Legislative Research Department December 5, 1975

M I N U T E S

SPECIAL COMMITTEE ON MEDICAL MALPRACTICE

November 13 and 14, 1975

Members Present

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

Staff Present

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

Others Present

Jerry Slaughter, Kansas Medical Society, Topeka, Kansas
Joe Wempe, Kansas Insurance Department, Topeka, Kansas
Jim Wallace, Kansas Independent Insurance Agents, Topeka
Darb Ratner, Kansas Medical Society, Wichita, Kansas
Carl Schmitthenner, Kansas State Dental Association, Topeka
Florence Nelson, Kansas State Nurses Association, Topeka
Dick Brock, Kansas Insurance Department, Topeka, Kansas
Ron Todd, Kansas Insurance Department, Topeka, Kansas
Mike Mullen, Kansas Insurance Department, Topeka, Kansas
Bob Hayes, Kansas Insurance Department, Topeka, Kansas
George Trombold, Kansas Council for Health Legislation, Wichita
Mildred Rumpf, Nurse Anesthetists, Topeka, Kansas
Mark Bennett, Association of Independent Agents, Topeka
Homer Cowan, Jr., Western Insurance Companies, Ft. Scott
Paul E. Fleener, Kansas Farm Bureau, Manhattan

Others Present (cont'd.)

Kathy Mannen, Kansas Trial Lawyers Association, Topeka
Harold Stones, Kansas Bankers Association, Topeka
Rosanne Winter, Kansas Trial Lawyers Association, Topeka
Carol McDowell, Kansas Trial Lawyers Association, Topeka
Nina Montgomery, Legal Aid Society, Topeka
Janeen Virnala, Legal Aid Society, Topeka
William Gough, Jr., Kansas Association of Commerce and Industry, Topeka
Lucy Campbell, Region 3 Health Systems Agency Board, Humboldt
Carol Chalmers, Kansas League of Women Voters, Manhattan
Marilyn Bradt, Kansas League of Women Voters, Lawrence
Joan M. Baker, Kansas Insurance Department, Topeka
David Moses, State Treaturers' Office, Topeka
Ruth Groves, Kansas League of Women Voters, Topeka
Cathy Talbert, Kansas Trial Lawyers Association

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

The following rules were established to aid the Committee in completing its task with dispatch. Anything discussed up to now can be brought up again; any action taken now will stand unless there is a motion to reconsider.

The Chairman reported that as a result of two meetings Insurance Commissioner Bell held with representatives of the groups involved, his staff drafted a bill to assure medical malpractice coverage without offending anyone and which would eliminate the constitutional question. The bill combines the JUA and the Patient Compensation Fund bills and places a cap on what can be received from the fund, but does not place a cap on the total which can be recovered. Staff from Mr. Bell's office will discuss the bill later.

Immunity

This bill (Attachment 1) extends the provision for immunity from civil action in reporting information in good faith to the boards licensing health care providers as defined in previous bills approved by the Committee. Staff noted that if passed, each section would be inserted in the correct section of the appropriate statutes. Making Section 1 a part of the Healing Arts Act, as the previous bill draft did, would have limited it to the definitions of that act and would have made false reporting a perjury which did not seem necessary.

Requiring the reporting to be under oath was questioned as this would discourage people from reporting, while the intent was to encourage reporting. Staff noted this was put in to carry out the Committee's instructions to avoid nuisance complaints.

Changes suggested were: changing "under oath" to "in writing"; requiring the complaint be in writing for the Board's record and testimony before the Board be oral.

A motion was made and seconded to approve the immunity bill, 5 RS 1659, as drafted for introduction. Motion carried.

Screening Panels

(See Attachment 2.) Staff noted the Committee had voted to eliminate Section 5A but it did not get deleted from this draft. The Chairman noted the Committee has been given differing opinions about the advisability of having screening panels, how they should be formed, and how they should be used. Proponents hoped the panels would help people with small meritorious claims to get their claims considered and settled.

Staff reported they had contacted staff in Indiana, as requested by the Committee, and they said there was no indication how their screening panel law would work, since only one panel had been convened to date.

Concern was expressed that this bill did not require panel members to have any expertise, and yet, it envisioned them considering medical testimony and making decisions based on this information. It was noted the judge would appoint the panel and it could be assumed he would select qualified doctors and an attorney. Because of Section 4, it would be imperative to have an attorney on the panel, because doctors are not that familiar with substantive law.

A motion was made and seconded to amend the bill to require that as a minimum, the screening panel be composed of a designee of the defendant, a designee of the paintiff and an attorney selected by the judge from a roster maintained by the judge. Motion carried.

A motion was made and seconded to approve the screening panel bill, 5 RS 1636, for introduction.

A question was raised as to the advisability of requiring the panels to state conclusions of law. After discussion a substitute motion was made and seconded to strike "and its conclusions of law" page 2, line 23. The substitute motion carried. By consensus, staff was instructed to delete this language whereever it appears in the bill.

A substitute motion was made and seconded to amend the bill to make the actual testimony of witnesses before the screening panel admissable at future proceedings. Basically this would be making testimony before the screening panel a deposition and would be helpful in the impeachment of a witness or in cases where a witness dies prior to any future proceedings. A transcript

would still be optional. Striking Section 6 and permitting the judge to establish such rules as he deems advisable was suggested.

By consent of the persons making and seconding the substitute motion, the substitute motion was changed to amend the bill by inserting "unless otherwise ordered by the court" or some such language, before "All" page 3, section 6. The substitute motion carried.

The original motion to approve the bill was called for and carried.

JUA and Patient Compensation Fund

(Attachment 3.) Dick Brock, Administrative Assistant, Insurance Commissioner's Office, stated the Insurance Commissioner had held meetings with representatives of the Kansas Medical Society, Kansas Bar Association, Kansas Trial Lawyers Association, Kansas Hospital Association, Kansas Nurses Association, a large domestic insurance company, Kansas insurance companies and the American Insurance Association, to work out their differences in these two areas - to insure availability of coverage and reasonableness of cost. A second meeting was held to discuss the draft of a bill combining the JUA and patient compensation fund concepts. Copies of the bill drafted as a result of these two meetings were distributed. (Attachment 3.) It was noted that this bill which addresses only availability and cost, does not solve all the problems, but it does remove the major disagreements between the groups involved.

