M I N U T E S

SPECIAL COMMITTEE ON MEDICAL MALPRACTICE

October 28, 1975

Members Present

Senator Wesley H. Sowers, Chairman
Representative Earl D. Ward, Vice-Chairman
Senator Robert V. Talkington
Senator D. Wayne Zimmerman
Representative Ronald Hein
Representative Loren Hohman
Representative Rex B. Hoy
Representative Michael G. Johnson
Representative Marvin L. Littlejohn
Representative Ruth Luzzati
Representative Harry A. Sprague

Staff Present

Bill Wolff, Legislative Research Department
Emalene Correll, Legislative Research Department
Norman Furse, Revisor of Statutes Office
Bill Edds, Revisor of Statutes Office

Others

Rosanne B. Winter, Kansas Trial Lawyers Association, Topeka
Douglas P. Johnson, Kansas Pharmaceutical Association, Topeka
Larry Zanto, AMIA, Chicago, Illinois
Mark Bennett, AIA, Topeka
Frank Gentry, Kansas Hospital Association, Topeka
L. B. Cornish, Kansas Association of Property and Casualty, Topeka
Jeremy Slaughter, Kansas Medical Society, Topeka
Mildred Rumpf, Kansas Nurse Anesthetists, Topeka
George Trombold, Kansas Council for Health Legislation, Wichita
Judy Runnels, Kansas State Nurses Association, Topeka
Payne Ratner, Kansas Medical Society, Wichita
Fred Hollomon, House of Representative's Staff, Topeka

Others (Continued)

Representative Ruth Wilkin, State Representative, Topeka
Dave Williams, Lt. Governor's Office, Topeka
Mary Browne, Kansas Association of Osteopathic Medicine, Topeka
Joe Wempe, Insurance Department, Topeka
Paul E. Fleener, Kansas Farm Bureau, Manhattan
Cathy Talbert, Kansas Trial Lawyers Association, Topeka
Joan Baker, Insurance Department, Topeka
Dave Moses, Intern, State Treasurer's Office, Topeka
Charles Hamm, Department of Social and Rehabilitation Services, Topeka

The meeting was called to order at 10:10 a.m., by the Chairman.

The following correction was made to the minutes of the September meeting: Page 5, second paragraph under "Statutes of Limitations", change "every" to "several". A motion was made and seconded to approve the minutes of the September meeting as corrected. Motion carried.

Screening Panel Bill (Attachment 1). Staff reviewed the Committee's discussion of the bill and the Committee's directions to the staff.

Two major problems with a screening panel discussed were the difficulty of keeping proceedings of the panel secret from the jury when so many people are involved, and the possibility the panel may be used as a dress rehearsal for the jury trial. Some states make the screening panel proceedings open and admissable in court and allow both witnesses and panel members to be called to testify in subsequent court proceedings.

A Committee member reported the following comments upon a screening panel proposal given to him by a district court judge: a transcript of the proceedings should be required; the decision of panel should be admissable in future proceedings; the panel and its membership should be left to the discretion of the court; if the panel's decision is unanimous, the person ruled against should pay the costs of the panel; and panel members should not appear in future proceedings. The judge felt that a screening panel duplicated the trial process and in effect there could be two trials for the same action. This judge had not tried any medical malpractice cases as a judge, but had been involved in three cases as a practicing attorney.

The feeling was expressed that to insure expert medical members on the panel, membership should be specified in the bill. A motion was made to amend Section 1 by specifying that each

party select one member of the panel and the judge select one attorney. Motion lost for lack of a second.

Staff noted the primary differences between Sections 5A and 5B were that 5B provides that if a party does not file an acceptance or rejection of the panel's decision within 30 days after it was received, the decision would be considered accepted. Section 5B also provides that the parties can agree that no judgment be entered.

A motion was made and seconded to adopt alternative 5B as Section 5. A question was raised regarding what would happen if the parties agreed to be bound by the decision of the panel, but the panel members could not reach a conclusion. The panel is required to reach a decision as to liability and if they find the party liable, to determine a fair amount. If the panel did not carry out this responsibility, the judge could dismiss them and appoint a new panel. A suggestion was made to provide for this specifically in the bill. A question was raised as to the necessity for putting this in the law. A substitute motion was made and seconded to authorize the staff to insert language in Section 4, providing that in cases where a panel cannot reach a decision, the judge shall discharge the panel and appoint a new one. The substitute motion lost for lack of a second.

A motion was made and seconded to defer action on this bill, with the understanding that if someone wanted to revive it in some form at the last meeting, it would be possible. The motion carried. Representative Hohman recorded a no vote.

