Kansas Legislative Research Department December 16, 1977

M I N U T E S

HEALTH CARE PROVIDER MALPRACTICE COMMISSION

October 4, 1977
Room 519 - State House

Members Present

Senator W. H. Sowers, Chairman
John D. Corpolongo, D.O.
Representative Loren Hohman, II
Representative Marvin Littlejohn
Spencer C. McCrae, M.D.
Senator Elwaine Pomeroy
Judith C. Runnels
Daniel K. Roberts, M.D.

Staff Present

Emalene Correll, Kansas Legislative Research Department
Norman Furse, Revisor of Statutes Office

Others Present

Frank L. Gentry, Kansas Hospital Association, Topeka
Elizabeth W. Carlson, Board of Healing Arts, Topeka
Doug Johnson, Kansas Pharmaceutical Association, Topeka
Darb Ratner, Kansas Medical Society, Ozawkie
Jerry Slaughter, Kansas Medical Society, Topeka
Homer Cowan, Jr., The Western Insurance Company, Fort Scott
Ron Todd, Kansas Insurance Department, Topeka
Robert D. Hayes, Kansas Insurance Department, Topeka
Susan Lambrecht, Board of Healing Arts, Topeka
Joseph Shalinsky, Executive Director, State Board of Pharmacy, Kansas City

Morning Session

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

Staff reported that the following groups contacted stated they were not having significant problems currently so would not appear: Kansas Association of Osteopathic Medicine, Kansas Optometric Association, Kansas Hospital Association, Kansas Podiatry Association, Department of Health and Environment, and the Department of Social and Rehabilitation Services. The Kansas Pharmaceutical Association submitted a letter (Attachment A). Mr. Showalter, State Board of Nursing, was not able to appear as requested because of a long-standing prior commitment.

The Chairman stated a reasonable inference would seem to be that the statutes are working reasonably well although some amendments will be proposed.

Insurance Commissioner's Report

Ron Todd, Assistant Commissioner of Insurance, presented a written report (Attachment B). In answer to a question about Section II of Attachment B, Mr. Todd stated

stated Fund monies are invested according to Kansas statutes by a designated group with reports made to the Insurance Commissioner. Answering further questions relative to the Health Care Stabilization Fund and information relative to petitions sent to the Commissioner (Attachment C), Mr. Todd made the following points: Not very many claims were anticipated in the first year but it is thought the number will increase. The Fund can pay out no more than $150,000 per year on any judgment. Since the statute says pay out cannot exceed this amount, the Insurance Commissioner feels this also includes settlements. It is the Commissioner's understanding that the law will not permit the Fund to pay for any incident occurring before July 1, 1976. When a petition is received for an incident prior to this date, a letter is sent spelling out the determination of no basis for the claim. The Commissioner's Office can provide its own adjusting service and defense or can contract for such services. In the one case settled, outside help was hired. The policy will probably be to review the merits of each case to make a determination of whether or not outside help is needed. The Commissioner's Office has assumed that any time someone files a lawsuit they are going to allege it is over $100,000 to include the Fund. Legislation similar to that proposed for Workmens Compensation which would require the payment of attorney fees if the case is found to be without merit could not hurt. However, there is not sufficient experience to provide a basis for recommending such legislation. In answer to a question, Mr. Hays, Insurance Commissioner's Office, stated they plan to match petitions received with cases resulting in payments to the best of their ability and will include this information in future reports.

Referring to Chart I, page 4 of Attachment B, concern was expressed that some of the petitions for incidents prior to July 1, 1976, might be against physicians who had had claims-made policies at the time the law became effective and who did not get prior acts coverage. In answer to questions, Mr. Hays stated the Department required admitted companies to include in their claims-made policies that they would make prior acts coverage available to the insured. However, they could not require this of non-admitted companies and some of these companies would not make it available, i.e., Lloyds of London. Hopefully the number of providers with this problem is small and hopefully they are aware they should purchase prior acts coverage. If the Fund assumed responsibility for this, it would be taking on a liability not contemplated in the legislation. Mr. Hays stated that in Missouri, the Medical Defense Association will provide prior acts coverage for those previously covered by Lloyd's of London. His understanding is they charge one year's premium for each year of prior acts coverage wanted but he could not document this. It was noted this was prohibitive because providers needing this coverage would have been in a higher rate classification.

In further explanation of the Health Care Provider Insurance Availability Plan (Section III of Attachment B), Mr. Todd stated the Plan is basically underwritten by the Fund -- profits from the Plan go to the Fund and losses of the Plan are paid by the Fund. At some point in the future, after actual creditable premium information has been collected, premiums will be set on the basis of experience under the Plan. It is difficult to estimate pay-out since the number of claims that will be attributed back to this period is unknown. Also, some instances have been reported but no claim has been filed as of this date.

In answer to a question, Mr. Todd stated most chiropractors and nurse anesthetists are currently covered under the Plan. At the time the law went into effect, most chiropractors were insured through the Kansas Association of Chiropractors under a mass policy written by a non-admitted company. When the company was first admitted, they offered an occurence policy at a higher rate and chiropractors wanted a claims-made policy.

Referring to Section IV of Attachment B, Mr. Todd stated the withdrawal of some companies from the medical malpractice market had been anticipated since these companies had stayed only at the request of the Insurance Commissioner. Only one withdrawal came as a surprise.

Mr. Todd stated there have been minor problems which have taken time to work out in implementing the part of the law administered by the Insurance Department. However, from the Department's point of view, the program is working as invisioned. It is providing availability of coverage, which was the main intent of the legislation, and it is also creating the side effect of stabilizing insurance costs.

Mr. Todd referred to the recommended amendment to the definition of "health care provider" in K.S.A. 1976 Supp. 40-1126, contained in his letter to Senator Sowers dated October 1, 1977 (Attachment D). A motion was made and seconded to ask staff to draft a bill to amend the definition of "health care provider" in K.S.A. 1976 Supp. 40-1126 as recommended in the first paragraph of Attachment D. Motion carried.