Mr. Brock outlined the following basic changes and the reasons for them:

1. Requiring all liability carriers writing insurance in Kansas, except small Kansas companies, to participate in the JUA. Contrary to the automobile insurance situation, there are very few companies willing to write medical malpractice insurance and these companies indicated they would withdraw from the Kansas market if there was not a broad base for the JUA. Although it is not spelled out in this bill, it is envisioned that the plan would require that services to those insured under the JUA would be provided only by companies with expertise in this area.

2. JUA to operate on a no profit - no loss basis. Concern had been expressed that companies might recoup dollar losses sustained by participation in the JUA by raising premiums on other types of insurance. At the end of each year the JUA's profit or loss would be determined. Losses would be paid from the health care stabilization fund to the carriers via the JUA and profits would go to the health care stabilization fund.

3. All basic policies issued on a claims made basis. This would provide a more responsive mechanism and statistics

from companies could be combined to give a total Kansas picture. When a health care provider becomes inactive, the tail end coverage would be underwritten by the health care stabilization fund. This will be taken into account in setting the surcharge for the fund.

4. Establish a limit of one million - three million per provider on the fund and remove the cap on recovery. If a $1,000,000 cap was passed, it would alleviate the necessity for a provider purchasing coverage in excess of this amount, but would not destroy this bill.

5. Included the system for processing claims as recommended by the Kansas Bar Association, Kansas Trial Lawyers Association and Kansas Medical Society. This draft also replaced the public representative on the board with a health care provider. Matters with which the Board would be dealing relate primarily to health care providers and do not involve the public. This maintains the odd number on the Board.

6. Changed effective date to published in the official state paper. The problem is serious and the quicker the plan is implemented the better.

In the discussion, the Insurance Commissioner's staff stated this bill requires health care providers to carry basic coverage only if they want to participate in the fund. They envision that all policies covered by the JUA will be issued by one company experienced in the field which would be reinsured by all companies. The JUA is a pass through or front organization. They estimate the JUA will have to pick up about 20 percent of the market.

Having a JUA was questioned since participation in it is on a no profit - no loss basis. It was noted the basic reason is to keep a voluntary market in Kansas. Other reasons given were to spread the advance dollars required to establish the JUA over more companies so it would be a relatively insignificant amount per company; to provide a broader base from which to assess needed funds until reimbursed by the health care stabilization fund; to keep private companies as involved as possible; and to use the expertise of a company already in the field. The only alternative would be to establish a state operated insurance company.

Insurance companies, it was noted, were in basic agreement with the concept, but did not state specifically that they would oppose or support this plan.

The Insurance Commissioner administering a fund held by the State Treasurer was questioned. This would be similar to the way the Workmen's Compensation Fund is handled.

A question was raised as to whether it would be better to have the Attorney General employ outside counsel as needed rather than giving this authority to the Insurance Commissioner. It was pointed out that from an administrative point of view it was better to give the administrator of the fund this

authority, although this is not imperative. The Insurance Commissioner has this authority under the Second Injury Fund.

In answer to questions, the Insurance Commissioner's staff stated their actuary had indicated the fund might need more money initially than would be needed to maintain it. However, they had not asked him specifically if the $7,000,000 figure was a realistic amount. The provision for assessing insurance companies is not in the bill, but would be in the rules of operation established by the Board. The section providing for an original amount from the general fund would still be needed to pay back the JUA for what it advances. A large cancellation of policies on high risk groups is not anticipated. Insurance Department staff indicated all companies are considering going to claims-made policies at this time. The self-destruct clause applies only to Section 9 (JUA). Finally, they believe there should be a section giving the Insurance Commissioner the authority to develop rules and regulations to implement this act.

A motion was made and seconded to accept the concept of this bill and to continue the discussion. Motion carried.

The meeting was recessed for lunch at 12:10 p.m. and was reconvened by the Chairman at 1:45 p.m.

The following action was taken on the bill:

A motion was made and seconded to include a section giving the Insurance Commissioner the authority to write rules and regulations to carry out this act. Motion carried.

Section 1(e): Staff reported, as requested by the Committee, that the last clause in this subsection could be deleted avoiding the problem of whether or not janitors, etc., were included. A motion was made and seconded to insert a period after "therapist" page 1, line 14 and to delete the rest of line 14 and all of lines 15 and 16. It was noted that people providing direct services under orders not covered by this definition would be covered by the insurance of the provider under whom they were working. Motion carried. Representative Hohman recorded a no vote.

Section 1(i): Staff noted this section seems to cover more than professional liability and, therefore, the surcharge could be higher especially for hospitals. The Insurance Commissioner's staff noted the last phrase was put in because of the experience in Wisconsin, but they would be willing to try it either way. It was noted that if this phrase is deleted and insurance is obtained through the JUA (Section 9(a)), the insured might have difficulty getting premise coverage. This is usually written as a package since sometimes it is difficult to determine which a claim comes under.

Following a suggestion by staff, a motion was made and seconded to insert a period after "provider" page 1, line 32 and

to delete the rest of line 32 and all of line 33 and to insert the deleted phrase after "insurance" page 7, line 31 (Section 9(a)). In answer to a question, staff noted inserting this in Section 9(a) would make it permissive and not mandatory to include it in the plan. Motion carried.

Section 2(a): The Insurance Commissioner's staff clarified that the intent was not to make liability insurance a requisite for practicing in the state, but to make it a requisite for participation in the fund. Following a staff suggestion, a motion was made and seconded to delete all after "provider" page 2, line 9 and all of lines 10 and 11 and to insert in lieu thereof" as a condition to coverage by the fund" or such similar wording.

In answer to a question, it was noted the bill includes more than doctors and that as worded it required people not previously carrying insurance because they felt they did not need it or not need this much, to carry a $100,000 - $300,000 basic policy, whether or not they wanted to be covered by the fund. Staff noted the bill would seem to make participation in the fund permissive.

To clarify the Committee's intent, a substitute motion was made to insert "covered by basic coverage professional liability insurance" after "provider" in Section 4(d) page 4, line 18. The substitute motion carried.

The original motion was called for and carried.