JUA. Staff distributed copies of the bill prepared by the Office of the Insurance Commissioner (Attachment 2), having made some technical changes to comply with action the Committee had taken on other bills. This bill accomplishes the intent of the Committee. Staff then read through the bill.

By consensus "or agency" is to be inserted after "employment" in line 8 of Section 2(c).

Staff was asked to check if Blue Cross-Blue Shield would be included under Section 2(a).

Staff clarified that Section 2(g) would include private rating agencies.

In answer to questions, staff explained that the Insurance Commissioner has the authority to approve or disapprove any plan which is submitted. If he approves a plan, it then becomes the official plan. If no plan submitted meets the requirements set forth in this bill, the insurance commissioner may prepare a plan. A question was raised as to why the last sentence in Section 5 dealing with non-compliance with the plan, appeared

in Section 5 but not in Section 4. Staff was instructed to check if this is to apply to both Sections 4 and 5 and, if it is, to change the language to make this clear. Staff was also instructed to find out what this bill is based on, i.e., existing auto liability statutes.

Deleting "unfairly" before "discriminatory" in Section 3(b) was suggested since discrimination seemed to imply unfairness. It was clarified that as used in this context, discriminatory did not necessarily mean unfair but rather selective.

In a discussion of how business would be allocated to the insurance companies involved, it was stated that in the bill placement would be determined by the companies involved or the insurance commissioner.

In further discussion, it was noted that the cap on recovery would be dependent on what happened to the Patient's Compensation Fund Bill. The Committee was also informed that there are two cases pending, in North Carolina and Tennessee, both of which have adopted a JUA approach, to determine the constitutionality of their JUA. Section 3 of the draft would probably be limited to professional liability since there is a distinction between general and professional liability. Both types of liability insurance are included in one policy for hospitals, although there are two separate contracts.

A question was raised regarding the necessity of the word "independent" in Section 6(a). This is not a well defined term in the business. Staff stated the insurance commissioner probably picked this language from an existing statute, but it apparently is not defined in that statute either. A motion was made and seconded to strike "independent" in the fourth line of Section 6(a) and to insert in lieu thereof "casualty" and to insert terminology clarifying licensed in Kansas. The feeling was expressed that the purpose of this phrase was to insure that there would be a person on the board whose business is field underwriting or selling of insurance. Present wording does not seem to insure that. Wording suggested was "Engaged in business of selling casualty insurance" or "whose principle business is". It was noted that the motion would be adopted with instructions to staff to find out if there was a better phrase to accomplish the intent as stated. Motion carried and staff was instructed to confer with the insurance commissioner to see if it can be worded more explicitly

Members from the public having only two year terms when all other members have three year terms was questioned. Staff is to check this with the insurance commissioner.

A motion was made and seconded to insert that the members representing the general public cannot be related to the insurance industry as officers, directors or agents. Motion carried.

There is usually a self destruct clause in this type of JUA legislation and that the time usually used is two years. A motion was made and seconded to insert a two year self destruct clause in the bill. Motion carried. This action took care of the discrepancy in terms between members noted earlier. By consensus all terms on the board as described in Section 6 are to be made two years.

By consensus a further discussion of Section 2 and 3 and final action on the bill was deferred until the Patient's Compensation Fund Bill is considered.

Incompetency Clause. Staff explained that this bill (Attachment 3), reinserts the phrase "or professional incompetency" which was inadvertently left out of Section 1(b) when the bill was last amended. By consensus "state board of health" on page 1, line 16 is to be deleted and "secretary of health and environment" inserted in lieu thereof.

A motion was made and seconded to approve this bill for introduction. It was noted that H.B. 2008 amending the Healing Arts Act is still on the calendar. However, since action will need to be taken quickly on it, the Committee had decided to introduce a separate bill to reinsert this phrase.

A question was raised as to whether professional incompetency meant the same as not competent to engage in or practice a profession. Because of the other terms in the subsection and a ruling of the Kansas Supreme Court, it was felt the point raised was covered. Motion carried.

The feeling was expressed that language in this bill should comply with the equivalent section of H.B. 2008 because the problem is the person committing malpractice. A suggestion was made to add "and to amend this bill to comply with H.B. 2008". Then, if H.B. 2008 does not pass, the legislature would still have the language in this bill and the other grounds added in H.B. 2008 to consider.

Staff noted that if Section 1 was made to comply with the comparable section of H.B. 2008, several other sections would have to be included to comply. If H.B. 2008 does not pass, this bill could be amended to include specific items from H.B. 2008.

A motion was made and seconded to insert "restricted" after "revoked" in line 2. The motion lost.

Staff was instructed to include in the Committee report that a grant of authority to the Board of Healing Arts to restrict a license is desirable and incorporated in another bill. This bill ties in with H.B. 2008 still on the calendar. Staff is also to mention the problem of complying with H.B. 2008 discussed above.

