Kansas Health Care Stabilization Fund

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Report to the

Health Care Stabilization Fund Oversight Committee

October 21, 2015

on behalf of the

Health Care Stabilization Fund Board of Governors

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Medical Professional Liability Experience
Fiscal Year 2015

By Rita Noll
Deputy Director and Chief Counsel

This report for the Board of Governors of the Health Care Stabilization Fund summarizes medical professional liability experience in Kansas during fiscal year 2015. (Fiscal year 2015 covers the period of time from July 1, 2014 through June 30, 2015.) The report is based on statistical data gathered by the Fund in administering the Health Care Provider Insurance Availability Act.

This report on medical malpractice litigation is based on all claims resolved in fiscal year 2015, which includes dismissals, settlements, and judgments. By far, the majority of medical malpractice cases are resolved by settlement rather than by jury trial.

Medical professional liability refers to a claim made against a health care provider for the rendering of or failure to render professional services (K.S.A. 40-3403). Health care provider is defined in K.S.A. 40-3401 to include physicians, chiropractors, podiatrists, registered nurse anesthetists, and certain medical care facilities. As of January 1, 2015, "health care provider" also includes nurse midwives, physician assistants, nursing facilities, assisted living facilities, and residential health care facilities.

It should be noted that dollar amounts will not necessarily correspond with the agency's accounting and budgeting documents because claims are not necessarily paid in the same fiscal year that the settlement was approved by the court, or the judgment was rendered by a jury. Data in this report reflects the status of cases at the end of the fiscal year. Data for prior years is for comparison purposes only, as case outcomes may have changed due to subsequent court proceedings.

MEDICAL PROFESSIONAL LIABILITY EXPERIENCE

A. Jury Verdicts

From HCSF data, 17 medical malpractice cases involving 18 Kansas health care providers were tried to juries during fiscal year 2015. An additional case was tried to the judge in small claims court. Sixteen cases were tried in Kansas courts and two cases involving Kansas health care providers were tried in Missouri courts. These trials were held in the following jurisdictions:

Sedgwick County	8
Johnson County	4
Jackson County, MO	2
Harvey County	1
Reno County	1
Shawnee County	1
Wyandotte County	1

Of the 18 cases tried, 13 resulted in defense verdicts and three cases ended in mistrial. Juries returned verdicts for plaintiffs in two cases as follows:

Case	Court	Verdict Amount	HCSF Amount
Plaintiff v. Professional Corporation	Jackson Co. Mo.	$459,429.02	$259,429.02
Plaintiff v. Doctor	Johnson Co.	$322,308.59	$322,308.59

*Both cases are on appeal

The following chart compares this year's experience to previous fiscal years:

Fiscal Year	Total Trials	Defense Verdict	Plaintiff Verdict	Split Verdict	Mistrials
2015	18	13	2		3
2014	27	23	3		1
2013	18	14	4		
2012	21	19	1		1
2011	19	16	2	1	
2010	32	21	7	1	3
2009	27	20	5	1	1
2008	34	25	4	1	4
2007	36	31	5		
2006	29	23	6		
2005	34	22	7	3	2
2004	28	23	3	2	
2003	27	23	3		1
2002	19	10	6		1
2001	21	13	6	2	2
2000	28	18	7	1	2

B. Settlements

Claims settled by the Fund. During FY 2015, 60 claims in 53 cases were settled involving HCSF monies. Settlement amounts incurred by the HCSF for the fiscal year totaled $24,322,582. These figures do not include settlement contributions by primary or excess insurance carriers. The settlement amounts are payments made, or to be made, by the HCSF in excess of primary coverage or on behalf of inactive health care providers.

Fiscal Year	Number of Claims/Cases	Fund Amount	Settlement Average
FY 2015	60/53	$24,322,582.00	$405,376
FY 2014	63/52	$24,005,914.00	$381,046
FY 2013	79/62	$27,610,000.00	$349,494
FY 2012	67/62	$21,431,000.00	$319,866
FY 2011	61/57	$17,518,727.54	$287,192
FY 2010	61/54	$19,745,200.00	$323,692
FY 2009	81/72	$23,867,283.72	$294,658
FY 2008	65/57	$17,352,500.00	$266,962
FY 2007	61/53	$20,929,250.00	$343,102
FY 2006	89/81	$24,917,984.00	$279,977
FY 2005	90/74	$23,544,658.00	$261,607
FY 2004	79/64	$18,905,505.00	$239,310
FY 2003	87/76	$17,483,778.00	$200,963
FY 2002	67/58	$16,173,742.00	$241,399
FY 2001	54/44	$15,592,748.80	$288,755
FY 2000	69/59	$20,071,607.50	$290,893
FY 1999	70/57	$18,344,368.15	$262,062
FY 1998	60/53	$11,461,345.13	$191,022
FY 1997	39/33	$12,448,978.83	$319,204
FY 1996	67/51	$21,808,406.14	$325,498
FY 1995	42/36	$15,344,749.98	$365,351
FY 1994	59/45	$19,526,821.53	$330,963
FY 1993	45/37	$18,239,093.06	$405,313
FY 1992	33/27	$ 7,890,119.83	$239,095
FY 1991	44/NA	$16,631,491.94	$377,988

Health Care Stabilization Fund individual claim settlement contributions during fiscal year 2015 range from a low of $48,750 to a high of $800,000. HCSF settlements fall within the following ranges and are compared to individual claim settlements in previous years:

	FY 15	FY14	FY13	FY12	FY11	FY10	FY09	FY08	FY07
$000-$9,999	0	0	0	0	0	0	2	0	0
$10,000-$49,999	1	5	2	7	6	5	12	6	6
$50,000-$99,999	8	10	5	10	12	11	10	12	7
$100,000-$499,999	27	24	52	32	29	29	37	34	27
$500,000-$800,000	24	24	20	18	14	16	20	13	21
Total Claims	60	63	79	67	61	61	81	65	61

Of the 60 claims, the Fund provided primary coverage for inactive health care providers in three claims. Also, the Fund "dropped down" to provide first-dollar coverage for a claim in which aggregate primary policy limits were reached. Primary insurance carriers tendered their policy limits to the Fund in 56 claims. Therefore, in addition to the $24,322,582 incurred by the Fund, primary insurers contributed $11,200,000 to these settlements. Further, five claims involved contribution from an insurer whose coverage was excess of Fund coverage. The total of these contributions was $14,400,000.