A motion was made and seconded to instruct staff to amend the definition of "basic coverage" Section 1(b) to conform with the amendment made in Section 2(a). Motion carried.

Consideration was given to adding the option of proving financial responsibility to come under the fund. Consensus was not to provide any options.

Section 5(a): It was pointed out this notification provision would give the Insurance Commissioner more than it would give a defendant. The Insurance Commissioner's staff stated that if the claim is in excess of $100,000 they need to appoint a counsel and handle some other matters as soon as possible, so they need some advance notice. It was noted Section 5(a) was not necessary in light of Section 5(b). A motion was made and seconded to delete Section 5(a) and to renumber the remaining subsections. It was noted that leaving this section in would also affect the statute of limitations. Motion carried.

Section 3(a)(5): In answer to questions, the Insurance Commissioner's staff stated Section 3(a)(5) authorizes payments to the JUA from the fund annually, payments to be by a voucher procedure. Use of "or assessable" page 3, line 25 was questioned. The Insurance Commissioner's staff stated this was a time and money saving mechanism.

By consensus "6" page 3, line 26 is to be deleted and "9" inserted in lieu thereof, and "and any such amount" page 3, line 26 is to be deleted.

In answer to questions regarding Section 1(f), the Insurance Commissioner's staff stated that no one covered by the fund would have to carry coverage after leaving the profession. After a person leaves their profession, the fund would cover all claims including basic coverage up to the one million-three million dollar limits. The fund however, would not cover any incidents prior to the effective date of this act. The insuror is not relieved under this subsection of liability incurred under an occurrence policy. The fund will cover someone after they leave the state.

In answer to questions, the Insurance Commissioner's staff stated that Section 2(a) requires that the basic coverage be a claims made policy. The phrase "or during the prior term of a similar policy" page 2, line 13, was necessary to prevent two companies from being liable for the same incident. So that a person could immediately discern it is to be a claims-made policy, a motion was made and seconded to insert "claims-made" before "policy" page 1, line 4. Motion carried.

Further Action on this bill was deferred until the next day's meeting.

Continuing Education Bill

Staff distributed a bill (Attachment 4) which inserts a continuing education requirement in each of the licensing acts as the Committee instructed. All other changes are technical or for clarification. By consensus "a majority of" page 4, line 18, is to be deleted. Since the requirements must be established, a majority is not needed.

A motion was made and seconded to approve the continuing education bill (5 RS 1720) as amended for introduction. Motion carried.

The meeting was adjourned.

November 14, 1975

The meeting was called to order at 9:10 a.m., by the Chairman, Senator W. H. Sowers.

Minutes

Staff noted the following corrections to the minutes of the October 28, 1975 meeting: Page 3, third paragraph from the bottom - the section reference should be 2(d) instead of 2(a); page 7, top paragraph - needs to indicate the hearing at which time the certificate of the insuror would be suspended rather than the person or facility; page 5, paragraph 5 - change "competency" to "incompetency"; page 8, top of page - the motion should be to delete line 24 only. A motion was made and seconded to approve the minutes as amended. Motion carried.

JUA and Patient Compensation Fund

Staff commended the Insurance Commissioner's staff for the work they had done on this bill (Attachment 3) in such a short time. Staff then raised the following points to be resolved:

Is the name of the fund accurate? After discussion, consensus was to leave the name of the fund as it appears.

Is $100,000 - $300,000 coverage the only coverage that entitles a provider to be in the fund? The $100,000 - $300,000 is to be considered a minimum for participation in the fund.

The proviso in Section 3(a)(1) indicates there is a $300,000 aggregate limit, but the proviso in Section 3(a)(2) seems to indicate there is no aggregate limit. The Insurance Commissioner's staff stated their intent was not to expand the aggregate limit. The second proviso was to cover cases in which a provider became liable in excess of the $300,000 aggregate limit of his basic coverage. The fund would cover the excess up to the three million dollar limit. Staff was instructed to amend the bill to clarify the intent and to indicate the limits above.

This bill gives the Insurance Commissioner the authority to administer the fund, but is silent on his authority to contract for the administration of the fund. By consensus staff was instructed to amend the bill to make it permissive for the Insurance Commissioner to contract for the administration of the fund as previously decided by the Committee.

Page 3, line 22: The purchasing of reinsurance seems to imply it is done in the best interest of the fund. The Insurance Commissioner's staff stated the intent was to make it clear reinsurance would not have to be purchased. By consensus the phrase is to be left in.

Page 3, lines 25-27: Where is authority given for assessment to be made? The Insurance Commissioner's staff stated this authority would be included in the plan submitted under Section 9. Staff noted this was not among the specific things listed in Section 9. By consensus staff is to add words to include this in the plan in Section 9.

Page 3, lines 26-27: This seems to make it mandatory that amounts be paid to the fund annually but another section states nothing will be paid if there is a profit. By consensus staff is to amend the bill to indicate it is to be paid only if needed. The suggestion was to insert "annually to the plan" after "(5)" page 3, line 25 and to delete all after "act" in line 26 and through the "." in line 27.

Page 5, lines 4-7: These lines do not seem to fit into this subsection. Staff was instructed to put this in the proper place. By consensus all after "statement" page 5, line 6 is to be deleted and "with" and "other" line 7 are to be deleted. This deleted phrase is covered by the phrase "any information necessary".

Page 5, lines 18-21 present a problem since for the inactive health care provider the fund would also pay amounts up to $100,000. The policy decision was to allow this language to apply to any final judgment for which the fund might be liable. Staff was instructed to alter language wherever necessary to reflect this policy decision. It was clarified that this section applies to both the per occurrence and the aggregate limits.

Page 6, subsection (b): The staff took exception to this section noting several specific problems. By consensus "medical malpractice action" is to be deleted since it is not a defined term in this act and language used previously in this bill inserted; "practicing or located" is to be deleted since these are the only ones with which the fund would be concerned and "covered by the fund" inserted for clarification. Staff questioned serving a petition within ten days and suggested the language of the previous draft stating the fund shall not be liable unless named a party defendant. The Insurance Commissioner's staff stated the intent of the groups with which they met was to avoid naming the fund as a party to the defendant. An insurance company cannot be sued directly and the fund was considered as an insurance company. Consideration was given to modifying this section to clarify the intent to relate to those cases in which the fund might be liable.