The meeting was adjourned at 12:00 noon and was reconvened by the Chairman at 1:40 p.m.

Patient's Compensation Fund Bill. Staff explained the bill which was distributed. (Attachment 4).

By consensus "fund" is to be used instead of "patient's compensation fund" and "commissioner" instead of "insurance commissioner" as they are used after the definition section.

Section 2. A motion was made and seconded to delete Section 2 and to renumber the remaining sections. Reasons given for this were the constitutional question of denying equal protection and concern for the effect a recovery cap has upon a person seriously injured by a doctor obviously committing malpractice.

If the Patient's Compensation Fund is constitutionally wrong, it is believed that someone will come up with a case, but while this constitutional question needs to be given consideration, attention must be focused on the overall problem of medical malpractice and solutions for it. It was pointed out that without the cap it is doubtful the bill would pass.

The motion lost.

Section 4(c). Staff pointed out that Alternative (c) on page 3 is possibly, but not necessarily an alternative. Staff also stated that reference to health maintenance organizations should not appear where it does in Alternative (c), since an HMO may contract with a facility rather than operate its own. HMO's could fall under one or both categories included in this alternative section. Alternative (c) is patterned after the Florida law. It was noted that Alternative (c) could hurt the small medical facility. Increasing the initial surcharge, or a first year assessment of $1,000 for each physician were suggested as other alternatives.

The first assessment would be at the time the policy was renewed so not all providers and facilities would be covered in the beginning. Staff felt most of the costs of the fund the first year would be administrative.

It was observed that (c) provided for a continuing authority but probably would not make it possible for the commissioner to ask for funds immediately. However, if the bill passed, the legislature would have to appropriate a top amount with such an appropriation to be used as needed.

The motion carried.

Section 4(e). In answer to a question about whether there should be a penalty if an insurer is late in paying or does not pay the surcharge, it was noted it would be suspended according to present statutes.

Regarding the authority of the commissioner to collect money instead of the Director of Revenue, it was disclosed that in the Workmen's Compensation second injury fund, the money is not collected by the Director of Revenue, but goes through the Workmen's Compensation Department.

Section 5. The limit of $100,000 on the provider's liability was questioned. Many cases are over this amount, but would be included under the provider's liability if this limit was $250,000 or $300,000. Testimony from insurance companies however, indicated that the $100,000 - $300,000 coverage is the type available.

In answer to questions, comments were made that while there is a limit on occurrences in basic coverage, there is not the same limitation on this fund. There was disagreement as to whether the intent was to limit basic coverage to an occurrence policy and whether the fund operates on a claims made basis. All providers as defined by the bill would have to carry $100,000 - $300,000 basic coverage and pay into the fund.

In discussion the following observations were made: medical facilities are willing to go to a claims made policy but they do not worry about the premiums at the end because they do not plan to "retire"; not including claims made policies will place a greater burden on the JUA; the non-admitted market writes claims made policies; one company writing only claims made policies has 25% of the market; if the provider's liability is left at $100,000, companies writing $200,000 or more limit will drop to $100,000 raising the amount to be picked up by the fund; there is a differing opinion as to how many companies are writing policies with a $200,000 limit or how many policies they are writing; most nurses and LPN's carry insurance and aides are beginning to but there was no information relative to limits of coverage.

Staff was asked to check with the commissioner if claims made policies are included in the JUA.

A question was raised as to why "private counsel" is used in the last paragraph instead of using the Attorney General's office. It was noted that the expertise needed might preclude already having a person on the Attorney General's staff.

Section 6. Including "no material dispute" in line 12 of Section 6 was questioned. The facts may be disputed but in the commissioner's judgment it may still be better to settle

than to continue litigation. A motion was made and seconded to delete all of line 24.

A motion was made and seconded to approve the bill as amended for introduction.

In answer to a question, it was stated that Section 3 mandates basic coverage for all. If anyone elects not to get basic coverage, they are not covered by the funds nor do they come under the cap on recovery. Whether this was the original intent was questioned. Adding the words, "In order to qualify under the provisions of this act" was suggested for clarification. Staff stated this is a policy decision. If all providers and facilities are required to participate, the suggestion would not be appropriate; if participation is to be optional, the suggestion is appropriate with some additional changes.

There are some health providers employed by health facilities who might not want to buy insurance because they are not dealing directly with patients and, therefore, are not at risk. Since the facility's coverage includes all employees only those wanting extra protection for cases in which they may be named as co-defendant may purchase basic coverage presently. It was related that if basic coverage is mandated, the premium and surcharge for the people mentioned would be negligible.