Total settlement amounts for claims involving Fund contribution are as follows:

FY	Primary Carriers	HCSF	Excess Carriers	Total
2015	$11,200,000.00	$24,322,582.00	$14,400,000.00	$49,922,582.00
2014	$10,135,000.00	$24,005,914.00	$ 3,875,000.00	$38,015,914.00
2013	$13,310,000.00	$27,610,000.00	$ 6,000,000.00	$46,920,000.00
2012	$10,800,000.00	$21,431,000.00	$ 5,083,500.00	$37,314,500.00
2011	$10,400,000.00	$17,518,727.54	$ 4,350,000.00	$32,268,727.54
2010	$ 9,400,000.00	$19,745,200.00	$14,972,500.00	$44,117,700.00
2009	$11,471,170.00	$23,867,283.72	$ 4,954,830.00	$40,293,283.72
2008	$10,612,500.00	$17,352,500.00	$ 2,425,000.00	$30,390,000.00
2007	$ 9,488,750.00	$20,929,250.00	$ 3,125,000.00	$33,543,000.00
2006	$14,580,000.00	$24,917,984.00	$ 5,089,425.00	$44,587,409.00
2005	$15,800,000.00	$23,544,658.00	$10,450,000.00	$49,794,658.00
2004	$12,600,000.00	$18,905,505.00	$ 8,550,000.00	$40,055,505.00
2003	$14,200,000.00	$17,483,778.00	$ 2,787,500.00	$34,471,278.00
2002	$11,400,000.00	$16,173,742.00	$ 2,680,000.00	$30,253,742.00
2001	$ 8,800,000.00	$15,592,748.80	$ 6,710,000.00	$31,102,748.80
2000	$12,515,000.00	$20,071,607.50	$ 2,465,000.00	$35,051,607.50

Claims settled by primary carriers. In addition to the settlements discussed above, the HCSF was notified that primary insurance carriers settled an additional 89 claims in 80 cases. The total amount of these reported settlements is $7,268,626. These figures compare to previous fiscal years as follows:

Fiscal Year	Settlement Reported Claims/Cases	Amount Paid by Primary Insurance Carriers
2015	89/80	$ 7,268,626.00
2014	97/86	$ 8,909,740.00
2013	88/76	$ 6,664,000.00
2012	98/81	$ 6,603,521.00
2011	99/83	$ 7,865,915.00
2010	110/92	$ 8,958,622.00
2009	90/80	$ 7,182,241.00
2008	104/88	$ 8,486,032.00
2007	167/146	$10,870,339.00
2006	110/98	$ 8,545,218.00
2005	103/88	$ 8,058,894.00
2004	99/85	$ 6,978,801.00
2003	122/99	$ 9,087,872.00
2002	141/124	$10,789,299.00
2001	109/88	$ 8,124,459.00
2000	116/102	$ 8,390,869.00

C. HCSF Total Settlements and Verdict Amounts

During fiscal year 2015 the HCSF incurred $24,322,582 in 60 claim settlements and became liable for $581,737.61 for two claims as a result of jury verdicts for a total 62 claims. The following figures show total Fund settlements and awards since the inception of the Health Care Stabilization Fund.

Fiscal Year	Total Claims	Settlements & Jury Awards	Average Per Claim
FY 2015	62	$24,904,319.61	$401,682.57
FY 2014	66	25,559,409.00	387,263.77
FY 2013	79	29,382,484.69	371,930.19
FY 2012	67	21,431,000.00	319,965.67
FY 2011	63	19,118,727.54	303,471.87
FY 2010	65	20,970,021.10	322,615.71
FY 2009	85	25,505,208.67	300,061.28
FY 2008	68	19,085,004.00	280,661.82
FY 2007	64	22,589,655.27	352,963.36
FY 2006	90	25,017,984.00	277,977.60
FY 2005	97	26,119,569.91	269,273.30
FY 2004	81	19,055,505.00	235,253.15
FY 2003	90	18,295,320.32	203,281.34
FY 2002	71	17,467,033.19	246,014.55
FY 2001	58	17,114,748.80	295,081.86
FY 2000	73	20,868,192.91	285,865.66
FY 1999	71	21,344,368.15	300,624.90
FY 1998	66	12,834,705.13	194,465.23
FY 1997	41	13,653,618.34	333,015.08
FY 1996	70	23,258,406.14	332,262.94
FY 1995	45	17,023,882.17	378,308.49
FY 1994	65	21,194,765.96	326,073.32
FY 1993	48	24,614,093.06	492,281.86
FY 1992	35	8,824,834.14	252,138.11
FY 1991	49	19,666,797.32	401,363.21
FY 1990	48	13,627,222.20	283,700.46
FY 1989	58	18,713,543.00	315,750.00
FY 1988	51	13,402,756.00	262,799.00
FY 1987	47	13,296,808.00	282,910.00
FY 1986	42	11,492,857.00	273,639.00
FY 1985	41	15,152,042.00	369,562.00
FY 1984	34	9,538,741.00	280,551.00
FY 1983	25	6,522,369.00	260,894.00
FY 1982	24	3,060,126.00	127,505.00
FY 1981	8	1,760,645.00	220,080.00
FY 1980	0	0.00	-
FY 1979	3	203,601.00	67,867.00
FY 1978	0	0.00	-
FY 1977	1	137,500.00	137,500.00

D. New Cases by Fiscal Year

The Health Care Stabilization Fund was notified of 235 new cases during fiscal year 2015. The following chart lists the number of new cases opened in each fiscal year since the Fund was established:

Fiscal Year	Number of Cases
2015	235
2014	268
2013	229
2012	260
2011	267
2010	290
2009	310
2008	329
2007	304
2006	457
2005	336
2004	368
2003	392
2002	361
2001	341
2000	294
1999	319
1998	293
1997	318
1996	296
1995	326
1994	247
1993	263
1992	245
1991	230
1990	205
1989	251
1988	285
1987	320
1986	276
1985	245
1984	175
1983	153
1982	124
1981	98
1980	87
1979	50
1978	19
1977	2

University of Kansas Foundations and Faculty; Residents
Self-Insurance Programs/Primary Coverage
Reimbursement to the Health Care Stabilization Fund

I. KU Foundations and Faculty

Foundation Self-Insurance Program Costs

FY 2015	FY 2014	FY 2013	
$1,006,000.00	$1,530,000.00	$ 975,000.00	Settlement Amounts
$ 911,190.41	$ 645,457.87	$ 562,668.29	Attorney Fees and Expenses
$1,917,190.41	$2,175,457.87	$1,537,668.29	Totals