Referring to the second paragraph of Attachment D, it was noted that at the time S.B. 646 was discussed, the interim Committee was led to believe that all nurse anesthetists were certified registered nurse anesthetists. Later it was found this was not true. Insurance companies have been collecting the surcharge for the Fund from nurse anesthetists and the Insurance Department is having to refund it because they are not included. Judy Runnels stated the nursing profession felt only those registered nurses passing the national exam for nurse anesthetists and who are registered as such should be included in the Fund; nurses giving anesthesia under the direction of a physician should not be included. Mr. Todd stated this had been primarily a problem of communication and was getting better.

In answer to a question, Mr. Todd stated it is difficult to get an exact figure for compliance because how many licensed practitioners are actually practicing is not known. However, 90 percent compliance would be a fair estimate. There are isolated instances where 5 percent to 10 percent of a classification have not submitted insurance information.

In answer to a question, Mr. Hays stated each insurance company has established its rate based on its own experience so rates differ between companies. However, the rates of the larger companies differ by only about 5 to 10 percent. The Department does not have the statutory authority to determine classes and rates and say all companies must adopt these. Rates were not the same prior to enactment of this law.

Mr. Todd referred to David H. Fisher's letter to Senator Sowers and the Insurance Commissioner's answers to the questions raised in this letter (Attachment E).

The Commission requested that the Insurance Commissioner's report be mailed in advance of Commission meetings and that some of the material be put on graphs so trends could be noted.

Liggett Case

Staff stated the decision of the Barton County District Court set out clearly that the court held the Kansas Health Care Provider Insurance Availability Act to be constitutional and rejected all contentions that the act was not constitutional. On appeal, the attorneys requested that the case be transferred directly to the Supreme Court. It is staff's understanding that the Supreme Court has agreed to this transfer and will hear the case without a determination from the Court of Appeals. In answer to a question, staff stated this transfer would not automatically expedite hearing by the Supreme Court. By consensus the Chairman was asked to send a letter on behalf of the Commission to the Attorney General with a copy to the Chief Justice requesting that the docketing and hearing of Liggett be expedited because of its importance to the people of Kansas. (Attachment F is a copy of the letter which was sent and Attachment G is a copy of the reply received from the Chief Justice).

Bill Drafts

Staff stated a proposed bill had been drafted, as requested by the Commission, relative to the exemption of VA physicians who do not practice outside federal employment. However, the Attorney General has issued an opinion at the request of Frank L. Johnson, attorney for the Board of Healing Arts, which states these physicians are exempt under present law (Attachment H). Elizabeth Carlson, State Board of Healing Arts, in answer to a question, stated this opinion resolves the Board's questions and problems. Based on the Attorney General Opinion No. 77-216, the Commission decided by consensus it was not necessary to introduce a bill.

Referring to the Commission's request relative to the issue of confidentiality, staff stated two separate issues need to be considered: (1) open meetings, and (2) disciplinary action. The proposed bill draft (Attachment I) speaks to the first issue and would add certain subjects which can be discussed at closed meetings. This language attempts to carry out the intent of the Commission as expressed at the last meeting. It includes health care providers but does not include facilities. Staff noted a meeting can be closed for discussion but must be opened before any formal action is taken.

Staff reviewed the Santa Fe case which makes a distinction between investigations and hearings and which states the accused party is not entitled to disclosure until the matter is proceeding to court. Attention may need to be given to the question of disclosure to the accused party prior to the hearing.

Staff reviewed the attorney's disciplinary proceedings and Rule 223 relative to confidentiality, noting what the Commission is considering for health care providers is essentially the same.

Concern was expressed that after discussion of an investigation in a closed meeting, the meeting would have to be opened before formal action could be taken to continue the investigation or to have formal hearings and this would make it a matter of public record. It was noted this would depend somewhat on procedures presently followed by Boards. Concern was also expressed that if a formal complaint were filed prior to the investigation, it would become a matter of public record prior to hearings. In answer to a question, staff stated that to address confidentiality as it related to administrative procedures, would require amending the statutes governing each Board.

It was noted that the Commission was interested in confidentiality because it wanted to make sure that the licensing agency had all the necessary tools to carry out its functions relative to restricting, suspending, or revoking licenses. Staff stated investigations are not public but formal complaints and hearings are. There is no way to completely close proceedings, but within certain parameters there are some alternatives. A suggestion was made to recommend the bill as drafted with the understanding further changes may need to be made during the Session.

After further discussion, a motion was made and seconded to instruct staff to draft a bill or bills amending the statutes governing each licensing agency to cover confidentiality of administrative procedure and to ask a legislator serving on the Commission to introduce such bill or bills by request. It was clarified this might necessitate additional amendments to the open meeting statute. Motion carried. A motion was made and seconded to have a legislator on the Commission introduce the proposed bill amending the open meeting statute by request keeping in mind the Commission may want to have amendments to this bill prepared at the proper time. Motion carried.

The meeting was recessed at 12:15 p.m. and was reconvened at 1:40 p.m.

Screening Panels

Darb Ratner, attorney, reported that the rules for screening panels had been written and had been adopted by the Chief Justice. He noted there has not been much interest expressed in using screening panels and he felt it would take a push from someone to encourage their use. In Wichita, through the special interest of Judge Klein and the cooperation of attorneys, a screening panel will definitely be used in six cases, three of which involve multiple defendants. A screening panel may be used in three additional cases. Mr. Ratner distributed an informational sheet developed for persons serving on screening panels (Attachment J).

In answer to questions, Mr. Ratner stated a panel was being used in the multiple defendant cases in Wichita only by agreement of the parties and the cooperation of the attorneys. Present statutes do not require agreement and do not address multiple defendant cases. Although not having a procedure for multiple defendant cases is a deficiency, Mr. Ratner recommended not going back to the Supreme Court or amending the present statute until screening panels had been used. The experience in Wichita may provide a basis for some recommendations by January.