The feeling was expressed that people should have the option of not coming under the act with the suggestion that those taking this option submit a signed declaration to the insurance commissioner. It was added that this could allow people to come in when claims against the fund are low and to get out when claims are high.

In a discussion of the minimum percentage to be used in Section 3(d), the commissioner felt he could furnish the necessary figures. Having a maximum percentage, except that in cases where the fund is insufficient the commissioner may use his discretion, was suggested. Also, the bill could be approved with the professional surcharge subject to further consideration.

Motion carried on a hand vote of 5 to 4. Representative Hein recorded a no vote.

If the courts find the recovery cap unconstitutional and the rest of the act remains in affect, there could easily be a deficit in the fund. Considering a limit on fund liability but not total liability was suggested. This would require the provider or facility to find a third level of coverage above one million dollars.

JUA. A question was raised as to whether the burden of proving that the unavailability of coverage was on the commissioner or on the health provider and facility. The Chairman stated he had understood from the commissioner it was to be on the provider or the facility, with the requirement that letters from insurance companies be submitted to the commissioner stating that insurance was not available. The feeling was expressed that if all casualty companies were included in the JUA, then a provider or facility would be able to get a letter from any of these companies, whether or not they sold medical malpractice insurance.

A motion was made and seconded to delete "bodily injury or property damage" and insert in lieu thereof "professional" and to insert "as defined herein" after "insurance" in line 3 of Section 2(d).

In answer to a question, staff interpreted Section 3 to mean that a certain provider is to be assigned to a certain company and that company is to be responsible for claims against that provider. A certain company might carry the policy but a portion of the policy would be underwritten by other companies. By consensus "applicants" is to be deleted in line 3 of Section 3 and "risks" inserted in lieu thereof.

Motion carried.

The Chairman stated he would discuss with the commissioner whether this is still a viable bill. The Chairman was requested to ask the commissioner if a company could be assessed for a percentage of coverage without being forced to write professional liability insurance. In view of the last motion, staff was instructed to change the title of the bill after discussing appropriate wording with the commissioner.

Staff noted that the insurance commissioner's office had clarified that the last sentence of Section 5, page 3 should apply to any plan in Section 4 or 5. Staff suggested creating a new section including this sentence and stating it is applicable to all plans.

In view of the previous motion, a motion was made and seconded to make the following changes in Section 6: line 4 delete "nine (9) and insert in lieu thereof "five (5)"; line 5 delete "Seven (7)" and insert in lieu thereof "Four (4); line 6 delete "three (3) and insert in lieu thereof "two (2)"; line 7 delete "two (2)" and insert in lieu thereof "one (1)"; line 8 delete "two (2)" and insert in lieu thereof "one (1)"; page 4, line 1 delete "two (2)" and insert in lieu thereof "one (1)". Motion carried.

A motion was made and seconded to approve the bill as amended for further consideration. It was noted that since the commissioner now has the authority to create a JUA -- he listed this

under recommended regulatory changes rather than statutory changes in his report to the Committee -- he should make the decisions in this area rather than being directed by statute. The feeling was expressed that an alternative to a JUA is being provided by action this Committee has taken and possibly will take. There were varying opinions as to whether insurance companies had given any assurance they would provide insurance if certain changes were made or to what extent any such assurances had been given.

In answer to a question, it was noted that the insurance commissioner would make the decision as to whether a provider should be covered by the JUA and that in making the decision, he would rely on others such as the Board of Healing Arts.

Motion carried.

Staff suggested requesting another meeting date approximately ten days after the last scheduled meeting to give final approval to the Committee report and to wrap up any other lose ends. The Chairman stated he would like to complete things at the next meeting even though it may necessitate giving the Chairman and Vice-Chairman authority to approve the Committee report.

The next meeting will be November 13 and 14, 1975.

The meeting was adjourned at 4:00 p.m.

Prepared by William G. Wolff

Approved by Committee on:

10/28/75
(Date)

Attachment 1

_____ BILL NO._____

By Special Committee on Medical Malpractice

AN ACT authorizing the convening of medical malpractice screening panels; providing for the powers, duties and functions thereof.

Be it enacted by the Legislature of the State of Kansas:

Section 1. Where a petition is filed in a district court of this state claiming damages for personal injury or death on account of alleged medical malpractice, the judge of the district court or of the division of the district court to which such case is assigned may convene a medical malpractice screening panel hereafter referred to as the "screening panel." The district judge shall appoint such persons as he or she deems necessary to serve on the screening panel. The persons appointed shall constitute the screening panel for the particular medical malpractice claim to be heard.

Sec. 2. The district judge shall notify the parties to the action that a screening panel has been convened and that the members of such screening panel have been appointed. One member of the screening panel shall be designated by the district judge to serve as chairman of the screening panel. Members of such screening panel shall receive compensation and expenses as may be provided by rules of the supreme court of Kansas.