Reimbursable Amounts

FY 2015	FY 2014	FY 2013	
$ 500,000.00	$ 500,000.00	$ 500,000.00	Reimbursement Private Practice Reserve
$1,417,190.41	$1,675,457.87	$1,037,668.29	Reimbursement State General Fund
$1,917,190.41	$2,175,457.87	$1,537,668.29	Totals

II. KU and WCGME Residents

Residents Self-Insurance Program Costs

FY 2015	FY 2014	FY 2013	
$ 40,000.00	0	0	Settlements, WCGME Residents
0	0	0	Settlements, KU Residents
$496,271.45	$539,702.75	$628,820.35	Fees & Expenses, WCGME Residents
$154,328.09	$259,661.06	$305,874.74	Fees & Expenses, KU Residents
$690,599.54	$799,363.81	$934,695.09	Totals

Reimbursable Amounts

FY 2015	FY 2014	FY 2013	
$536,271.45	$539,702.75	$628,820.35	WCGME Reimbursement-General Fund
$154,328.09	$259,661.06	$305,874.74	KU Reimbursement-General Fund
$690,599.54	$799,363.81	$934,695.09	Totals - State General Fund

III. Expenditures by Fiscal Year

Fiscal Year	Foundations and Faculty*	KU and WCGME Residents**
2015	$ 1,917,190.41	$ 690,599.54
2014	2,175,457.87	799,363.81
2013	1,537,668.29	934,695.09
2012	1,759,733.60	1,201,108.99
2011	1,184,218.79	455,621.25
2010	1,445,658.21	1,201,718.01
2009	2,693,099.94	812,492.66
2008	966,327.58	648,269.80
2007	2,037,227.63	1,194,968.11
2006	1,407,837.70	871,719.27
2005	1,706,763.57	1,749,032.25
2004	1,825,116.29	2,787,112.99
2003	1,113,326.84	1,418,927.85
2002	583,566.19	723,834.54
2001	1,540,133.41	953,304.62
2000	691,253.39	735,633.12
1999	1,371,640.73	645,997.65
1998	1,018,435.78	1,072,324.05
1997	1,111,787.72	999,388.16
1996	4,003,062.51	1,331,521.75
1995	255,117.85	534,124.84
1994	1,959,284.79	574,758.65
1993	1,453,444.21	650,033.67
1992	645,670.10	810,703.77
1991	435,540.69	458,561.65
1990	261,035.55	120,796.12

*Foundations and Faculty:
Amounts up to $500,000 are reimbursed from the Private Practice Reserve Fund.
Amounts over $500,000 are reimbursed from the State General Fund.
FY 10, FY 11, FY 12, FY 13, HCSF received reimbursement only from the Private Practice Reserve Fund.

**KU and WCGME Residents:
All amounts are reimbursed from the State General Fund.
FY 10, FY 11, FY 12, FY 13, HCSF received no reimbursement.

The total accrued amounts to be received from the State General Fund were $7,720,422.23. The HCSF received $1,544,084.43 reimbursement in July 2013, $1,544,084.45 in July 2014, and $1,544,084.45 in July 2015. The remaining reimbursement receiveables are $3,088,168.90 (40% of total).

IV. Monies Paid by the Health Care Stabilization Fund for Excess Coverage Claims

	FY 15	FY 14	FY 13	FY 12	FY 11
WCGME Residents	0	0	0	0	0
K.U. Residents	0	0	0	$150,000	0
Faculty, Foundations	$1,013,000	$2,975,000	$1,267,500	$600,000	$195,000
Total	$1,013,000	$2,975,000	$1,267,500	$750,000	$195,000

IN THE SUPREME COURT OF THE STATE OF KANSAS

No. 108,607

KANSAS BUILDING INDUSTRY WORKERS COMPENSATION FUND, *et al.*,
Appellants,

v.

STATE OF KANSAS and KENT OLSON,
DIRECTOR OF DIVISION OF ACCOUNTS AND REPORTS,
DEPARTMENT OF ADMINISTRATION,
Appellees.

SYLLABUS BY THE COURT

1.

Because a claim that an issue is a nonjusticiable political question presents a question of law, appellate review of justiciability is plenary.

2.

Prominent on the surface of any case held to involve a political question is found (1) a textually demonstrable constitutional commitment of the issue to a coordinate political department; or (2) a lack of judicially discoverable and manageable standards for resolving it; or (3) the impossibility of deciding without an initial policy determination of a kind clearly for nonjudicial discretion; or (4) the impossibility of a court's undertaking independent resolution without expressing lack of the respect due coordinate branches of government; or (5) an unusual need for unquestioning adherence to a political decision already made; or (6) the potentiality of embarrassment from multifarious pronouncements by various departments on one question. Unless one of these formulations is inextricable from the case presented to the court, it should not dismiss the case for nonjusticiability on the ground of a political question's presence.

3.

Not all moneys deposited into the State Treasury represent public moneys subject to unfettered general appropriation by the legislature. "[M]oneys received or to be used under constitutional or statutory provisions or under the terms of a gift or payment for a particular and specific purpose are to be kept as separate funds [within the State Treasury] and shall not be placed in the [State General Fund]. . . ." K.S.A. 75-3036.

4.

Under its police power, the State may reimburse itself for the costs of otherwise valid regulation and supervision by charging the necessary expenses to the businesses or persons regulated. A statute, however, exceeds the valid exercise of the police power if it extracts more than adequate remuneration, *i.e.*, if the assessment so exceeds the cost of regulation that it is apparent the legislature is using it as a general revenue raising measure. The claim that the legislature has invalidly exercised its police power is not a nonjusticiable political question.

5.

The existence of jurisdiction and standing are both questions of law over which an appellate court's scope of review is unlimited. When a district court grants a motion to dismiss based on a lack of standing, the appellate court accepts the facts alleged in the petition as true, and if those facts demonstrate that the appellants have standing to sue, the decision of the district court must be reversed.

6.

Standing is a party's right to make a legal claim or seek judicial enforcement of a duty or right. While standing is a requirement for case-or-controversy, *i.e.*, justiciability, it is also a component of subject matter jurisdiction that may be raised at any time. A

justiciable controversy has definite and concrete issues between the parties and adverse legal interests that are immediate, real, and amenable to conclusive relief.

7.