Kansas Medical Society

Darb Ratner, Kansas Medical Society, asked the Commission to consider the following recommendations:

1. Recommend that the medical malpractice insurance premium and surcharge for residents be paid by the state. Present statutes define residents as health care providers and require them to carry medical malpractice insurance. This should be considered an expense of the training program and should be paid by the state.

2. Recommend that S.B. 367 (Attachment K), passed by the Senate last session, be acted on favorably by the House Judiciary Committee and the House and be signed by the Governor. Mr. Ratner noted it is important to provide for the meetings and proceedings of these peer review committees to be confidential if they are to function effectively.

3. Recommend legislation requiring a notice of intent to sue (Attachment L). Mr. Ratner stated the intent of this proposal, similar to statutes in other states, is

to help prevent the filing of frivolous cases which might damage the reputation of the health care provider if filed; protect against the attorney filing for publicity for himself or his clients, or against the client with an axe to grind. It could also mean that the attorney and client would get the records and look at them prior to filing, and would provide an opportunity to settle without the expense of litigation. Subsection (d) deals with the statute of limitations problem. In answer to a question, Mr. Ratner stated his assumption was that this would come prior to a screening panel. If the individual is thinking about a screening panel with an agreement between the parties, notice should still be given. He noted this concept might fit into the screening panel statute with the provision the judge can call the screening panel during this thirty days. In answer to questions, he stated they would have no objection to making this recommendation applicable to more than health care providers; thirty days was chosen because it seemed reasonable and was used by other states. It was noted that the California law uses ninety rather than thirty days. Also noted was the fact that it is traumatic to first learn you are being sued by hearing it on the radio.

4. Recommend legislation enabling the court to award reasonable attorney fees to any prevailing defendant if an action brought is found to be without probable cause (Attachment M). Mr. Ratner stated this recommendation is not viewed as a cure all but as a step toward discouraging the filing of some frivolous cases. It was noted this would take a long time and would not protect the provider who may be damaged by the filing of a frivolous case. Mr. Ratner stated that under present law a defendant cannot file a countersuit until the original suit has been settled in his favor which would take a longer period of time.

5. Recommend legislation prohibiting recovery on an oral contract (Attachment N). This would require that guarantees for results must be in writing so there is no question as to what was said. In answer to questions, Mr. Ratner stated they viewed the concept as applying only in certain cases, i.e., if there were promises of results from surgery. It was noted a definition of medical malpractice would have to be included in the statute.

6. Recommend legislation to reinstate the locality rule as it was thought to have been previously. Mr. Ratner referred to the Chandler case in which there were no physicians from Chanute or a similar community. Physicians from two out-of-state universities testified they had read about level of care in this type community and were therefore familiar with it. The Supreme Court found that since they said they had knowledge of this they were entitled to testify. Previously, it was thought the physician testifying had to be from the same or a similar community.

State Board of Healing Arts

Elizabeth Carlson, State Board of Healing Arts, noted the following problems in determining compliance with the law: the licensee uses one address on his license and another address on his insurance; a licensee gets married and uses her maiden name on the license and her married name on her insurance; insurance companies may delay 40 to 45 days in reporting to the Insurance Department and there is another delay in getting the information in the computer; licensees may be covered under a blanket policy which does not list those covered individually. The Board did a second mailing to check non-compliance in August and will be doing a third mailing soon. The Insurance Department now sends only the names of those who show on the printout as not having insurance and furnish labels for the mailings. The names of five licensees who do not have insurance and who say they will not get any, have been turned over to the Attorney General. In answer to questions, Mrs. Carlson stated a letter is sent notifying those refusing to comply that if the Board does not hear from them in ten days, their name will be turned over to the Attorney General. Notification of this action is not sent to the professional organization. Mrs. Carlson agreed there is about 90 percent compliance. It was noted the Attorney General has told the Board they can use persuasive action with those not complying but they cannot use legal action until there is a final decision in Liggett.

In answer to a question, Mrs. Carlson stated this program has necessitated increases in the temporary help and postage items in their budget.

Board of Pharmacy

Mr. Shalinsky stated that in conjunction with the Insurance Commissioner they have been able to determine which members of the pharmaceutical profession come under the law. However, one problem is the pharmacist practicing full-time in another state who covers for someone in Kansas for only a few hours once a year. The interpretation of the Board is that this person must have the required coverage. He stated it might help if this was made clear one way or the other. Mr. Shalinsky stated it is difficult to determine which pharmacists continue to come under the law because pharmacists, especially those hired by large chains, change locations. The task of going through the printout furnished by the Insurance Commissioner is time consuming.

Mr. Shalinsky noted that results of an investigation to determine why so many pharmacists were obtaining coverage from the JUA indicated it is primarily an administrative problem. Mr. Cowan, Western Insurance Company, stated insurance is available in the market. However, in some cases the agent does not have access to it so he says it is not available. He suggested the next letter the Board sends include information relative to availability. Mr. Shalinsky stated they will not take any action against licensees until they are sure they understand the requirements. It was noted the Attorney General would probably tell them the same thing he had told the Board of Healing Arts.

Commission Action on Recommendations of the Kansas Medical Society

S.B. 367 - A motion was made and seconded to send a letter to the House Judiciary Committee stating the Commission supports the passage of S.B. 367. Including nursing staff committees in this bill was suggested. In discussion it was noted that the medical staff is a self-governing body in a facility and nurses are employed by the facility; the medical staff committee has policy setting responsibility and the nursing committee does not. Attention was called to the fact that there are some things discussed by the nursing staff committees which should be held confidential. Concern was expressed that this bill might mean the hospital board, which is responsible for taking action, or the Board of Healing Arts could not have access to the proceedings of the Committee. Mr. Ratner stated a proper function of the Medical Staff Committee is to go to the Hospital Board. A Commission member referred to a case in which a physician filed a suit and his attorney subpoenaed all minutes of the Medical Staff Committee in which this physician's name appeared whether they were pertinent to the case or not. Opening these minutes to discovery will defeat the purpose of the committee.