Section 4: The word "amount" in line 30 refers to the amount of settlement and, therefore, cannot apply to settlements of $1.1 million. The wording is to be changed to clarify it is the amount for which the fund is liable and is not to exceed one million dollars.

For clarification "for any one claim" is to be inserted after "($1,100,000)" page 5, line 28. By consensus staff is to amend this section to indicate it applies only to health care providers covered by the fund.

Section 6: Staff noted this section would not include the inactive provider.

Lines 12 through 18 seem to imply that in every case in which the insuror has settled with the plaintiff for the maximum amount of coverage, the claim will then be negotiated with the fund and this may not necessarily be true. Although the use of "may" may cover this, staff was instructed to amend this section for clarification.

In answer to a question, the Insurance Commissioner's staff stated that as a practical matter they do not think there will be any basic coverage policies for $200,000 - $600,000.

Section 7(a): It is not clear whether action is to be started against the fund or gainst the insuror and the fund. The Insurance Commissioner's staff stated the intent was to avoid direct action against the fund. After discussion it was determined that the intent of this section is that if a settlement has been allowed but the Insurance Commissioner does not agree to the excess amount, the plaintiff must continue the action which has been started against the health care provider. Staff was instructed to amend this section to reflect this intent and to clarify that this section refers only to a health care provider covered by the fund.

It was noted that Section 7(d) is covered by the fact the case is in court. By consensus this subsection is to be deleted.

Section 7(e): By consensus the Committee adopted the policy set forth in this section.

Section 8(a): Staff suggested the inclusion of who the action is against - the health care provider - for clarification.

Section 8(b): Staff was instructed to clarify that the fund is paying for health care provider damages under this act and that "any such action" page 7, line 22 refers to action against the health care provider.

Section 9: In lines 26-28 page 7 the cite is to be changed to the total bill rather than just this section.

Section 8(c): It was noted this is contrary to most tort law relative to insurance companies. By consensus this section is not to be changed.

By consensus the Revisor's Office was given full authority to amend the bill as they deemed necessary for clarification

and conformity of sections without changing the intent of the Committee and to make technical changes such as deleting the provisos.

By consensus the staff is to include a definition of health care stabilization fund in the definition and refer to it as the fund in the remaining sections.

Section 3(d): The Insurance Commissioner's staff reported the actuary in their office recommended a fund of not less than ten million dollars. By consensus "65" is to be inserted in the blank page 4, line 27 and "40" in the blank in line 30 as recommended by the actuary.

A motion was made and seconded to approve this bill as amended and as changed by concept today for introduction. Motion carried. Senator Zimmerman recorded a no vote.

Staff is to submit a copy of the amended bill to the Insurance Commissioner for his comments. A copy of the amended bill is to be sent to Committee members for their comments and suggestions.

Civil Procedure (Attachment 5). The substantive change is removing the dollar amount from a pleading. Other changes are technical. Including S.B. 354, which is still in Committee, in this bill was suggested but was not adopted. Concern was expressed over the time lag that might occur before the defense attorney would get the specific dollar amount. It was noted that if the plaintiff's attorney did not provide this, the court could order him to do so right away. In answer to a question, it was pointed out the intent of this bill is to avoid the publicity given a specific dollar amount claim which usually exceeds the final settlement.

A motion was made and seconded to approve this bill (5 RS 1723) for introduction. Motion carried.

Committee Report. The Committee recommended the report include a statement that the Committee has tried to meet the problem by recommending some steps that will provide some solutions fully realizing they have not solved the total problem nor satisfied every group involved. The Committee proposed to take action on those things most likely to affect cost and availability. Although some proposals made to the Committee were emotional reactions to social change, the Committee tried to address itself to the factual rather than the emotional factors and issues. The report should show that some recommendations do not have the unanimous support of the Committee but the Committee felt they needed to be recommended to help meet the problem.

The Committee recommends the appointment of a commission representing the groups involved to continue a study of this problem.

It was further recommended that this commission include some members of this group to provide a continuity. The continuing study should include attention to the doctor-patient relationship which was given as one of the major factors in the increasing problem of medical malpractice, but to which this Committee did not have time to direct its attention.

The report is to reflect the late arrival of the JUA-Fund bill prepared by the Insurance Commissioner's office which precluded any opportunity for the Committee to discuss it with constituents or other interested parties.

The report is also to include a background of the problem, Committee deliberations, the points of view expressed by the various groups appearing before the Committee or submitting written statements to the Committee, and summaries and copies of the bills recommended for introduction.

Staff was instructed to send a draft of the Committee report with the copies of the amended bills to Committee members. The Chairman asked Committee members to have any comments, suggestions or changes to the staff within ten days of receipt of the drafts of the report and the amended bills. By consensus if the Chairman feels the response received necessitates an additional meeting, he will call such a meeting.

It was noted that a dissenting report could be submitted and included.

By consensus the Chairman and Vice-Chairman are to recommend in which house each bill should be introduced to the Coordinating Council.

The Chairman commended the Committee on its faithfulness in the way in which it conducted its business, stating he considered it a privilege to have served as Chairman. The Committee congratulated the staff on the work they have done.

The meeting was adjourned at 3:30 p.m.

Prepared by Emalene Correll

Approved by Committee on:

12/18/75

_____ BILL NO._____

By Special Committee on Medical Malpractice

Re Proposal No. 42

AN ACT providing immunity from a civil action for damages for persons reporting information relating to alleged incidents of malpractice to certain licensing boards.

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

Section 1. No person reporting to the state board of healing arts under oath and in good faith any information such person may have relating to alleged incidents of malpractice by a person licensed or registered by such board shall be subject to a civil action for damages as a result of reporting such information.

Sec. 2. (a) No person reporting to the board of examiners in optometry under oath and in good faith any information such person may have relating to alleged incidents of malpractice by a person licensed to practice optometry shall be subject to a civil action for damages as a result of reporting such information.

(b) This section shall be a part of and supplemental to the optometry law.

Sec. 3. No person reporting to the Kansas dental board under oath and in good faith any information such person may have relating to alleged incidents of malpractice by a person licensed to practice dentistry shall be subject to a civil action for damages as a result of reporting such information.