Under the traditional test for standing in Kansas, a person must demonstrate both that (1) he or she has suffered a cognizable injury; and (2) there is a causal connection between the injury and the challenged conduct. Despite our citation to the federal test for standing in some earlier cases, this court has not abandoned the traditional Kansas test in favor of the federal model.

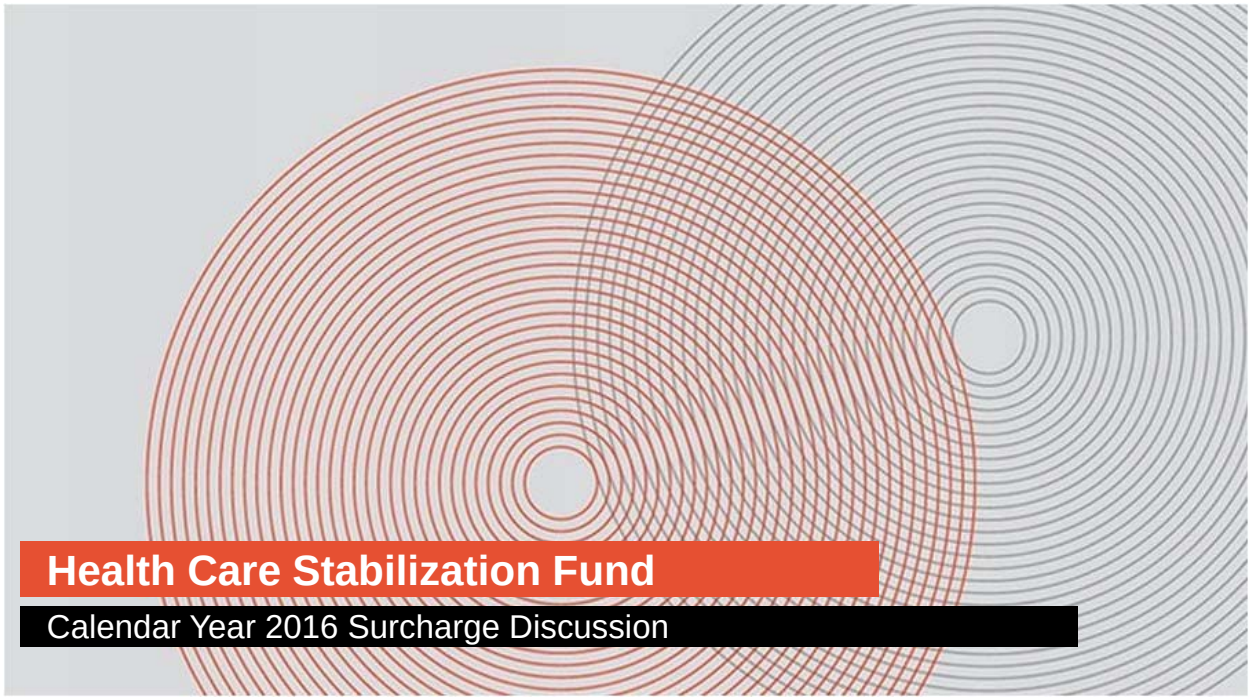
8.

Where the State transfers moneys into the State General Fund from a fee fund statutorily established for a specific purpose, the persons or entities subject to assessment to replenish the fee fund have a colorable claim for a cognizable injury that is fairly traceable to the State's action, thereby giving those assessed or assessable persons or entities standing to challenge the State's transfer of moneys.

9.

An association has standing to sue on behalf of its members when: (1) the members have standing to sue individually; (2) the interests the association seeks to protect are germane to the organization's purpose; and (3) neither the claim asserted nor the relief requested requires participation of individual members.

Review of the judgment of the Court of Appeals in 49 Kan. App. 2d 354, 310 P.3d 404 (2013). Appeal from Shawnee District Court; FRANKLIN R. THEIS, judge. Opinion filed August 28, 2015. Judgment of the Court of Appeals reversing the district court is affirmed. Judgment of the district court is reversed and remanded with directions.



Health Care Stabilization Fund

Calendar Year 2016 Surcharge Discussion

A presentation to the Health Care Stabilization Fund Oversight Committee
by Russel L. Sutter

October 21, 2015

This document was designed for discussion purposes only.
It is incomplete, and not intended to be used, without the accompanying oral presentation and discussion.

TOWERS WATSON

Table of Contents

This presentation will address the following topics:

- Our projections of unassigned reserves at June 2015 and June 2016
- Rate level indications for CY16 (January 1, 2016 – December 31, 2016)
- Rating by Years of Compliance
- The experience by provider class
- A history of surcharge rate changes

Questions are welcome throughout the presentation

This presentation is based on our review of Fund data as of April 30, 2015 and is an addendum to our report dated September 14, 2015. As such, the **Distribution and Use** and **Reliances and Limitations** sections of that report apply to this presentation

Recent Fund Changes

There have been several law changes affecting the Fund over the last two years, including:

- Expanding the definition of Health Care Provider to include additional practitioners/facilities
- Increases in the caps on non-economic damages in Kansas
- Restoring caps on non-economic damages in Missouri
- Eliminating the five-year compliance requirement for tail coverage eligibility
- Increasing the Fund coverage for inactive providers by the minimum basic coverage required (i.e., for most providers, from $800,000/$2,400,000 to $1,000,000/$3,000,000)

In addition, Fund surcharge rates are now being established on a calendar year basis instead of a fiscal year basis

Conclusions

Our forecasts of the Fund's financial positions at June 30, 2015 and June 30, 2016 are as follows (in $millions)

	June 30, 2015	June 30, 2016
Assets	$271.31	$278.22
Liabilities	223.03	230.02
Unassigned Reserves	$ 48.28	$ 48.20

Based on our analysis, the Fund will need to raise its surcharge rates by 2.5% for CY16 in order to maintain its unassigned reserves at the expected year-end CY15 level

Conclusions (cont.)