A substitute motion was made and seconded to send a letter to the House Judiciary Committee stating the Commission supports the passage of S.B. 367 and recommending that consideration be given to adding nursing staff committees to the bill. This should insure that the House Judiciary Committee review the matter. Motion carried. Staff was asked to draft the letter for the Chairman's signature.

Notice of Intent To Sue - A motion was made and seconded to have staff draft a bill based on Attachment L. By consensus the bill is to include the definition of health care provider used in other statutes, a definition of medical malpractice, correct the reference to how the notice is to be sent, and any other changes staff deems appropriate to carry out the intent of the Commission. In answer to a question, it was noted that preventing news coverage is not the only intent of the bill. It also provides an opportunity for the defendant, either directly or through his attorney, to discuss with the plaintiff or the plaintiff's attorney the basis for the suit. Mr. Cowan noted this is a cost factor for insurance companies who do not have an attorney on their staff since it gives the company thirty days to meet with the plaintiff to find if the case has merit or to make a settlement. Motion carried.

Award of Reasonable Attorney Fees - In answer to a question, it was noted there is not much hard data relative to the number of cases filed which are frivolous; there would not be many payments of such awards; the value of the bill is to deter the filing of frivolous cases and not to recover in such cases; if a case is filed, it is very difficult to prove it is a frivolous case.

A motion was made and seconded to have staff draft a bill based on the proposal in Attachment M with appropriate changes. In answer to a question, Mr. Ratner stated he saw no objection to making the provisions of the bill applicable to a defendant bringing in another party. He did not think this would toll any provisions of existing statutes relative to bringing in another party. Motion carried.

Prohibiting Recovery on Oral Contract - In answer to a question, Jerry Slaughter, Kansas Medical Society, stated the number of cases filed on the basis of an oral contract is insignificant but, taken on an individual basis, it is very significant to the physician or the hospital. Mr. Ratner stated this reason is usually joined with negligence in an action. It was noted a very definitive definition of medical malpractice is needed to prevent the defense from using this as a basis not to pay and to insure that collection is not made more difficult than it already is.

A motion was made and seconded to have staff draft a bill based on Attachment N. Questions were raised about whether consideration should be given to limiting this bill to certain health care providers since the relationship between a patient and all health care providers is not the same, i.e., is there an implied contract between a patient and a hospital? Motion carried.

Locality Rule - It was noted a physician from Wichita can speak to some general standards of care but he cannot speak to the standard of care in Chanute. Practice in New York, Texas and Kansas is different. Also in recent cases the plaintiff bar has been acquiring witnesses from a firm in Philadelphia and these witnesses could be from another country. Hopefully this proposal would deter this type activity which is suspect. A motion was made and seconded to ask staff to draft a bill to reinstate the locality rule as it was thought to have been previously. Staff noted the present rule says the same or similar community and asked how the Commission wished to clarify what was intended by the term "similar community". Suggestions were to restrict it to a region or the same or adjoining states with some consideration given to comparability of size since a factor in level of care is the ratio of doctors to patients. Motion carried.

Medical Malpractice Insurance for Residents - A motion was made and seconded to ask staff to draft a bill requiring the state to provide medical malpractice insurance for any residency approved in Kansas in medicine and osteopathy. Motion carried. After a discussion of which state agency should be made responsible for procuring the insurance, consensus was to make the Board of Regents responsible. It was noted that if objections were raised or this caused problems this decision could be reconsidered.

By consensus the Commission requested that the legislative members from Shawnee County work with staff on the drafting and review of the bills requested by the Commission. Drafts of the bills are to be sent to Commission members for review and comments. By consensus the legislative members of the Commission are to be asked to introduce these bills by request.

In answer to a question, Mr. Ratner stated he had no objection to the effective date of the bills recommended by the Kansas Medical Society (Attachments L through N) being changed to publication in the statute book.

Other Issues

A Commission member questioned the fact that the surcharge is not prorated under certain circumstances, i.e., a doctor comes in from another state, takes out insurance and dies the next day. It was noted the surcharge by law is fully earned when paid and there is no statutory provision for the fund to refund the surcharge. Mr. Cowan explained that in these situations there can be instances of exposure which would be open to liability until the statute of limitations expired. The Fund would become liable for the first dollars in this situation. The surcharge has purchased the tail coverage.

Noting that the medical malpractice statutes require continuing education for nursing, concern was expressed over the fact that courses are not easily accessible to all nurses and over the seemingly capricious way in which the State Board of Nursing is approving and denying programs. It was noted the rules only require five contact hours for the first two years at which time it is raised to ten contact hours per year. By 1982, fifteen contact hours per year or thirty contact hours every two years will be required. The philosophy of the Board is that there is no point in having continuing education if the programs approved are not of a certain quality. They are against approving in-service programs that teach someone how to run a machine or how to redo the backrub. The Commission member raising this issue will contact the Board of Nursing and if there appears to be a problem, the Commission will take it up at a later meeting.

Noting that the Commission is to terminate in 1978, looking at whether or not this is sufficient time to look at all aspects of the Medical Malpractice Act was suggested for a later meeting.