Sec. 3. The screening panel shall convene with notice in writing to all parties and their counsel and shall hear evidence and argument on the question of liability and on the question of damages. The screening panel shall give notice and conduct its meetings in accordance with rules of procedure adopted by the supreme court of Kansas to govern notice and conduct of such meetings, except strict adherence to the rules of procedure and evidence applicable in civil cases shall not be required. All

meetings of the screening panel shall be held in camera.

The chairman of the screening panel shall preside at all meetings of the screening panel and shall determine all questions of procedure, including the admissibility of evidence. Witnesses may be called, all testimony shall be under oath, testimony may be taken either orally before the screening panel or by deposition, copies of records, x-rays and other documents may be produced and considered by the screening panel and the right to subpoena witnesses and evidence shall apply as in all other proceedings in the district court. The right of cross-examination shall apply to all witnesses who testify in person. The parties to the action shall be entitled, individually and through counsel, to make opening and closing statements. No transcript or record of the proceedings shall be required, but any party may have the proceedings transcribed or recorded. No screening panel member shall participate in a trial arising out of the cause of action either as counsel or witness.

Sec. 4. (a) The screening panel shall make its determination according to the applicable substantive law. Its determination on the issue of liability and, if liability is found, on the issue of fair and just compensation for damages shall be made in a written opinion. The screening panel shall state its findings of fact and its conclusions of law. A concurring or dissenting member of the screening panel may file a written concurring or dissenting opinion.

(b) The screening panel shall notify all parties when its determination is to be handed down, and, within seven (7) days of its decision, shall provide a copy of its opinion and any concurring or dissenting opinion to each party and each attorney of record and to the district judge.

(c) The findings of fact, conclusions of law and final determination of the screening panel shall not be admitted into evidence in any subsequent legal proceeding.

Sec. 5A. Within thirty (30) days following the date of decision of the screening panel, the parties shall file written

notice with the clerk of the district court, with copies to other of their acceptance or rejection of final determination of the screening panel. If all of the parties accept the final determination of the screening panel, judgment may be entered accordingly. In the event that one or more of the parties rejects the final determination of the screening panel, the plaintiff may proceed with the action in the district court. Nothing herein shall be construed to prohibit the parties from agreeing in writing at any time prior to the final determination of the screening panel that such determination shall be binding upon the parties.

Sec. 5B. (a) The parties may, by unanimous written agreement, elect to be bound by the determination of the screening panel at any time. Whenever the parties have unanimously agreed to be bound by the determination of the screening panel, the district court shall enter judgment thereon, unless the parties shall unanimously agree that no judgment be entered.

(b) In cases where the determination of the screening panel is unanimous, and where the parties have not unanimously agreed in writing to be bound by the determination of the screening panel, each party shall file with the clerk of the district court a written acceptance or rejection of the determination within thirty (30) days of receipt of the written opinion. Any party not timely filing a rejection of the determination shall be deemed to have accepted such determination. If the determination is accepted by all parties, the district court may enter judgment thereon.

(c) In the event that one or more of the parties rejects the final determination of the screening panel, the plaintiff may proceed with the action in the district court.

Sec. 6. All proceedings, records, findings of fact, conclusions of law, final determinations and deliberations of a screening panel shall be confidential and shall not be used in any other proceeding, or otherwise publicized, except as herein

provided, nor disclosed by any party, witness, counsel, screening panel member, or other person, on penalty of being found in contempt of court. The manner in which a screening panel and each member thereof deliberates, decides, and votes on any matter submitted to the screening panel, including whether the final determination is unanimous or otherwise, shall not be disclosed or made public by any person, except as herein provided.

Sec. 7. No member of the screening panel shall be subject to a civil action for damages as a result of any action taken or recommendation made by such member acting without malice and in good faith within the scope of such member's official capacity as a member of the screening panel.

Sec. 8. No witness testifying in good faith before any screening panel shall be subject to a civil action for damages as a result of such testimony.

Sec. 9. Unless otherwise provided by order of the district judge, the costs shall be allowed to the party in whose favor the final determination of the screening panel was made. Items which may be included in the taxation of costs shall be those items enumerated by K. S. A. 1975 Supp. 60-2003.

Sec. 10. This act shall take effect and be in force from and after its publication in the statute book.

Attachment #2

PROPOSED BILL NO. ____

By Special Committee on Medical Malpractice

RE: Proposal No. 43

AN ACT relating to insurance; concerning the apportionment or assignment of risk for professional liability insurance on health care providers; requiring certain insurance companies to participate in a plan providing such insurance; providing for preparation, approval and review of such plan.