The forecasts of unassigned reserves assume

- Changes in surcharge rates for CY16 as described on page 11
- $26.2 million in surcharge revenue in the July 1, 2015 – June 30, 2016 period (FY16)
- A 2.0% interest rate for estimating the tail liabilities on a present value basis
- A 3.70% yield on Fund assets for estimating investment income
- Full reimbursement for KU/WCGME claims
- No change in current Kansas tort law or Fund law

We suggested the Board consider a modest increase in rates for CY16, perhaps by starting to lessen the differences in rates by Years of Compliance

Liabilities at June 30, 2015

The split of the Fund's liabilities at June 30, 2015 is as follows (in $millions)

Active Providers – Losses	$ 81.8
Active Providers – Expenses	15.4
Inactive Providers – Known at 6/30/15	8.3
Inactive Providers – Tail	103.5
Future Payments	14.4
Claims Handling	7.1
Other	2.1
Subtotal – Gross Liabilities	$232.7
Reimbursements	-9.7
Total Net Liabilities	$223.0

Rate Level Indications

The Fund's rate level indications for CY16 are shown below; assumes a break-even target

CY16 Item	Amount ($000s)	Comments
1. Payments	$29,977	Net of Reimbursement
2. Change in Liabilities	4,460	
3. Administrative Expenses	1,720	Based on FY14 and YTD FY15
4. Plan and KDHE	200	Assumes no Plan transfer
5. Total CY16 Costs (1) + (2) + (3) + (4)	$36,357	
6. Investment Income	9,974	3.70% on average assets
7. Surcharge Needed for Break-Even (5) – (6)	$26,382	
8. Projected Surcharge Revenue	25,734	At CY15 rates
9. Rate Level Indications (7) / (8) – 1.00	+2.5%	

Findings – Rating by Year of Compliance

The table below shows current Fund surcharge rates for Class 2 for $800,000/$2,400,000 coverage

Years of Compliance (YOC)				
1	2	3	4	5+
$340	$873	$1,376	$1,522	$1,699

With the passage of HB2516 in 2014, the Fund now provides tail coverage at no additional cost to all providers upon becoming inactive

- Effectively converts Fund coverage from claims-made to occurrence

Consequently, the incremental cost of providing coverage to providers with less than 5 YOC is no longer lower than the cost of providing coverage to providers with YOC 5+

- YOC 1-4 providers are, in a relative sense, being undercharged
- We suggested to the Board that they consider lessening the difference in rates by YOC

Findings – Indications by Provider Class

Our analysis of experience by Fund class continues to show differences in relative loss experience among classes

Relative Rate Change Indicated		
Decrease > 10%	**Increase < 10% or Decrease < 10%**	**Increase > 10%**
Class 8 (-24%)	Class 1 (-9%)	Class 5 (+10%)
Class 10	Class 9	Class 7
Class 13	Class 20	Class 17
Class 3	Class 19	Class 11
Class 16	Class 2	Class 15 (+49%)
Class 18	Class 4	
Class 14 (-12%)	Class 12	
	Class 6 (+4%)	

Page 12 has further details on class definitions

History of Surcharge Rate Changes

The table below shows changes in surcharge rates since 2004. Column (2) also includes the impact of the increases in the MO surcharge in FY2008 and FY2014

Fiscal Year	Overall Change	Classes 1-14 Range of Rate Changes		Classes 15-21 % Basic Coverage Premium*
		Low	High	
(1)	(2)	(3)	(4)	(5)
2004	-2%	0%		35%
2005	-2%	0%		32%
2006	+15%	+5%	+25%	35%
2007	+6%	0%	+15%	35%
2008	+1%	0%	+5%	35%
2009	+5%	0%	+6%	37%
2010	+5%	0%	+7%	40%
2011	0%	0%	0%	40%
2012	0%	0%	0%	40%
2013	-5%	-10%	0%	40%
2014	-5%	-20%	-5%	38%**
2015	0%	0%	0%	38%**

*For $800,000/$2,400,000 coverage
**40% for Class 15

CY16 Surcharge Rates

We offered the following for the Board to consider in establishing Fund rates for CY16

Option	Specific Changes	Overall Impact
1	No Changes	0.0%
2	Classes 1-14: +2.5% Class 15: From 40% to 41%% Classes 16-24: From 38% to 39%	+2.5%
3	Classes 1-14: Move YOC 1 to YOC 2 Classes 15-24: No changes	+2.7%

CY16 Surcharge Rates (cont.)

The Board of Governors decided on the surcharge rate changes below. We estimate the overall impact of these changes to be a 1.6% increase in surcharge revenue

1. Providers with 5+ Years of Compliance

Class 11	+5.0%
All Other Classes	No Change

2. Providers with < 5 Years of Compliance – Classes 1-14

	Relativity to YOC5	
	CY15	CY16
YOC 1	20%	25%
YOC 2	51%	55%
YOC 3	81%	85%
YOC 4	90%	95%

3. Providers with < 5 Years of Compliance – Classes 15-24

	% Basic Coverage Premium			
	CY15		CY16	
Coverage Limit	Class 15	Class 16-24	Class 15	Class 16-24
$100,000/$300,000	23.0%	22.0%	24.0%	23.0%
$300,000/$900,000	35.0%	33.0%	37.0%	35.0%
$800,000/$2,400,000	40.0%	38.0%	42.0%	40.0%

Class Definitions, Distributions and Rates

		FY14 # Providers	FY15 Rate*
Class 1	Physicians, No Surgery. Includes dermatology, pathology, psychiatry	670	$ 753
Class 2	Physicians, No Surgery	3,241	1,699
Class 3	Physicians, Minor Surgery	1,603	2,339
Class 4	Family Practitioners, including minor surgery and OB	151	2,616
Class 5	Surgery Specialty – Includes urology, colon/rectal, GP with major	254	2,861
Class 6	Surgery Specialty – Includes ER (no major), ENT	527	3,322
Class 7	Anesthesiology	378	2,482
Class 8	Surgery Specialty – Includes general, plastic, ER with major	461	6,377
Class 9	Surgery Specialty – Includes cardiovascular, orthopedic, traumatic	360	6,399
Class 10	Surgery Specialty – Includes OB/GYN	259	9,379
Class 11	Surgery Specialty – Neurosurgery	56	15,724
Class 12	Chiropractors	1,033	481
Class 13	Registered Nurse Anesthetists	775	827
Class 14	Podiatrists	103	1,833
Class 15	Availability Plan insureds	361	40%
Class 16	Professional corporations, partnerships	1,119	38%
Class 17	Medical care facilities	188	38%
Class 18	Mental health centers	24	38%
Class 19	Psychiatric hospitals	1	38%
Class 20	Residency training program	800	38%
Class 21	Physician Assistants	NA	38%
Class 22	Nurse Midwives	NA	38%
Class 23	Assisted Living and Residential Health Care Facilities	NA	38%
Class 24	Nursing Facilities	NA	38%
Class 30	Other	5	38%
		12,369	

*$800,000/$2,400,000 Fund coverage, 5+ years of Fund compliance

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FISCAL YEAR 2015 ANNUAL REPORT

Prepared by C. Wheelen, Executive Director
Adopted by the Board of Governors September 10, 2015

The following information is reported on behalf of the Health Care Stabilization Fund Board of Governors in accordance with K.S.A. 40-3403(b)(1)(C). This report is for the fiscal year that ended June 30, 2015.