Committee Report

The Commission report is to include highlights of the Insurance Commissioner's Report noting that thus far the Plan and the Fund have functioned as envisioned and with success. The report is to note that demands on the Plan and Fund have been less than was anticipated but are expected to increase; that the Plan attempts to keep rates high enough to discourage health care providers coming to the Plan for coverage; that the expiration date of the Plan is uncertain but there are factors operating to discourage its continuance; that the service carrier for the Plan will be refunding to the Plan a portion of the service contract fee they collected for administering the Plan since expenses were less than anticipated primarily because of the small number of claims. Information presented at this meeting is to be used in the report since the conclusions and actions of the Commission were based on this information. The report is to state

that the Commission's view at this time is that no major legislation relative to the Plan or the Fund is needed. The bills the Commission is asking legislators to introduce are ancillary in nature filling out the legislation enacted previously. A summary of the bills and the background for requesting their introduction is to be included.

The report is to include a summary of the status of screening panels, including the reasons why they have not been implemented' an update on Liggett; a reference to the problem of "tail" coverage or prior acts coverage; the status of compliance and noncompliance of health care providers at a given time; that the Commission recognizes the increased workload for certain Boards created by the medical malpractice acts and is supportive of the increased budgetary requests this has necessitated.

The meeting was adjourned.

Prepared by Emalene Correll

Approved by Committee on:

9/7/78
(Date)

EC/jsf

THE KANSAS PHARMACEUTICAL ASSOCIATION
1308 WEST 10TH
P. O. BOX 4219, GAGE CENTER STATION
PHONE (913) 232-0439
TOPEKA, KANSAS 66604

DOUGLAS P. JOHNSON, R. PH.
EXECUTIVE DIRECTOR

Attachment A

To: Health Care Provider Malpractice Study Commission

From: Douglas P. Johnson

Date: October 3, 1977

I appreciate the opportunity to comment before the Commission in writing as my schedule will not permit attendance at your October 4, 1977 meeting.

Comments and questions from Kansas pharmacists have tapered off in the past several months to the point that we have not had any questions for the past three months.

We have had one meeting with Bob Hayes of the Insurance Department recently, to obtain information as to why we have some pharmacists covered under the JUA. The explanation received, which we did confirm with several pharmacists, is based on the confusion between a pharmacy store policy and an individual liability policy.

Many pharmacists, prior to the new law, had liability coverage as a part of a store policy. When the law was passed, several insurance salesmen, who had written a particular pharmacy store policy, applied for individual coverage for the pharmacists under the JUA. As far as we can determine, no attempt was made to find the coverage from an admitted carrier. Bob Hayes has assured us that this will be cleaned up and they outlined their plan in this regard.

Contacts that our Association has had with several insurance carriers indicates that pharmacists do have an excellent choice in obtaining coverage.

We have no other comments at this time. However, we would be glad to respond to any questions of the Commission.

cs

Att. A

REPORT ON HEALTH CARE PROVIDER INSURANCE AVAILABILITY ACT

FLETCHER BELL

COMMISSIONER OF INSURANCE

STATE OF KANSAS

OCTOBER 4, 1977

Atch. B

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SECTION I

INTRODUCTION

During 1975 and the first six months of 1976, the Kansas medical professional liability insurance markets were impaired by declining availability of excess coverages and rising premium costs. The remaining voluntary insurance and those providing the excess professional liability insurance often produced situations where the primary and excess coverages were not compatable, thereby restricting available professional liability coverage to only the basic or primary policy affording limits of liability of only $100,000/$300,000 or $200,000/$600,000 per policy year. In addition to these problems, many Kansas physicians and surgeons were unable to obtain professional liability insurance without the assistance of this department. These problems of availability and price of medical professional liability insurance were the prime factors which resulted in the establishment of special studies conducted in 1975 by the Commissioner of Insurance, the Kansas legislature and other parties related to, or involved in, the Kansas health care delivery system.

Senate Bill No. 646 of the 1976 Legislative Session directly dealt with the availability of primary and excess professional liability insurance coverage for certain Kansas health care providers. (Senate Bill No. 646 was titled the Health Care Provider Insurance Availability Act and codified in K.S.A. 40-3401 et seq.) When this senate bill become effective on July 1, 1976, two insurance availability mechanisms were established. The Health Care Provider Insurance Availability Plan was established to provide basic profes-

sional liability and other primary insurance coverages. The Health Care Stabilization Fund, providing excess professional liability coverage, was also established and is funded by a surcharge levied on defined health care providers.

Appendix I of this report contains a copy of the Health Care Provider Insurance Availability Act and applicable 1977 Legislative senate bills which revised portions of the Act.

This report is intended to review the first year of operation of the Health Care Provider Insurance Availability Plan and the Health Care Stabilization Fund. Also reviewed in this report is the past and current results of the Kansas medical malpractice closed claims reporting requirements.

SECTION II

THE HEALTH CARE STABILIZATION FUND

In accordance with the provisions of K.S.A. 40-3403, the Health Care Stabilization Fund was established on July 1, 1976, for the purpose of providing excess professional liability coverage for health care providers who have qualified for coverage under the provisions of the Health Care Provider Insurance Availability Act. The Fund is administrated by the Commissioner and the first annual Fund surcharge was levied to be an amount equal to 45% of the premium paid by each health care provider for their basic $100,000/$300,000 professional liability insurance policy. For self-insurers under the Act, the 45% surcharge is levied against the annual premium which would have been charged

by the Health Care Provider Insurance Availability Plan. The first annual Fund surcharge percentage was based on an indepedent actuary's study and recommendation, as was the second annual Fund surcharge which was levied on July 1, 1977, to also be 45% of the basic coverage premium.

Because of the coverage to be provided by the Fund for qualified active and inactive health care providers, the Fund surcharge is deemed to be fully earned when paid. The fully earned requirement is necessary, since the Fund coverage continues to be subject to potential loss payments after the qualified health care provider terminates professional practice in Kansas. This continued exposure to loss could be in excess of any applicable insurance policy, or the Fund could be required to provide first dollar of loss and defense costs for qualified inactive health care providers. This continued exposure and the fully earned surcharge requirement were considered in the determination of the annual Fund surcharge percentages levied.