Be it enacted by the Legislature of the State of Kansas:

Section 1. This act shall be known and may be cited as the medical professional liability insurance availability act.

Sec. 2. When used in this act: (a) "Applicant" means any health care provider.

(b) "Commissioner" means the commissioner of insurance of this state.

(c) "Health care provider" means a person licensed to practice the healing arts or engaged in a postgraduate training program approved by the state board of healing arts, licensed medical care facility, health maintenance organization, licensed dentist, licensed professional nurse, licensed practical nurse, licensed optometrist, registered podiatrist or registered physical therapist or an officer, employee or agent thereof acting in the course and scope of his or her employment.

(d) "Insurer" means any corporation, association, reciprocal exchange, interinsurer and any other legal entity authorized to write bodily injury or property damage liability insurance in this state, including workmen's compensation and automobile liability insurance, pursuant to the provisions of article 9, 11, 12 or 16 of chapter 40 of Kansas statutes annotated.

(e) "Plan" shall mean the operating and administrative rules and procedures developed by insurers or the commissioner to make professional liability insurance available to health care providers.

(f) "Professional liability insurance" means insurance providing coverage for legal liability arising out of the performance of

professional services rendered or which should have been rendered by a health care provider and such other liability insurance as may be included in or added to the plan required by this act.

(g) "Rating organization" means a corporation, an unincorporated association, a partnership or an individual which is licensed pursuant to K. S. A. 40-930 and/or K. S. A. 40-1114 to make rates for professional liability insurance.

Sec. 3. Every insurer and every rating organization shall cooperate in the preparation of a plan or plans for the equitable apportionment among such insurers of applicants for professional liability insurance who are in good faith entitled to such insurance but are unable to procure the same through ordinary methods. Such plan or plans shall be prepared and filed with the commissioner within a reasonable time but not exceeding sixty (60) calendar days from the effective date of this act. Such plan or plans shall provide:

(a) Reasonable rules governing the equitable distribution of risks by direct insurance, reinsurance or otherwise;

(b) Rates and rate modifications applicable to such risks which shall be reasonable, adequate and not unfairly discriminatory;

(c) The limits of liability which the plan shall be required to provide, but in no event shall such limits be less than (1) those limits required of a health care provider under any other laws of this state, or (2) in the absence of such requirement, one million dollars ($1,000,000) per occurrence subject to a three million dollar ($3,000,000) annual aggregate;

(d) A method whereby applicants for insurance, insureds and insurers may have a hearing on grievances and the right of appeal to the commissioner.

Sec. 4. The commissioner shall review the plan as soon as reasonably possible after filing in order to determine whether it meets the requirements set forth in section 3. As soon as reasonably possible after the plan has been filed the commissioner shall in writing approve or disapprove the same. Any plan shall be deemed approved unless disapproved within thirty (30) days. Subsequent to the waiting period the commissioner may disapprove any plan on the ground that it does not meet the requirements set forth in section 3, but only after a hearing held upon not less than ten (10) days'

written notice to every insurer and rating organization affected specifying the matter to be considered at such hearing, and only by an order specifying in what respect the commissioner finds that such plan fails to meet such requirements, and stating when within a reasonable period thereafter such plan shall be deemed no longer effective. Such order shall not affect any assignment made or policy issued or made prior to the expiration of the period set forth in said order. Amendments to such plan or plans shall be prepared, and filed and reviewed in the same manner as herein provided with respect to the original plan or plans.

Sec. 5. If no plan meeting the requirements set forth in section 3 is submitted to the commissioner within sixty (60) calendar days from the effective date of this act or within the period stated in any order disapproving an existing plan, the commissioner shall, if necessary to carry out the purpose of this act after hearing, prepare and promulgate a plan meeting such requirements. If after a hearing the commissioner finds that any activity or practice of any insurer or rating organization in connection with the operation of such plan or plans is unfair or unreasonable or otherwise inconsistent with the provisions of this act, the commissioner may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this act and requiring discontinuance of such activity or practice.

Sec. 6. For every such plan or plans, there shall be a governing board to be appointed by the commissioner of insurance which shall meet at least annually to review and prescribe operating rules, and which shall consist of the following nine (9) members:

(a) Seven (7) members who shall be appointed as follows: Three (3) of such members shall be representatives of foreign insurers, two (2) members shall be representatives of domestic insurers and two (2) members shall be licensed independent insurance agents. Said members shall be appointed for a term of three (3) years, except that the initial appointment shall include two (2) members appointed for a two-year term and two (2) members appointed for a one-year term as designated by the commissioner; and

(b) Two (2) members representative of the general public interest with said members to be appointed for a term of two (2) years.