Sec. 4. No person reporting to the board of nursing under oath and in good faith any information such person may have relating to alleged incidents of malpractice by a person licensed to practice professional nursing or licensed to practice practical nursing shall be subject to a civil action for damages as a result of reporting such information.

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

_____ 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 each 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.

T 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) "Applicant" means any health care provider;

~~(a)~~ (b) "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 2;

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

~~(c)~~ (d) "Fund" means the health care stabilization fund established pursuant to subsection (a) of section 4 3;

~~(d)~~ (e) "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.

(f) "Inactive health care provider" means a health care provider who subsequent to the effective date of this act did purchase basic coverage but who, at the time of payment or settlement pursuant to section 3 did not have basic coverage in effect solely because such person is no longer engaged in rendering professional service as a health care provider.

(g) "Insurer" means any corporation, association, reciprocal exchange, inter-insurer 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.

(h) "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.

(i) "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.

(j) "Rating organization" means a corporation, an unincorporated associati 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 2. (a) A policy of professional liability insurance approved by the commissioner and issued by an insurer duly authorized to transact business in this state in 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 for all claims made during the policy period, shall be maintained in effect by each health care provider prior to performing professional services within this state unless, pursuant to federal or state law such health care provider cannot be held legally liable for professional services. Such policy shall provide coverage for claims made during the term of the policy which were incurred during the term of such policy or during the prior term of a similar policy.

(b) Each insurer providing basic coverage shall within thirty (30) days after the premium for the basic coverage is received by the insurer notify the commissioner that such coverage is or will be in effect. Such notification shall be on a form approved by the commissioner and shall include information identifying the professional liability policy issued or to be issued, the name and address of all health care providers covered by the policy, the amount of the annual premium, the inception and expiration dates of the coverage and such other information as the commissioner shall require. A copy of the notice required by this subsection shall be furnished the named insured.

(c) In the event of termination of basic coverage by cancellation, nonrenewal, expiration or otherwise by either the insurer or named insured, notice of such termination shall be furnished the commissioner and the named insured by the insurer. Such notice shall be provided no less than thirty (30) days prior to the effective date of any termination initiated by the insurer or within ten (10) days of the date coverage is terminated at the request of the named insured and shall include the name and address of all health care providers for whom basic coverage is terminated and the date basic coverage will cease to be in effect. No basic coverage shall be terminated by cancellation or failure to renew by the insurer unless such insurer provides a notice of termination as required by this subsection.

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

Sec. 4 3. (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 health care stabilization fund, such fund to be held in trust in a segregated account in the state treasury and to be administered by the commissioner of insurance. The fund shall be liable to pay: (1) Any amount due from a judgment or settlement which is in excess of the ~~total~~ basic coverage liability of all liable health care providers for any such injury or death not to exceed one million dollars ($1,000,000) per liable health care provider per claim subject to a three million dollar ($3,000,000) aggregate limit for all claims against any one health care provider during any one (1) year: Provided, That, in the case of an inactive health care provider, the fund shall also be liable for any amount due from a judgment or settlement which is within the basic coverage limits specified in section 2 (a): And Provided Further in the case of a health care provider or inactive health care provider, That the fund shall also be liable for any amount due from a judgment or settlement in excess of the annual aggregate amount specified in section 2 (a); (2) reasonable and necessary expenses for attorney's fees incurred in defending the fund against claims; (3) any amounts expended for reinsurance obtained to protect the best interests of the fund: Provided, That such reinsurance is purchased by the committee on surety bonds and insurance pursuant to K.S.A. 1974 Supp. 75-4101; (4) expenses of administering the fund; and (5) any amount assessed (or assessable ? minutes) from insurers pursuant to any plan existing pursuant to section 6 of this act and any such amount shall be payable annually to the plan. 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 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 a Kansas bank for direct obligations of, or obligations that are insured as 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 health care stabilization 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 health care stabilization fund. Such amount shall be a debt upon the health care stabilization 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 health care stabilization fund is indebted to the state general 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 the first day of the month immediately following the effective date of this act. Such premium surcharge shall be an amount equal to a percentage of the premium paid by the health care provider for the basic coverage required 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, and calculated to obtain the amount necessary to accumulate approximately seven million dollars ($7,000,000) within a ten (10) year period following the effective date of this act, but in no event shall such premium surcharge be ~~less than percent (%) nor more than~~ exceed _____ percent (_%) of the annual premium paid by the health care provider for the basic coverage required to be maintained by subsection (a) of section 3. Provided, however, That the premium surcharge shall not be less than _____ percent (_%) of the annual basic coverage premium for the first three (3) years immediately following the effective date of this act.

(e) The premium surcharge shall be collected as a ~~part of~~ in addition to the annual premium for the basic coverage by the insurer and shall not be subject to the provisions of K.S.A. 40-252, 40-2801 et seq. or K.S.A. 40-1113. The amount of

premium surcharge shall be shown separately on the policy or an endorsement thereto and shall be specifically identified as such. Such premium surcharge shall be due and payable by the insurer to the commissioner within thirty (30) days after the annual premium for the basic coverage is received by the insurer. Within fifteen (15) days immediately following the effective date of this act, 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 pursuant to K.S.A. 40-222 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 and, with respect to claim payments, accompanied by (a) a certified copy of a final judgment in excess of one hundred thousand dollars ($100,000) against a health care provider; or (b) a certified copy of a court approved settlement in excess of one hundred thousand dollars ($100,000) against a health care provider. For investment purposes amounts shall be paid from the fund upon vouchers approved by the chairperson of the pooled money investment board.

Sec. 4. The insurer of a health care provider shall be liable only for the first one hundred thousand dollars ($100,000) of a medical malpractice claim against the health care provider. The health care provider, or, if he has appropriate insurance, his insurer shall also be liable for all amounts in excess of one million one hundred thousand dollars ($1,100,000). Any amount due from a judgment or a settlement that is in excess of one hundred thousand dollars ($100,000) shall be paid from the health care stabilization fund if such amount is not over one million dollars ($1,000,000).