Refund of duplicate Fund surcharges paid because of duplicate basic professional liability coverage situations for individual health care providers is permitted. Duplication of Fund surcharge payment frequently happens when health care providers change employment, join existing groups of health care providers, and in some instances, duplicate basic coverage results from the health care provider changing insurance companies to obtain lower premium charges.

The current status of the fund is presented in the following chart:

CHART I

Status of the Kansas

Health Care Stabilization Fund

as of September 30, 1977

I. Balance and Expenses

Fund Balance (including amounts invested).	$3,279,623.54
Loss Payments from the Fund:	
a) One Claim Paid February 22, 1977	$ 137,500.00
b) Defense Cost of Claim Paid	$ 9,604.93
Actuaries Expense Paid	$ 6,563.00

II. Investments and Anticipated Investment Income

Current Fund monies invested	$2,925,000.00
Anticipated Income from Investments	$ 136,468.75

It is anticipated that the Fund may attain a balance in excess of $5,000,000 by June 30, 1978, which would permit the reduction of the annual Fund surcharge percentage below 40%. (Note: The current actuary's report indicated that the $5,000,000 balance would be reached during FY 1979; however, it is now believed by the Commissioner that the desired balance will be attained as presented in this report.) This situation will be monitored and the FY 1979 Fund surcharge percentage will be levied pursuant to subsection (a) of K.S.A. 40-3404.

If loss activity under the Fund remains consistent with existing actuarial calculations, a $10,000,000 Fund balance is projected for FY 1982 under a "slowed" rate of loss payments. The actuary's report also indicates that total loss payments from the Fund would be approximately $11,510,000 by FY 1982. Should Kansas loss payments from the Fund accelerate in the future, the $10,000,000 Fund balance may not be attained until some time after FY 1985.

To summarize the Fund's loss payment and potential loss payments as currently known as of this report, it can be concluded that the basis of an apparently sound excess professional liability coverage mechanism has been established under the provisions of the Health Care Provider Insurance Availability Act. The exercise of continuing high standards of health care services and reduction, or elimination when possible, of potential patient injuries will only enhance the viability of the continued success of the Health Care Stabilization Fund.

SECTION III

THE KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN

Also established by the Health Care Provider Insurance Availability Act, was the Kansas Health Care Provider Insurance Availability Plan under the provisions of K.S.A. 40-3413. As required by this section of the Act, the Plan became effective on July 1, 1976, for the purpose of assuring health care providers that the required basic professional liability insurance coverage would be available. In addition to professional liability insurance, the Plan also insures some related liability coverages for medical care facilities, mental health centers and mental health clinics.

The Plan's rate levels were promulgated by the Board of Governors and approved by the Commissioner. Currently, the Plan's rate levels are somewhat higher than a majority of the voluntary insurance markets, but when compared to certain individual insurance companies, the Plan's rate levels are lower. The result is that the Plan's rates are noncompetitive with the majority of the voluntary insurance markets in an effort to minimize the number of health care providers insured by the Plan.

A detailed breakdown of the Plan's policy writings as of July 31, 1977, is contained in the following charts, as well as the information with regard to the premiums and Fund surcharges collected by the Plan.

CHART II

Policies Issued by the Kansas Health Care Provider Insurance Availability Plan

As of June 30, 1977

Physicians - No Surgery	92
Physicians - Minor Surgery	100
Surgeons	113
Anesthesiologists	15
Fellowship Licensed Medical Doctors	65
Psychiatrists	14
Podiatrists	36
Chiropractors	269
Optometrists	16
CRNAs	69
Pharmacists	56
Registered Physical Therapists	14
Hospitals	10
TOTAL Health Care Providers	869*

*The difference between the total number of health care providers shown here and the number of Plan policies issued results from two or more health care providers being insured under one Plan policy.

CHART III

Premiums and Health Care Stabilization Fund Surcharges

Collected by the Kansas Health Care Provider Insurance Availability Plan

As of June 30, 1977

Number of Policies Issued by the Health Care Provider Insurance Availability Plan	850
Total Premium Written	$1,062,250
Total Premiums Earned	$ 736,376
Health Care Stabilization Fund	$ 450,083

As of the date of this report, the actual profitability of the Health Care Provider Insurance Availability Plan from the first year of its operation has not been finalized; however, it can be reported at this time that it is anticipated some transfer of money will be made to the Health Care Stabilization Fund from the Plan's premium earned during the first year of operations.

SECTION IV

REVIEW OF THE KANSAS PROFESSIONAL LIABILITY INSURANCE MARKETS

The Kansas medical professional liability insurance markets, prior to July 1, 1976, demonstrated a general lack of availability and a steady trend of spiralling insurance rate increases. In physicians, surgeons and hospital professional liability insurance at least four insurance companies had either withdrawn or indicated their intended withdrawal from this line of insurance. All other medical professional liability insurance companies had restricted or reduced either availability or policy limits for their insureds. Premium levels for The Medical Protective Insurance Company had increased 475% during the eight previous years. Many other insurance companies and rating organizations were proposing rate increases in excess of 100% in 1975 and early 1976.

Since the effective date of the Health Care Provider Insurance Availability Act (July 1, 1976), the availability problem has been completely diminished due to the Health Care Provider Insurance Availability Plan and the excess coverage provided by the Health Care Stabilization Fund. Although the Health Care Provider Insurance Availability Act was not designed to prevent Kansas professional liability insurance rates from increasing, the overall rate level changes since the effective date of the Act has been restricted to three insurance companies. Those professional liability insurance programs for which rate increases have been granted can be termed as generally acceptable and in keeping within sound rate-making principals and techniques. One insurance company, The St. Paul Fire and Marine Insurance Company, reduced their Kansas hospital professional liability insurance rates from 17.8% to 24.1%.