Sec. 7. An insurer participating in the plan approved by the commissioner may pay a commission with respect to insurance written under the plan to an insurance agent licensed for any other insurer participating in the plan or to any insurer participating in the plan.

Sec. 8. If any clause, paragraph, subsection or section of this act shall be held invalid or unconstitutional, it shall be conclusively presumed that the legislature would have enacted the remainder of this act without such invalid or unconstitutional clause, paragraph, subsection or section.

Sec. 9. This act shall take effect and be in force from and after its publication in the official state paper.

5 RS 1686

Attachment #

_____ BILL NO._____

By Special Committee on Medical Malpractice

Re Proposal No. 42

AN ACT relating to the Kansas healing arts act; amending K. S. A. 65-2836 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K. S. A. 65-2836 is hereby amended to read as follows: 65-2836. A license may be revoked or suspended when the licensee is guilty of any of the following acts or offenses: (a) Fraud in securing the license. (b) Immoral, unprofessional or dishonorable conduct or professional incompetency. (c) Conviction of a felony if the board determines, after investigation, that such person has not been sufficiently rehabilitated to warrant the public trust. (d) Use of untruthful or improbable statements or flamboyant, exaggerated or extravagant claims in advertisements concerning such licensee's professional excellence or abilities. (e) Use and distribution of literature advertising professional abilities. (f) Other unethical advertising practice. (g) Addiction to or distribution of intoxicating liquors or drugs for any other than lawful purposes. (h) Willful or repeated violation of this act or the rules and regulations of the state board of health. (i) Unlawful invasion of the field of practice of any branch of the healing arts in which the licensee is not licensed to practice. (j) Failure to pay annual renewal fees specified in this act. (k) Failure to take some form of postgraduate work each year as required by the board.

Sec. 2. K. S. A. 65-2836 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

Attachment 4

PROPOSED BILL NO. _____

By Special Committee on Medical Malpractice

RE: Proposal No. 42

AN ACT

Be it enacted by the Legislature of the State of Kansas:

Section 1. As used in this act the following terms shall have the meanings respectively ascribed to them herein: (a) "Basic coverage" means the policy of professional liability insurance required to be maintained by each health care provider pursuant to the provisions of subsection (a) of section 3;

(b) "Commissioner" means the commissioner of insurance;

(c) "Fund" means the patients' medical malpractice compensation fund established pursuant to subsection (a) of section 4;

(d) "Health care provider" means a person licensed to practice the healing arts or engaged in a postgraduate training program approved by the state board of healing arts, licensed medical care facility, health maintenance organization, licensed dentist, licensed professional nurse, licensed practical nurse, licensed optometrist, registered podiatrist or registered physical therapist or an officer, employee or agent thereof acting in the course and scope of his or her employment or agency.

Sec. 2. The aggregate amount recoverable in any action for damages for any personal injury or death arising out of the rendering of or the failure to render professional services by any health care provider subsequent to the time that such health care provider has qualified for coverage under the provisions of this act shall not exceed one million dollars ($1,000,000).

Sec. 3. (a) A policy of professional liability insurance which the limit of the insurer's liability is not less than one hundred thousand dollars ($100,000) per occurrence, subject to a three hundred thousand dollar ($300,000) annual aggregate, shall be maintained in effect by each health care provider performing professional services within this state. Each health care provider shall certify that he or she has such coverage in effect to the commissioner of insurance, and in addition thereto, shall provide the commissioner with the amount of the annual premium, the date such annual premium was due and such other information as the commissioner shall require.

(b) A health care provider shall be deemed to have qualified for coverage under the provisions of this act at the time that such health care provider, on or after July 1, 1976, initially commences or continues in effect by renewal or otherwise, the basic coverage required by subsection (a) of this section.

Sec. 4. (a) For the purpose of paying damages for personal injuries or death arising out of the rendering of or the failure to render professional services by any health care provider there is hereby established the patients' medical malpractice compensation fund, such fund to be held in trust in a segregated account in the state treasury. The fund shall be liable to pay: (1) Any amount due from a judgment or settlement which is in excess of the total liability of all liable health care providers for any such injury or death; (2) reasonable and necessary expenses for attorney's fees incurred in defending the fund against claims; and (3) expenses of administering the fund. The fund shall only be liable for damages for personal injuries or death which arose from the rendering of or the failure to render professional services by a health care provider subsequent to the time that such health care provider has qualified for coverage under the provisions of this act.