1. Net premium surcharge revenue collections amounted to $27,829,034.

2. The lowest surcharge rate for a health care professional was $50 for a chiropractor in his or her first year of Kansas practice who selected the lowest coverage option ($100,000 per claim with $300,000 annual aggregate).

3. The highest surcharge rate for a health care professional was $15,724 for a neurosurgeon with five or more years of Health Care Stabilization Fund liability exposure who selected the highest coverage option ($800,000 per claim with $2.4 million annual aggregate). If a Kansas resident neurosurgeon was also licensed to practice in Missouri, the 30% Missouri modification factor would result in a total premium surcharge of $20,441.

4. There were 18 medical professional liability cases involving 19 health care providers that went to trial. Of these 18 cases against health care providers, three resulted in mistrials. Two of the cases resulted in verdicts for the plaintiff and both of those verdicts were appealed. The other 13 cases resulted in verdicts for the defense.

5. During the past fiscal year 585 open claims were closed. Of those claims, only 62 claims (10.6%) resulted in Fund obligations. Fifty three cases involving 60 claims were settled, which resulted in Health Care Stabilization Fund obligations amounting to $24,322,582. The average Stabilization Fund compensation per settlement was $405,376, a 6.4% increase compared to FY2014. These amounts are in addition to compensation paid by primary insurers (typically $200,000 per claim).

6. Because of periodic payment of compensation and other cash-flow characteristics, the amounts reported above in items four and five were not necessarily paid during FY2015. The total amount attributable to claims paid during the fiscal year amounted to $26,654,184.

7. The balance sheet as of June 30, 2015 accepted by the HCSF Board of Governors indicates assets amounting to $273,581,184 and liabilities amounting to $231,467,025.

Overview

The Health Care Provider Insurance Availability Act was passed in 1976 at a time in Kansas history when many physicians and other health care providers could not purchase affordable professional liability insurance. Oftentimes, insurers were not willing to provide adequate coverage limits and in some cases physicians could not obtain liability insurance at all.

The original Act contained three principal features that have always remained intact. Those features are: (1) a requirement that all health care providers, as defined in K.S.A. 40-3401, maintain professional liability insurance coverage as a condition of active licensure, (2) creation of a joint underwriting association, the "Health Care Provider Insurance Availability Plan," to provide professional liability coverage for those health care providers who cannot purchase coverage in the commercial insurance market, and (3) creation of the Health Care Stabilization Fund to (a) provide supplemental coverage above the primary coverage purchased by health care providers and (b) to serve as reinsurer of the Availability Plan. The original Act delegated responsibility for administration of the Stabilization Fund to the Kansas Insurance Commissioner. In 1994 the Legislature transferred responsibility and authority to the HCSF Board of Governors. Board members are appointed by the Insurance Commissioner.

For a more detailed history of the Health Care Provider Insurance Availability Act, please see the addendum to this report.

Significant Recent Events

In October 2012 the Kansas Supreme Court announced that it upheld the constitutionality of a Kansas statute that limits the amount a plaintiff can recover for noneconomic damages in a personal injury lawsuit. The media release issued by the Court's Education-Information Officer stated, "Our court has long recognized that the legislature may modify the common law in limited circumstances, as long as the legislature provides an adequate substitute remedy or quid pro quo." The media release went on to say, "The decision relied in part on the statutory cap's relationship to the Health Care Provider Insurance Availability Act. That Act requires that all health care providers maintain liability insurance with designated levels of excess coverage."

The Miller v. Johnson decision resulted in renewed interest in the Availability Act. A number of organizations representing health care professionals or health care facilities inquired about the possibility of becoming defined health care providers under the Act. We provided information to those organizations, but our Board of Governors remained neutral regarding whether those new categories of professionals and facilities should be added to the Board of Governor's responsibilities. In view of the likelihood that a bill

would be introduced, we drafted some technical amendments to update the Health Care Provider Insurance Availability Act as well as two significant tail coverage amendments.

House Bill 2516 was introduced early in the 2014 Session at the request of the Kansas Medical Society. It contained the technical amendments we drafted as well as the amendments to improve HCSF tail coverage for Kansas health care providers. One of the major features of 2014 HB2516 was the addition of two professions and three types of adult care homes to the Availability Act definition of health care provider. These amendments were requested by associations representing the two professions and the adult care industry. The effective date of these definitions was deliberately delayed until January 1, 2015 to give nurse midwives, physician assistants, assisted living facilities, nursing homes, and residential health care facilities adequate time to make any changes in their insurance coverage that might be needed in order to comply with the requirements stipulated in the Availability Act. The bill was passed unanimously in both the House and the Senate.

House Bill 2516 repealed the five-year compliance requirement for HCSF tail coverage. In addition, when a health care provider becomes inactive, the amount of tail coverage is equal to the level of HCSF coverage on the date of the incident that resulted in a claim, plus the minimum coverage required for primary insurance (currently $200,000 per claim subject to not less than $600,000 annual aggregate coverage). This means that most health care providers will have $1.0 million per claim tail coverage immediately upon retiring or otherwise becoming inactive at no additional cost to the health care provider. This improvement benefits patients as well as health care providers. It assures there will always be a reliable remedy available in the event of an unfortunate medical outcome. Of course this resulted in an immediate increase in HCSF liabilities and thereby reduced our unassigned reserves.

Another bill enacted in 2014 increased the limit on recovery of noneconomic damages in personal injury actions. Senate Bill 311 incrementally increased the cap on noneconomic damages as follows for causes of action accruing on or after the specified July 1 date:

- As of July 1, 2014 = $300,000
- As of July 1, 2018 = $325,000
- As of July 1, 2022 = $350,000

In other words, there was an immediate 20% increase in the amount that may be awarded by a court for pain and suffering or other noneconomic damages, and over a period of eight years, there will be a 40% increase in the cap on noneconomic damages. Obviously this legislation increased our liabilities and will continue to increase our liabilities in the future.

Implementation Progress

Last year at this time we reported to you that there were some minor technical problems that arose primarily because of differences among the Nurse Practice Act, the Physician Assistant Licensure Act, and the Healing Arts Act. Provisions in the Availability Act were previously designed to be compatible with the Healing Arts Act and the hospital licensing laws. Adding the five new categories required some technical adjustments. Two bills were passed in the 2015 Session of the Legislature that addressed most of those concerns.