Currently, approximately 41 to 45 insurance companies have, or are, participating in the voluntary professional liability insurance market for Kansas health care providers. Only a few insurance companies have withdrawn or are in the process of withdrawing from the Kansas professional liability insurance market. Two insurance companies, the National Chiropractic Mutual Insurance Company and the Professional Mutual Insurance Company, were admitted to write professional liability insurance in Kansas on July 1, 1976, and the Vigilant Insurance Company has recently filed a new professional liability insurance program for psychiatrists. Some insurance companies have expanded availability for Kansas health care providers.

The Kansas Health Care Provider Insurance Availability Plan has issued 850 policies to Kansas health care providers. This apparently higher-than-expected number of Plan insureds is due, in part, to reasons other than a

lack of availability from the normal insurance markets. For example, several health care providers sought coverage from the Plan because of their own or their insurance agent's lack of knowledge with regard to availability from the normal insurance markets, or because the Plan rate levels were initially lower than the normal insurance market rate levels. In the latter instance, the normal markets have adjusted their rate levels to be somewhat lower than the Plan, and the former instance is being alleviated by furnishing a listing of insurance companies writing each type of health care provider and also requiring written declinations from the voluntary insurance markets.

Professional liability insurance rates are anticipated to remain generally stable for the next six to eight months. Rate projections beyond this short range period cannot be determined from the information currently available. As indicated in the past, Kansas professional liability insurance rates will continue to reflect the loss severity and frequency of medical malpractice claims.

Achievement of increasing the availability of professional liability insurance for Kansas health care providers was the primary goal of the Health Care Provider Insurance Availability Act and has been realized through the implementation of the Health Care Provider Insurance Availability Plan and the Health Care Stabilization Fund. Without the Health Care Provider Insurance Availability Act, significant numbers of Kansas health care providers would continue to be unable to obtain basic professional liability coverage desired. Only minor difficulties have been encountered in the implementation of the provisions of the Health Care Provider Insurance Availability Act. For the most part, these problems are related to obtaining the notices of basic coverage and the Health Care Stabilization Fund surcharges for only a small

percentage of the total Kansas health care providers and usually result from policy midterm changes in the basic coverage (addition or deletion of employed health care providers, changes in professional practice, etc.), premium payment delays by the health care provider, and in some instances difficulty in identifying health care providers insured under commercial package policies.

As previously stated, the cornerstones of the Health Care Provider Insurance Availability Act are the Health Care Provider Insurance Availability Plan and the Health Care Stabilization Fund. At this point, it is essential to the availability of professional liability insurance coverage that these provisions continue to exist.

SECTION V

KANSAS CLOSED CLAIMS REPORTS

Reporting requirements for any medical malpractice claim closed for certain Kansas health care providers by insurance companies became effective on July 1, 1975. Appendix II of this report contains the summarized reports of Kansas closed claims for the period of July 1, 1975 through April 30, 1977, and the period of May 1, 1977 through September 30, 1977. Separation of these two periods has been provided in order that a comparison may be made between the earlier report results and the results being reflected in recent closed claims reports. The following charts have been compiled from the summary reports contained in Appendix II.

CHART IV

Review of Claim Cost from Claims Closed

From 7-1-75 through 4-30-77 and 5-1-77 through 9-30-77

	CLAIMS CLOSED		
Amount of Settlement	7-1-75 thru 4-30-77	5-1-77 thru 9-30-77	Total
No Payment	200	58	258
$1 - 49,999	160	48	208
$50,000 - 99,999	10	6	16
$100,000 and over	5	2	7
TOTAL NUMBER	375	114	489

CHART V

Comparison of Average Claim Costs

	CLAIMS CLOSED		Total
	7-1-75 thru 4-30-77	5-1-77 thru 9-30-77	7-1-75 thru 9-30-77
Average Settlement of Awards Based on Closed Claims Producing Payment to Claimant	$13,579	$20,103	$15,189
Average Claim Payment Based on Total Number of Closed Claims	$ 6,192	$ 9,875	$ 7,051
Total Average Claim Cost (total Claim Costs divided by total number of closed claims)	$ 8,328	$12,879	$ 9,389

The above charts reflect an increase in the claims expenses related medical malpractice claims being closed in Kansas. These increases, while not directly related to insurance rate making, do in fact indicate that Kansas loss severity of medical malpractice claims are continuing to rise.

CHART VI

Closed Claims and Loss Costs

By General Type of Health Care Provider

July 1, 1975 through September 30, 1977

	Hospitals	Physicians	Surgeons	Other	Total
Total Cost to Company	$952,141	$425,940	$2,715,399	$498,644	$4,592,124
Total No. of Claims	162	82	179	66	489
Average claim cost by general type of health care provider	$5,877	$5,194	$15,170	$7,555	$9,391

THE KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY ACT

AND AMENDMENTS

APPENDIX I

Article 34.—HEALTH CARE PROVIDER INSURANCE

40-3401. Definitions. As used in this act the following terms shall have the meanings respectively ascribed to them herein: (*a*) "Applicant" means any health care provider;

(*b*) "Basic coverage" means a policy of professional liability insurance required to be maintained by each health care provider pursuant to the provisions of subsection (*a*) or (*b*) of K. S. A. 1976 Supp. 40-3402;

(*c*) "Commissioner" means the commissioner of insurance;

(*d*) "Fiscal year" means the year commencing on the effective date of this act and each year, commencing on the first day of that month, thereafter;

(*e*) "Fund" means the health care stabilization fund established pursuant to subsection (*a*) of K. S. A. 1976 Supp. 40-3403;