Sec. 5. (a) Any person making a claim for damages in excess of one hundred thousand dollars ($100,000) for personal injury or death arising out of the rendering of or the failure to render professional services by a health care provider shall notify the health care provider and the commissioner by registered mail of such claim at least sixty (60) days prior to filing suit. The commissioner shall have sixty (60) days in which to investigate and negotiate such claims.

(b) The plaintiff in any medical malpractice action filed against any health care provider practicing or located within this state shall serve a copy of the petition upon the commissioner by registered mail within ten (10) days from filing the same. If such service is not made the fund shall not be liable for any amount due from a judgment or a settlement nor, in such case, shall the health care provider or his insurer be liable for such amount that, if service had been made, would havebeen paid by the fund.

(c) Such action shall be defended by the insurer, but if the commissioner believes a conflict of interest between the insurer and the fund is reasonably likely, the commissioner may employ independent counsel to represent the interests of the fund. The cost of employing such counsel shall be paid from the fund.

Sec. 6. In any situation in which 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), the claimant and the commissioner may negotiate on an amount to be paid from the health care stabilization fund. The commissioner may employ independent counsel to represent the interest of the fund in any such negotiations. In the event the claimant and the commissioner agree upon an amount the following procedure shall be followed:

(a) A petition shall be filed by the claimant with the court in which the action is pending against the health care provider, or if none is pending, in a district court of appropriate venue and jurisdiction, for approval of the agreement between the claimant and the commissioner.

(b) The court shall set such petition for hearing as soon as the court's calendar permits, and notice of the time, date and place of hearing shall be given to the claimant, the health care provider, and to the commissioner.

(c) At such hearing the court shall approve the proposed settlement if the court finds it to be valid, just and equitable.

(d) In the event the settlement is not approved, the procedure set forth in section 7 shall be followed.

Sec. 7. (a) In any claim in which 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's demand is in the amount in excess of one hundred thousand dollars ($100,000), to which the commissioner does not agree, an action must be commenced by the claimant against

health care provider in a court of appropriate venue and jurisdiction for su damages as are reasonable in the premises. If an action is already pending against the health care provider, no additional action shall be allowed, and the pending action shall be conducted in all respects as if the insurer had not agreed to settle by payment of its policy limits.

(b) Any such action shall be defended by the insurer in all respects as if the insurer had not agreed to settle its liability by payment of its policy limits. The insurer shall be reimbursed from the fund for the costs of such defense incurred after the settlement agreement was reached, including a reasonable attorney's fee.

(c) In any such action the health care provider against whom claim is made shall be obligated to attend hearings and trials, as necessary, and to give evidence.

(d) The procedure in any such action shall be in accordance with and governed by the Kansas code of civil procedure, and the parties to such action shall have all rights and duties granted to and imposed upon them by the code of civil procedure.

(e) The costs of the action shall be assessed against the health care stabilization fund if the recovery is in excess of the amount offered by the commissioner to settle the case and against the claimant if the recovery is less than such amount.

Sec. 8. (a) No claimant shall have any right of action directly against the health care stabilization fund. No claimant shall have any right of action under this act directly against an insurer.

(b) Evidence that a portion of any verdict would be payable from insurance or the health care stabilization fund shall be inadmissible in any such action.

(c) Nothing herein shall be construed to impose any liability on the fund in excess of that specifically provided for herein for negligent failure to settle a claim or for failure to settle a claim in good faith.

Sec. ~~6.~~ 9. The purpose of this section is to make professional liability insurance available for health care providers and may be cited as the medical professional liability insurance availability act.

(a) 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:

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

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

(3) a method whereby annually the plan shall compare the premiums earned to the losses and expenses sustained by the plan for the preceding calendar year. If there is any surplus of premiums over losses and expenses received for that year such surplus shall be transferred to the health care stabilization fund; or if there is any excess of losses and expenses over premiums earned such losses shall be transferred from the health care stabilization fund.

(4) the limits of liability which the plan shall be required to provide but in no event shall such limits be less than those limits provided for in subsection (a) of section 2 of this act.

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

(b) 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 (1), (2), (3), (4), and (5) above. As soon as reasonably possible after the plan has been filed the commissioner shall in writing approve or disapprove the same: Provided, That 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 (1), (2), (3), (4) and (5) above, 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 he 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.

(c) If no plan meeting the standards set forth in section 6 (a) (1), (2), (3), (4) and (5) 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 he 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

th ct he 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.

(d) 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 five (5) members:

(1) Four (4) members who shall be appointed as follows: Two (2) of such members shall be representatives of foreign insurers, one (1) member shall be a representative of domestic insurers and one (1) member shall be a licensed insurance agent actively engaged in the solicitation of casualty insurance. 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

(2) One (1) health care provider with said member to be appointed for a term of two (2) years.

(e) 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. Such commission shall be reasonably equivalent to the usual customary commission paid on similar types of policies issued in the voluntary market.

(f) This section expires on July 1, 1978, unless continued by the legislature.

Sec. 10. 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. 11. This act shall take effect and be in force from and after its publication in the official state paper.

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Attachment 4

_____ BILL NO._____

By Special Committee on Medical Malpractice

AN ACT requiring continuing education as a condition for continued licensure or registration of certain persons; amending K. S. A. 65-2809 and K. S. A. 1975 Supp. 65-1117, 65-1431 and 65-2910 and repealing the existing sections.

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

Section 1. K. S. A. 1975 Supp. 65-1117 is hereby amended to read as follows: 65-1117. (a) All licenses issued under the provisions of this act, whether initial or renewal, shall expire every two (2) years. The expiration date shall be established by the rules and regulations of the board. The board shall mail an application for renewal of license to every registered professional or licensed practical nurse at least sixty (60) days prior to the expiration date of such person's license. Every person so licensed who desires to renew his or her license shall file with the board, on or before the date of expiration of such license, a renewal application together with the prescribed biennial renewal fee. The board shall require every licensee to submit with the renewal application evidence of satisfactory completion of a program of continuing education required by the board. Upon receipt of such application ~~and~~, payment of fee and receipt of the evidence of satisfactory completion of the required program of continuing education and upon being satisfied that the applicant meets the requirements set forth in K. S. A. 1975 Supp. 65-1115 or 65-1116 and amendments thereto in effect at the time of initial licensure of the applicant, the board shall verify the accuracy of the application and grant a renewal license.