Unfortunately there were some adult care homes that failed to take the necessary steps to comply with the professional liability insurance requirements under the Availability Act. We made a diligent effort to communicate the importance of compliance and we offered assistance, but eventually it became necessary to file a report in accordance with K.S.A. 40-3416. The pertinent part of that section of the Availability Act says, "When the board of governors is informed or reasonably suspects that a health care provider licensed to render professional services is in violation of K.S.A. 40-3402, and amendments thereto, such board shall report the suspected violation to the state agency which licenses, registers or certifies such health care provider. Upon receipt of such report or other evidence of a violation of K.S.A. 40-3402, and amendments thereto, the state agency shall make such investigation as it deems necessary and take such other official action as deemed appropriate."

On July 31, 2015 we wrote to the Commissioner of Survey, Certification and Credentialing at the Kansas Department for Aging and Disability Services. In our letter we identified sixteen health care facilities that were not in compliance at that time. The Commissioner communicated with the administrators of the non-compliant health care facilities and the list was quickly reduced to seven. In early October we communicated with the Interim Commissioner of Survey, Certification and Credentialing who immediately followed up and the list of non-compliant facilities was then reduced to four.

Apparently there are a few administrators of health care facilities who think that compliance with the Health Care Provider Insurance Availability Act is voluntary. Compliance is not optional. For that reason, we have begun drafting legislation that would impose a daily fine on a non-compliant health care facility for each day of non-compliance. Our Board of Governors has appointed a committee to collaborate with the Department for Aging if it becomes necessary to pursue legislation.

With those few exceptions described above, implementation of 2014 HB2516 has been accomplished. We sincerely appreciate the support we have received from the Kansas Board of Healing Arts, the Kansas State Board of Nursing, and the Kansas Department for Aging and Disability Services.

The Medical Professional Liability Insurance Market

Following passage of 2014 HB2516 we received numerous telephone calls and emails from insurance agents asking if their clients could continue to obtain their liability insurance from non-admitted insurance companies. There seemed to be a particular interest in renewing policies that had been issued by excess and surplus lines insurance carriers. They argued that there were too few admitted insurance companies offering coverage to adult care facilities. Our answer was no; the Health Care Provider Insurance Availability Act requires that Kansas resident health care providers purchase their basic professional liability insurance from companies that are approved by the Kansas Insurance Commissioner.

Last year we predicted that because of the requirement described above there would be additional insurance companies applying for admission to do business in Kansas. That prediction was correct. We concluded fiscal year 2014 with 26 approved companies or risk retention groups offering professional liability insurance coverage to Kansas health care providers. By the end of fiscal year 2015 that number had increased to 37 companies and RRGs. In addition, we are aware of one captive insurance company that applied for and received approval to insure Kansas adult care homes.

We believe the Health Care Provider Insurance Availability Act creates a favorable environment for responsible professional liability insurance companies. Their liability never exceeds $200,000 per claim and they can engage in selective underwriting practices. They can reject questionable risks by referring them to the Availability Plan. Unlike joint underwriting associations in other states, the Kansas Availability Plan is reinsured by the Stabilization Fund instead of assessments on commercial insurers. In other words, health care providers rather than their insurers guaranty the solvency of the Plan. Furthermore, the fact that Kansas has a history of tort reforms, makes Kansas a good environment for insurance business in general.

Actuarial Integrity and Fiscal Discipline

In the past we have been asked why the Kansas Health Care Stabilization Fund is more successful than similar funds in other states. There are two principal reasons: (1) the HCSF Board of Governors has made an extraordinary effort to maintain the actuarial integrity of the Fund, and (2) the Legislature has maintained fiscal discipline by avoiding the temptation to divert HCSF revenues.

There have been occasions when the HCSF was among numerous special revenue funds identified for so-called “sweeps,” but in the final analysis the Legislature honored the statutory doctrine that “The fund shall be held in trust in the state treasury.” [K.S.A. 40-3403(a)] The only time that money has been taken from the Fund was when the Secretary

of Administration used statutory allotment authority to withhold approximately $2.9 million.

The HCSF Oversight Committee has consistently supported the principle that the HCSF should be used exclusively for its statutory purposes. On a number of occasions we have referred to your reports and recommendations during legislative hearings, particularly in the Senate Ways and Means Subcommittee and the House Budget Committee. Now it appears that your admonitions are supported by a recent Kansas Supreme Court decision in the case of *Kansas Building Industry Workers Compensation Fund, et al. v. State of Kansas*.

The Building Industry case questioned the constitutionality of transferring revenue from special revenue funds to the state general fund. These special revenue funds were created for specific statutory purposes and funded by assessments paid by particular licensees or businesses. There are numerous important components in the decision, but most important is the conclusion that it is unconstitutional to transfer money from special revenue funds to bolster the state general fund balance.

We recognize that the HCSF Board of Governors is an agency of the State of Kansas and the HCSF is a state fund. The Legislature can amend the Health Care Provider Insurance Availability Act in any session of the Legislature. We are nonetheless encouraged by the guidance provided as a result of the Building Industry decision. That decision is consistent with positions expressed by the Oversight Committee and it supports our fiduciary duty to Kansas health care providers.

Conclusion

The Health Care Provider Insurance Availability Act is a successful public-private partnership that has accomplished legislative intent. It provides stability in the commercial medical professional liability insurance market and guarantees that health care providers always have access to the liability coverage they need. Equally important, it assures that in the event that a patient is injured because of an unfortunate medical outcome, he or she always has a reliable remedy available to them.

The Health Care Stabilization Fund is actuarially sound; its liabilities are funded and there is a reasonable margin of unassigned reserves. Despite the resistance of a few of the new health care providers, the changes enacted by the Legislature last year have been successfully implemented. As a result of technical amendments enacted by the Legislature this year, we are unaware of any need to amend the Health Care Provider Insurance Availability Act in the 2016 Session.

Addendum

The Health Care Provider Insurance Availability Act was passed in 1976 at a time in Kansas history when many physicians and other health care providers could not purchase affordable professional liability insurance. In some cases, insurers were not willing to provide adequate coverage limits and some physicians could not obtain liability insurance at all.

