the state who has been disbarred or suspended by the federal government.⁴⁰⁸ The section also restricts a managed care organization from distributing marketing materials that contain certain false or misleading information.⁴⁰⁹ Furthermore, the advertising materials must market to the entire service area and no tie-ins with other insurance products are permitted.⁴¹⁰ The state must also have conflict-of-interest safeguards for officers and employees of the state with responsibilities relating to contracts with such organizations or to the default enrollment process that are at least as effective as the federal safeguards provided under section 27 of the Office of the Federal Procurement Policy Act that apply to procurement officials with comparable responsibilities.⁴¹¹

Section 1932(e) requires that states establish intermediate sanctions, which may include civil money penalties or other remedies if an organization fails substantially to provide medically necessary items and services that are required under law or under contract, by imposing excess premiums and charges, discriminating among enrollees, misrepresenting or falsifying information, or violating marketing guidelines.⁴¹²

D. Provisions Relating to Provider Payments

Numerous provisions in the BBA reduced payments to providers. Key reductions in the BBA include payment cuts for prospective payment system ("PPS") hospitals,⁴¹³ PPS-exempt hospitals subject to the Tax Equity and Fiscal Responsibility Act of 1982⁴¹⁴ and teaching hospitals, the transfer of most home health care spending to Medicare Part B, and the mandating of PPS for skilled nursing facilities, home health, rehabilitation and hospital outpatient services.⁴¹⁵ Beginning in fiscal year 1998, disproportionate share payments ("DSH") otherwise payable will be reduced by one percent a year continuing through 2001.⁴¹⁶ Within one year, the Secretary must submit a report to the House Ways

407. See Budget Act, *supra* note 380, § 1396u-(2).

408. See *id.* § 1396-2(d).

409. *Id.*

410. *Id.*

411. *Id.*

412. *Id.* § 1396u-(2)(e).

413. A PPS hospital is one that is paid on a per-case reimbursement scheme in which cases are divided into categories for which the price is set in advance.

414. Pub. L. No. 97-248, 96 Stat. 324.

415. See Clark et al., *supra* note 377 (for a more complete description and analysis of the provisions regarding payment reductions in the Balanced Budget Act).

416. See generally Budget Act, *supra* note 380, § 1395ww.

and Means Committee and the Senate Finance Committee, with recommendations for a new formula for determining DSH payments for hospitals.⁴¹⁷

Section 4413 of the BBA allows psychiatric, rehabilitation, children's cancer, and long-term care hospitals and psychiatric and rehabilitation units the opportunity to request a rebased TEFRA target amount.⁴¹⁸ To qualify for a rebased target amount, a hospital or unit must have received Medicare payments for services furnished during cost reporting periods beginning before October 1, 1990.⁴¹⁹ The rebasing will be determined by using the five latest settled cost reports as of August 5, 1997, updated for inflation, excluding the highest and lowest cost reporting periods and calculating an average for the remaining three reporting periods.⁴²⁰ A hospital or unit must affirmatively request rebasing.⁴²¹ Providers will be able to request rebasing only for fiscal year 1998. A provider that fails to timely request rebasing for 1998 will not have another chance.⁴²²

Section 4421 of the Act requires the Secretary to establish a prospective payment system ("PPS") for inpatient rehabilitation hospital or unit services (operating and capital costs) based on case mix group.⁴²³ A PPS will be phased in over two transition years.⁴²⁴ The Secretary will have much discretion in creating the PPS system for rehabilitation services, including the unit of payment.

Skilled nursing facilities ("SNFs") will also see payment methodology changes stemming from the BBA. The SNF cost limits for cost reporting periods beginning on or after October 1, 1997, will be based on the limits effective for the cost reporting period beginning on or after October 1, 1996.⁴²⁵ In addition, effective for cost reporting periods on or after July 1, 1998, there will be prospective payment for SNF services on a per diem basis.⁴²⁶ The new law calls for "bundling" of all SNF services, similar to the current practice for hospital patients.⁴²⁷

The BBA also removes the restriction on settings for services furnished by nurse practitioners and clinical nurse specialists,⁴²⁸ which currently is limited to

417. *Id.*

418. *Id.*

419. *Id.*

420. *Id.*

421. *Id.*

422. Dennis Barr, *Final Rule Implements Many Hospital Payment Provisions of Balanced Budget Act*, REIMBURSEMENT ADVISOR, Oct. 1997.

423. See Budget Act, *supra* note 380, § 1395ww.

424. *Id.* In the first year, the payment rate will be based two-thirds on the TEFRA methodology and one-third on the PPS methodology. In the second transition year the payment rate will be based one-third on the TEFRA methodology and two-thirds on the PPS methodology. For the third and subsequent years, payment will be based entirely on the PPS methodology. *Id.*

425. *Id.*

426. *Id.*

427. *Id.*

428. The definition of a clinical nurse specialist is also clarified to include only a registered

services provided in rural areas or in skilled nursing facilities.⁴²⁹ Beginning in 1998, nurse practitioner services in any setting will be reimbursed equal to eighty percent of the lesser of the actual charge or eighty-five percent of the physician fee schedule.⁴³⁰ However, reimbursement of nurse practitioner and physician assistant services under the BBA is contingent upon the absence of a facility charge associated with such services.⁴³¹

Section 4523 of the Act mandates implementation of a prospective payment system for hospital outpatient department services beginning January 1, 1999.⁴³² Cancer hospitals, however, will not be subject to the prospective payment system until January 1, 2000.⁴³³ The Secretary has been given great discretionary latitude over the details of the new payment methodology which is especially important as there will be no administrative or judicial review of the development of the classification system, including the establishment of groups and relative payment weights, wage adjustment factors, other adjustments, volume performance methodologies, the calculation of base amounts, periodic adjustments, and the establishment of a separate conversion factor for cancer hospitals.⁴³⁴ The goal of the BBA is to gradually reduce the current patient copayment based on individual hospital charges to one based on twenty percent of the outpatient department fee schedule.⁴³⁵