(b) Any person who shall fail to secure a renewal license within the time specified herein may secure a renewal of his or her lapsed license by making verified application therefor on a

form provided by the board and upon furnishing proof that the applicant is competent and qualified to act as a registered professional or licensed practical nurse and by satisfying all of the requirements for renewal ~~as~~ set forth ~~above~~ in subsection (a), including payment to the board of a reinstatement fee as established by the board.

Sec. 2. K. S. A. 1975 Supp. 65-1431 is hereby amended to read as follows: 65-1431. On or before the first day of December of each year, every dentist licensed to practice dentistry in this state shall transmit to the secretary of the board, upon a form prescribed by the board, his or her signature, post-office address, office address, the number of his or her license certificate, whether such licensee has been engaged during the preceding year in the active and continuous practice of dentistry, whether within or without this state, evidence that such licensee has satisfactorily completed a program of continuing education required by the board and such other information as may be required by the board, together with the fee ~~herein-provided--for~~ required by this section.

The board each year, on or before October first, shall determine the amount that may be necessary for the next ensuing fiscal year to carry out and enforce the provisions of this act, and shall fix the renewal fee at such reasonable sum as may be necessary for that purpose. Such fee, ~~however,~~ shall not be less than five dollars ($5) nor more than thirty dollars ($30). Upon fixing the annual renewal fee, the board shall immediately notify all registered licensees of the amount of ~~said~~ the fee for the ensuing year. Upon receipt ~~thereof--he~~ of such fee and upon receipt of evidence that the licensee has satisfactorily completed a program of continuing education required by the board, the licensee shall be issued a renewal certificate authorizing ~~him~~ the licensee to continue the practice of dentistry in this state for a period of one ~~(1)~~ year.

Any license granted under authority of this ~~or--any--prior dental~~ act shall automatically be canceled if the holder thereof

fails to secure ~~the~~ a renewal certificate ~~herein--provided--for,~~ within a period of three (3) months from the 30th day of November of each year. Any dentist whose license ~~shall be~~ is automatically canceled by reason of failure, neglect or refusal to secure the renewal certificate may be reinstated by the board at any time within six (6) months from the date of the automatic cancellation of said license, upon payment of the renewal ~~certificate~~ fee and a penalty fee of fifteen dollars ($15) and upon proof that such licensee has satisfactorily completed a program of continuing education required by the board. If said licensee ~~shall not apply~~ has not applied for renewal of his or her license within ~~said~~ six (6) months after it ~~shall have~~ has been automatically canceled and ~~pay~~ has not paid the required fees or presented proof of satisfactory completion of the required program of continuing education, then said licensee shall be required to file an application for and take the examination provided for in this act.

Upon failure of any licensee to pay the annual renewal fee or to present proof of satisfactory completion of the required program of continuing education within two (2) months after November 30 of any year, the board shall notify such ~~dentist~~ licensee, in writing, by mailing notice to his or her last registered address. Failure to mail or receive such notice~~,--however,~~ shall not affect the cancellation of his or her license~~:~~ ~~Provided,--however,--That--the.~~ The board may waive the annual payment of fees ~~herein-provided~~ and the required program of continuing education for the renewal of certificates ~~to--any--Kansas licensee~~ and issue a renewal certificate without the payment of any renewal fee to any Kansas licensee if said licensee has held a Kansas license at least twenty-five (25) years but, because of age or physical disability, has retired from the practice of dentistry. The waiver of fees ~~herein-provided~~ may be continued so long as ~~said~~ retirement because of age or physical disability continues.

Sec. 3. K. S. A. 65-2809 is hereby amended to read as fol-

lows: 65-2809. The license shall expire June 30 each year and may be renewed annually upon request of the licensee ~~without examination. The board may require licensees in any one or more branches of the healing arts to file proof of having taken approved postgraduate work in the preceding year as may be required by the board. The requirement of annual postgraduate education as a condition for renewal of license shall not be required of licensees of any branch of the healing arts or continued in force except upon the approval of a majority of the members of such branch on the board.~~ The request for renewal of a license shall be on a form provided by the board and shall be accompanied by the prescribed fee, which shall be paid not later than the expiration date of the license. The board shall require every licensee to submit with the request for renewal of a license evidence of satisfactory completion of a program of continuing education required by the board. The requirements for continuing education for licensees of each branch of the healing arts shall be established by [a majority of] the members of such branch on the board. At least thirty (30) days before the expiration of his or her license the secretary of the board shall notify each licensee by mail addressed to his or her last place of residence as noted upon the office records. Any licensee who fails to pay the annual fee within thirty (30) days after the expiration of his or her license shall be given a second notice that his or her license has expired and that the board will suspend action for ninety (90) days following the date of expiration and that, upon receipt of the annual renewal fee, together with an additional fee of ten dollars ($10) within the ninety (90) day period no order of revocation will be entered, but that upon the failure to receive the amount then due, including the additional fee of ten dollars ($10), an order of revocation will be entered. ~~Provided,~~ Any licensee who allows his or her license to lapse by failing to renew ~~same~~ as herein provided may be reinstated upon recommendation of the board and upon payment of the renewal fees then due and proof of compliance with the ~~postgraduate~~

continuing educational requirements ~~as~~ established by the board~~, if any~~.

Sec. 4. K. S. A. 1975 Supp. 65-2910 is hereby amended to read as follows: 65-2910. Every registered physical therapist or certified physical therapy assistant shall, during the month of January next following the effective date of this act and during each January thereafter, apply to the board for an extension of his or her registration or certification and pay a fee as determined by the board. The board shall require every registered physical therapist as a condition of extension of his or her registration to submit with the application for an extension of registration evidence of satisfactory completion of a program of continuing education required by the board. Registration or certification that is not so extended on or before January 31, each year, shall automatically lapse on said date. The board, in its discretion, may revive and extend a lapsed registration or certification upon payment of the full amount of the delinquent fee plus a fee not to exceed one dollar ($1) for each such month, or part thereof, the registration or certification has been allowed to lapse and, in the case of a registration, upon proof that the registered physical therapist has satisfactorily completed a program of continuing education required by the board.

Sec. 5. K. S. A. 65-2809 and K. S. A. 1975 Supp. 65-1117, 65-1431 and 65-2910 are hereby repealed.