(b) The commissioner of insurance shall administer or contract the administration of the fund with an insurance company authorized to do business in this state. The pooled money investment board may invest and reinvest moneys in the fund in obligations of the United States of America or obligations the principal and interest of which are guaranteed by the United States of America or in

interest bearing time deposits in any commercial bank or trust company located in Kansas, or, if the board determines that it is impossible to deposit such moneys in such time deposits, in repurchase agreements of less than thirty (30) days' duration with a Kansas bank for direct obligations of, or obligations that are insured as to principal and interest by, the United States government or any agency thereof. Any income or interest earned by such investments shall be credited to the patient's medical malpractice compensation fund.

(c) Upon certification by the commissioner of insurance to the director of accounts and reports that the fund is insufficient to pay an amount for which the fund is liable, the director shall issue a warrant in such amount drawn upon the state general fund to the commissioner for deposit in the patients medical malpractice compensation fund. Such amount shall be a debt upon the patient's medical malpractice compensation fund and shall be transferred back to the state general fund from such fund in the fiscal year following the fiscal year in which the initial transfer was made unless the legislature shall authorize an extension of such time. The commissioner shall levy the maximum premium surcharge authorized by subsection (d) of this section in any fiscal year in which the patient's medical malpractice compensation fund is indebted to the state general fund.

ALTERNATIVE

[(c) On or before August 1, 1976, each health care provider, excluding licensed medical care facilities and health maintenance organizations, shall pay an assessment of one thousand dollars ($1,000) and each licensed medical care facility and health maintenance organization shall pay an assessment of three hundred dollars ($300) per bed to the commissioner of insurance for deposit in the patient's medical malpractice compensation fund.]

(d) The commissioner of insurance shall levy an annual premium surcharge on each health care provider for each fiscal year commencing with the fiscal year beginning on July 1, 1976. Such premium surcharge shall be an amount equal to a percentage of the premium

paid by the health care provider for the basic coverage requir[illegible] to be maintained by subsection (a) of section 3. The commissioner shall determine the applicable percentage to be used in computing the premium surcharge in each fiscal year based upon actuarial principles, but in no event shall such premium surcharge be less than _____ percent (%) nor more than _____ percent (%) of the premium paid by the health care provider for the basic coverage required to be maintained by subsection (a) of section 3.

(e) The premium surcharge shall be collected as a part of the annual premium for the basic coverage by the insurer. Such premium surcharge shall be due and payable to the commissioner within thirty (30) days after the annual premium for the basic coverage is received by the insurer. Before July 15, 1976, the commissioner shall send to each insurer a statement explaining the provisions of this act together with any other information necessary for their compliance with this section. The certificate of authority of any insurer who fails to comply with the provisions of this subsection shall be suspended until such insurer shall pay the annual premium surcharge due and payable to the commissioner.

(f) If the fund exceeds the sum of seven million dollars ($7,000,000) at the end of any fiscal year after the payment of all claims and expenses, the commissioner shall reduce the surcharge in order to maintain the fund at an approximate level of seven million dollars ($7,000,000).

(g) Except for investment purposes, all payments from the patients' medical malpractice compensation fund shall be upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the commissioner of insurance. For investment purposes amounts shall be paid from the fund upon vouchers approved by the chairperson of the pooled money investment board.

Sec. 5. No individual health care provider or his or her insurer shall be liable for an amount in excess of one hundred thousand dollars ($100,000) in any action for damages for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider subsequent to the time that such health care provider has qualified for coverage

under the provisions of this act. Any amount due from a judgme which is in excess of the total liability for all liable health care providers shall be paid from the patient's medical malpractice compensation fund. No recovery shall be had against the fund in any such action unless the fund is named a party defendant to the action and a copy of the pleading and service is made in the manner prescribed by law for other civil actions in this state upon the commissioner of insurance in such commissioner's capacity as administrator of the fund.

The commissioner is hereby authorized to retain private counsel to defend the fund in any action naming the fund as a party defendant.

Sec. 6. Whenever the insurer of a health care provider has agreed to settle its liability on a claim against its insured by payment of its policy limits of one hundred thousand dollars ($100,000), and the claimant is demanding an amount in excess thereof for a complete and final release, the commissioner of insurance shall investigate, or cause to be investigated, such claim against the patients' medical malpractice compensation fund. For the purposes of such investigation, the commissioner is authorized to obtain expert medical advice regarding the personal injury or death involved in the claim. If based upon such investigation and any other available information, the commissioner finds that there is no material dispute as to any issue in the claim, that the claim is valid and that the claim should be dispensed with by settlement, the commissioner may proceed to enter into a settlement with the claimant for the patients' medical malpractice compensation fund.

Sec. 7. If any clause, paragraph, subsection or section of this act shall be held invalid or unconstitutional, it shall be conclusively presumed that the legislature would have enacted the remainder of this act without such invalid or unconstitutional clause, paragraph, subsection or section.

Sec. 8. This act shall take effect and be in force from and after its publication in the statute book.