Effective January 1, 1998, payment for outpatient therapy services and comprehensive outpatient rehabilitation services will consist of the lower of charges or the reasonable costs, reduced by ten percent, minus beneficiary coinsurance payments (which is based on twenty percent of charges).⁴³⁶ Therapy services furnished by hospitals will continue to be paid under the rules established for payment of outpatient department services in 1998.⁴³⁷ For rehabilitation agencies and certain outpatient therapy providers other than outpatient hospital departments, the BBA also includes the application of a fee schedule provision for therapy services beginning January 1, 1999 and per beneficiary therapy caps of \$1,500.00.⁴³⁸

E. Home Health Agencies

Numerous provisions in the BBA concerned home health agencies. The

nurse licensed to practice in the state who holds a Master's degree in a defined clinical area of nursing and from an accredited educational institution. *Id.*

429. *Id.*

430. *Id.*

431. *Id.*

432. *Id.*

433. *Id.*

434. *Id.*

435. *Id.*

436. *Id.*

437. *Id.*

438. *Id.* § 1395l(g)(1).

BBA requires that hospital discharge planning evaluations include the availability of home health services in the area, yet the hospital may not limit the qualified providers of home health services and must disclose financial relationships with the home health service entities.⁴³⁹ In addition, hospitals with a financial relationship with a home health agency would be required to report to the Secretary the nature of the financial interest, the number of individuals discharged from the hospital requiring home health services, and the percentage of those individuals receiving services from the home health agency.⁴⁴⁰

Home health reimbursement also saw changes with the enactment of the BBA. The BBA requires the Secretary to develop and implement a prospective payment system for all home health services effective for cost reporting periods beginning on or after October 1, 1999.⁴⁴¹ Once the PPS has been implemented, a home health agency will be required to submit claims for all services (including contracted services) furnished to an individual under a plan of care of that agency.⁴⁴² As an added security measure, the BBA prohibits Federal Medicaid matching funds for home health services unless the home health agency or organization provides the state Medicaid agency a surety bond in a form specified by the Secretary for Medicare home health providers. The amount of the surety bond must be no less than \$50,000 or an amount comparable to that specified by the Secretary for Medicare.⁴⁴³

F. Increased Beneficiary Protections

The BBA added numerous protections for beneficiaries of managed care including assuring coverage of emergency services.⁴⁴⁴ Utilizing the “prudent lay person” standard, each contract with a managed care entity must require coverage of emergency services without regard to prior authorization and must comply with Medicare guidelines for post-stabilization care.⁴⁴⁵ Furthermore, a managed care organization must not prohibit or restrict a health care professional from advising a beneficiary about his or her health status, medical care or treatment, regardless of whether benefits for the care are provided under the contract if the health care professional is acting within the lawful scope of practice.⁴⁴⁶ Each managed care organization must also establish an internal grievance procedure

439. See Budget Act, *supra* note 380, § 4321.

440. *Id.*

441. See Budget Act, *supra* note 380, § 1395fff.

442. *Id.*

443. *Id.*

444. See *generally id.* 1395w-22.

445. *Id.*

446. *Id.* This provision does not require a managed care organization to provide coverage of a counseling or referral service if it objects to the service on moral or religious grounds and makes available information on its policies available to prospective enrollees and to enrollees within 90 days after the date the organization adopts a change in policy regarding such a counseling or referral service. *Id.*

under which an enrollee may challenge the denial or coverage of, or payment for, such assistance⁴⁴⁷ and the organization must provide the Secretary and the State with adequate assurances that the organization has the capacity to serve the expected enrollment in the service area.⁴⁴⁸

Other beneficiary protections include not holding enrollees liable for payments to providers or entitlements that are not made by the state in the event of entity insolvency⁴⁴⁹ and prohibiting a managed care organization from discriminating with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider's license or certification under applicable state law, solely on the basis of such license or certification.⁴⁵⁰

G. State Children's Health Insurance Program

The BBA amends the Social Security Act to add a new title, Title XXI, the State Children's Health Insurance Program.⁴⁵¹ The purpose of the children's program is to enable states to initiate and expand the provision of child health assistance to uninsured, low-income children.⁴⁵² The BBA authorizes providing states with \$24 billion through 2002 to expand coverage for children.⁴⁵³ Under the BBA, states may expand Medicaid or receive the funds in a grant or both. Under the grant approach, states would have to provide coverage equivalent to one of three benchmark packages: the standard Blue Cross/Blue Shield Preferred Provider Option offered under the Federal Employees Health Benefits Program, a health benefits plan that is generally available to state employees, and is the HMO with the largest commercial enrollment in the state.⁴⁵⁴ The coverage of the plan must include basic services⁴⁵⁵ and must have an aggregate actuarial value that is at least equivalent to one of the benchmark packages.⁴⁵⁶ No more than ten percent of a state's payments may be used for the total costs of other child health assistance for targeted low-income children, health services initiatives, outreach, and administrative costs.⁴⁵⁷

447. *Id.*

448. *Id.*

449. *Id.*

450. *Id.*

451. *See generally id.* § 1397aa.

452. *Id.*

453. *Id.*

454. *Id.* § 1397cc.

455. *Id.* These services include inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and X-ray services, and well-baby and well-child care, including age-appropriate immunizations. *Id.*

456. *Id.*

457. *Id.* § 1397ee.