The original Act contained three principal features that have always remained intact. Those features are: (1) a requirement that all health care providers, as defined in K.S.A. 40-3401, maintain professional liability insurance coverage as a condition of licensure, (2) creation of a joint underwriting association, the "Health Care Provider Insurance Availability Plan," to provide professional liability coverage for those health care providers who cannot purchase coverage in the commercial insurance market, and (3) creation of the Health Care Stabilization Fund to (a) provide supplemental coverage above the primary coverage purchased by health care providers and (b) to serve as reinsurer of the Availability Plan. The original Act delegated responsibility for premium surcharge collections and administering the Stabilization Fund to the Kansas Insurance Commissioner.

Unlike commercial insurance policies, the original HCSF provided unlimited coverage. In other words, a doctor or hospital could be sued for any amount, and there was no limit on the amount a jury could award to a plaintiff, or the amount that could be agreed to in a settlement. Yet there was a statutory limit on the reserves that could be maintained in the Fund. In a few years, the accrued liabilities of the HCSF exceeded the $10 million cap on reserves for payment of claims and expenses.

The 1984 Legislature attempted to correct problems inherent in the original Act. The law was changed to limit the Fund's liability to $3 million per claim and $6 million annual aggregate liability for any one health care provider. Another major amendment removed the statutory limit on the Fund's balance and prescribed that the premium surcharges should be based on estimated liabilities. In other words, the Legislature decided the HCSF should be actuarially sound.

During the second half of the eighties decade there was significant pressure on the Legislature to reform the rules of civil litigation. The controversy surrounding tort reform focused a great deal of attention on the HCSF because there were those who blamed the Fund for the cost of medical liability coverage.

Significant amendments to the Health Care Provider Insurance Availability Act were initiated as the result of a 1988 interim study by a special committee of the Legislature. The interim committee report was published in the January 18, 1989 Journal of the House and concluded by saying, "The Committee agreed with the near unanimous position of the conferees that the Health Care Stabilization Fund should be phased out and recommends that the 1989 Legislature enact legislation to abolish the Fund."

The 1988 interim committee reported that there were insufficient reserves to afford the accrued HCSF liabilities and recommended that, "the providers develop a plan by January 1, 1990, for paying the unfunded liabilities of the Fund and submit that plan to the Insurance Commissioner for his approval."

The 1989 Legislature passed Senate Bill 18 which amended several features of the Availability Act. A major change in the Act created three different options allowing health care providers to choose one of three levels of HCSF coverage to supplement the basic $200,000 per claim coverage they are required to purchase from a commercial insurer or the Availability Plan. The three options are $100,000 per claim, $300,000 per claim, or $800,000 per claim. Annual aggregate limits are three times the per claim coverage.

Another significant change pertained to "tail" coverage. Until 1989, tail coverage was immediately provided when a health care provider became inactive. In other words, statutory HCSF coverage was similar to an occurrence type insurance policy. Any professional liability claims that arose after a health care provider had retired or otherwise discontinued his or her Kansas practice were still covered by the HCSF.

Because of concerns about the additional Fund liabilities attributable to tail coverage, the Legislature imposed a new requirement that health care providers must be in compliance, that is, pay surcharges into the Fund for at least five years in order to receive tail coverage. Provision was made such that any health care provider who lacked five years compliance could make additional payment to the Fund for the tail coverage. The payment had to be "sufficient to fund anticipated claims based upon reasonably prudent actuarial principles." In other words, tail coverage for health care providers with fewer than 1,825 days participation in the Fund became voluntary.

Senate Bill 18 also created a new eleven member Health Care Stabilization Fund Oversight Committee with a very specific duty. The new law required the Oversight Committee to meet and make a report to the Legislative Coordinating Council on or before September 1, 1990 and "include recommendations to the legislature for commencing the phase-out of the fund on July 1, 1991." It was the consensus of the 1989 Legislature that the HCSF should be abolished, but the Legislature was uncertain how to accomplish that task.

Somewhat inconsistent with the plan to phase out the HCSF and repeal the Availability Act, SB18 was amended such that full-time physician faculty members and their foundations at the University of Kansas Medical Center "shall be deemed a self-insurer for the purposes of the health care provider insurance availability act." The Availability Act was further amended to delegate responsibility for administration of claims against physician faculty members to the Insurance Commissioner and provisions were made for reimbursement from the state general fund as well as a new "private practice foundation reserve fund." This new fund was to receive $500,000 per year from the private practice corporations at K.U. Medical Center.

The filing of new cases began to level off during the early nineties and Fund assets steadily increased because the Commissioner imposed comparatively high surcharge rates. By 1992 the Fund was considered actuarially sound, and premium surcharges were reduced accordingly. By this time, interest in phasing out the HCSF had waned. Instead, the 1994 Legislature decided to delegate responsibility for administration of the Fund to a Board of Governors appointed by the Insurance Commissioner.

In October 2012 the Kansas Supreme Court announced that it upheld the constitutionality of a Kansas statute that limits the amount a plaintiff can recover for noneconomic damages in a personal injury lawsuit. The media release issued by the Court's Education-Information Officer stated, "Our court has long recognized that the legislature may modify the common law in limited circumstances, as long as the legislature provides an adequate substitute remedy or quid pro quo." The media release went on to say, "The decision relied in part on the statutory cap's relationship to the Health Care Provider Insurance Availability Act. That Act requires that all health care providers maintain liability insurance with designated levels of excess coverage."

As a result of the decision in Miller v. Johnson, there was renewed interest in the Availability Act. Some organizations representing health care professionals or health care facilities decided to pursue the possibility of becoming defined health care providers under the Act.

Early in the 2014 Session a bill was introduced that added five new categories of defined health care providers: nurse midwives, physician assistants, assisted living facilities, nursing homes, and residential health care facilities. The bill also contained a number of technical amendments intended to update the Availability Act as well as amendments to improve HCSF tail coverage for Kansas health care providers. The bill was passed unanimously in both the House and the Senate and became law July 1, 2014. The effective date of the new definitions was deliberately delayed until January 1, 2015 to provide adequate time for the new health care providers to make any changes in their insurance coverage that might be needed in order to comply with the requirements stipulated in the Availability Act.

House Bill 2516 repealed the five-year compliance requirement for HCSF tail coverage. In addition, when a health care provider becomes inactive, the amount of tail coverage is equal to the level of HCSF coverage on the date of the incident that resulted in a claim, plus the minimum coverage required for primary insurance. This means that most health care providers have $1.0 million per claim tail coverage immediately upon retiring or otherwise becoming inactive.