Sec. 6. This act shall take effect and be in force from and after its publication in the statute book.

_____ BILL NO._____

By Special Committee on Medical Malpractice

AN ACT relating to civil procedure; concerning the rules of pleading; amending K. S. A. 60-208 and 60-209 and repealing the existing sections.

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

Section 1. K. S. A. 60-208 is hereby amended to read as follows: 60-208. (a) Claims for relief. A pleading which sets forth a claim for relief, whether an original claim, counter-claim, cross-claim, or third-party claim, shall contain (1) a short and plain statement of the claim showing that the pleader is entitled to relief, and (2) a demand for judgment for the relief to which ~~he~~ the pleader deems himself or herself entitled, except that no dollar amount shall be included in a pleading demanding relief for unliquidated damages. Relief in the alternative or of several different types may be demanded.

(b) Defenses; form of denials. A party shall state in short and plain terms his or her defenses to each claim asserted and shall admit or deny the averments upon which the adverse party relies. If ~~he~~ the party is without knowledge or information sufficient to form a belief as to the truth of an averment, ~~he~~ the party shall so state and this has the effect of a denial. Denials shall fairly meet the substance of the averments denied. When a pleader intends in good faith to deny only a part or a qualification of an averment, ~~he~~ the pleader shall specify so much of it as is true and material and shall deny only the remainder. Unless the pleader intends in good faith to controvert all the averments of the preceding pleading, ~~he~~ the pleader may make ~~his~~ denials as specific denials of designated averments or paragraphs, or ~~he~~ the pleader may generally deny all the averments except such designated averments or paragraphs as ~~he~~ the pleader

expressly admits; but, when ~~he~~ the pleader does so intend to controvert all ~~its~~ averments, ~~he~~ the pleader may do so by general denial, subject to the obligations set forth in ~~section~~ K. S. A. 60-211.

(c) Affirmative defenses. In pleading to a preceding pleading a party shall set forth affirmatively accord and satisfaction, arbitration and award, assumption of risk, contributory negligence, discharge in bankruptcy, duress, estoppel, failure of consideration, fraud, illegality, injury by fellow servant, laches, license, payment, release, res judicata, statute of frauds, statute of limitations, waiver, and any other matter constituting an avoidance or affirmative defense. When a party has mistakenly designated a defense as a counterclaim or a counterclaim as a defense, the court on terms, if justice so requires, shall treat the pleading as if there had been a proper designation.

(d) Effect of failure to deny. Averments in a pleading to which a responsive pleading is required or permitted, other than those as to the amount of damage, are admitted when not denied in the responsive pleading. Averments in a pleading to which no responsive pleading is required or permitted shall be taken as denied or avoided.

(e) Pleading to be concise and direct; consistency. (1) Each averment of a pleading shall be simple, concise, and direct. No technical forms of pleading or motions are required.

(2) A party may set forth two or more statements of a claim or defense alternately or hypothetically, either in one count or defense or in separate counts or defenses. When two or more statements are made in the alternative and one of them if made independently would be sufficient, the pleading is not made insufficient by the insufficiency of one or more of the alternative statements. A party may also state as many separate claims or defenses as ~~he~~ the party has regardless of consistency and whether based on legal or on equitable grounds or on both. All statements shall be made subject to the obligations set forth in

~~section~~ K. S. A. 60-211.

(f) Construction of pleadings. All pleadings shall be so construed as to do substantial justice.

Sec. 2. K. S. A. 60-209 is hereby amended to read as follows: 60-209. (a) Capacity. It is not necessary to aver the capacity of a party to sue or be sued or the authority of a party to sue or be sued in a representative capacity or the legal existence of an organized association of persons that is made a party. When a party desires to raise an issue as to the legal existence of any party or the capacity of any party to sue or be sued or the authority of any party to sue or be sued in a representative capacity ~~he~~, the party raising the issue shall do so by specific negative averment, which shall include such supporting particulars as are peculiarly within the pleader's knowledge.

(b) Fraud, mistake, condition of the mind. In all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity. Malice, intent, knowledge, and other conditions of mind of a person may be averred generally.

(c) Conditions precedent. In pleading the performance or occurrence of conditions precedent, it is sufficient to aver generally that all conditions precedent have been performed or have occurred. A denial of performance or occurrence shall be made specifically and with particularity.

(d) Official document or act. In pleading an official document or official act it is sufficient to aver that the document was issued or the act done in compliance with law.

(e) Judgment. In pleading a judgment or decision of a domestic or foreign court, judicial or quasi-judicial tribunal, or of a board or officer, it is sufficient to aver the judgment or decision without setting forth matter showing jurisdiction to render it.

(f) Time and place. For the purpose of testing the sufficiency of a pleading, averments of time and place are material and shall be considered like all other averments of material mat-

ter.

(g) Special damage. When items of special damage are claimed, their nature shall be specifically stated. In actions where exemplary or punitive damages are recoverable, the petition shall not state ~~separately the~~ a dollar amount ~~of~~ for ~~such~~ damages sought to be recovered.

(h) Pleading written instrument. Whenever a claim, defense or counterclaim is founded upon a written instrument, the same may be pleaded by reasonably identifying the same and stating the substance thereof or it may be recited at length in the pleading, or a copy may be attached to the pleading as an exhibit.

(i) Tender of money. When a tender of money is made in any pleading, it shall not be necessary to deposit the money in court when the pleading is filed, but it shall be sufficient if the money is deposited in the court at the trial, unless otherwise ordered by the court.

(j) Libel and slander. In an action for libel or slander, it shall not be necessary to state in the petition any extrinsic facts for the purpose of showing the application to the plaintiff of the defamatory matter out of which the claim arose, but it shall be sufficient to state generally that the same was published or spoken concerning the plaintiff; and if such allegation be not controverted in the answer, it shall not be necessary to prove it on the trial; in other cases it shall be necessary. The defendant may, in his or her answer, allege both the truth of the matter charged as defamatory and any mitigating circumstances admissible in evidence to reduce the amount of damages; and whether ~~he--prove~~ the defendant proves the justification or not, ~~he~~ the defendant may give in evidence any mitigating circumstances.

Sec. 3. K. S. A. 60-208 and 60-209 are hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.