(*f*) "Health care provider" means a person licensed to practice any branch of the healing arts by the state board of healing arts, a person who holds a temporary permit to practice any branch of the healing arts issued by the state board of healing arts, a person engaged in a postgraduate training program approved by the state board of healing arts, a medical care facility licensed by the department of health and environment (excluding any medical care facility under the supervision and control of the state board of regents, within the department of social and rehabilitation services or within the department of human resources), a health maintenance organization issued a certificate of authority by the commissioner of insurance, an optometrist licensed by the board of examiners in optometry, a podiatrist registered by the state board of healing arts, a pharmacist registered by the state board of pharmacy, a licensed professional nurse who is licensed by the board of nursing and certified as a nurse anesthetist by the American association of nurse anesthetists, a professional corporation organized pursuant to the professional corporation law of Kansas by persons who are authorized by such law to form such a corporation and who are health care providers as defined by this subsection or a physical therapist registered by the state board of healing arts;

(*g*) "Inactive health care provider" means a person or other entity who purchased basic coverage or qualified as a self-insurer on or subsequent to the effective date of this act but who, at the time a claim is made for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider, does not have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider;

(*h*) "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;

(*i*) "Plan" shall mean the operating and administrative rules and procedures developed by insurers and rating organizations or the commissioner to make professional liability insurance available to health care providers;

(*j*) "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;

(*k*) "Rating organization" means a corporation, an unincorporated association, a partnership or an individual licensed pursuant to K. S. A. 40-930 or K. S. A. 40-1114, or both sections, to make rates for professional liability insurance;

(*l*) "Self-insurer" means a health care provider who has qualified as a self-insurer pursuant to K. S. A. 1976 Supp. 40-3414. [L. 1976, ch. 231, § 1; July 1.]

40-3402. Professional liability insurance to be maintained by health care providers as condition to rendering services in state, exception, limits of coverage; information to be furnished by insurer; termination of coverage, notice; contents of policies issued in state; duties of certain insurance companies; surcharge and information required of nonresident health care providers and self-insurers. (*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 not less than a three hundred thousand dollar ($300,000) annual aggregate for all claims made during the policy period, shall be maintained in effect by each resident health care provider as a condition to rendering professional service as a health care provider in this state, unless such health care provider is a self-insurer. Such policy shall provide as a minimum 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.

(1) Each insurer providing basic coverage shall within thirty (30) days after the premium for the basic coverage is received by the insurer or within thirty (30) days from the effective date of this act, whichever is later, 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.

(2) 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 by the insurer to the commissioner, the state agency which licenses, registers or certifies the named insured and the named insured. 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 after the date coverage is terminated at the request of the named insured and shall include the name and address of the health care provider or 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.

(3) Any professional liability insurance policy issued, delivered or in effect in this state on and after the effective date of this act shall contain or be endorsed to provide basic coverage as required by subsection (*a*) of this section. Notwithstanding any omitted or inconsistent language, any contract of professional liability insurance shall be construed to obligate the insurer to meet all the mandatory requirements and obligations of this act.

(*b*) Unless a nonresident health care provider is a self-insurer, such provider shall not render professional service as a health care provider in this state unless such provider maintains coverage in effect as prescribed by subsection (*a*) of this section, except such coverage may be provided by a non-admitted insurer who has filed the form required in paragraph (1) of subsection (*b*) of this section.

(1) Every insurance company authorized to transact business in this state, that is authorized to issue professional liability insurance in any jurisdiction, shall file with the commissioner, as a condition of its continued transaction of business within this state, a form prescribed by the commissioner declaring that its professional liability insurance policies, wherever issued, shall be deemed to provide at least the insurance required by this subsection when the insured is rendering professional services as a nonresident health care provider in this state. Any non-admitted insurer may file such a form.

(2) Every nonresident health care provider who is required to maintain basic coverage pursuant to this subsection shall pay the surcharge levied by the commissioner pursuant to subsection (*a*) of K. S. A. 1976 Supp. 40-3404 directly to the commissioner and shall furnish to the commissioner the information required in paragraph (1) of subsection (*a*) of this section.

(*c*) Every health care provider that is a self-insurer shall pay the surcharge levied by the commissioner pursuant to subsection (*a*) of K. S. A. 1976 Supp. 40-3404 directly to the commissioner and shall furnish to the commissioner the information required in paragraph (1) of subsection (*a*) of this section. [L. 1976, ch. 231, § 2; July 1.]

40-3403. Health care stabilization fund; establishment; administration; liability of fund; payments from fund; qualification of health care provider for coverage under fund. (*a*) For the purpose of paying damages for personal injury or death arising out of the rendering of or the failure to render professional services by a health care provider, self-insurer or inactive health care provider subsequent to the time that such health care provider or self-insurer has qualified for coverage under the provisions of this act, there is hereby established the health care stabilization fund. The fund shall be held in trust in a segregated fund in the state treasury. The commissioner shall administer the fund or contract for the administration of the fund with an insurance company authorized to do business in this state.

(*b*) The fund shall be liable to pay: (1) Any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable resident health care providers or resident self-insurers for any such

injury or death arising out of the rendering of or the failure to render professional services within or without this state; (2) any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable nonresident health care providers or nonresident self-insurers for any such injury or death arising out of the rendering or the failure to render professional services within this state. In no event shall the fund be obligated for claims against nonresident health care providers or nonresident self-insurers who have not complied with this act or for claims against nonresident health care providers or nonresident self-insurers that arose outside of this state; (3) any amount due from a judgment or settlement against a resident inactive health care provider for any such injury or death; (4) any amount due from a judgment or settlement against a nonresident inactive health care provider for any injury or death arising out of the rendering or failure to render professional services within this state. In no event shall the fund be obligated for claims against: (A) Nonresident inactive health care providers who have not complied with this act; or (B) nonresident inactive health care providers for claims that arose outside of this state, unless such health care provider was a resident health care provider or resident self-insurer at the time such act occurred; (5) reasonable and necessary expenses for attorney's fees incurred in defending the fund against claims; (6) any amounts expended for reinsurance obtained to protect the best interests of the fund purchased by the committee on surety bonds and insurance pursuant to K. S. A. 1976 Supp. 75-4101; (7) reasonable and necessary actuarial expenses incurred in administering the act; and (8) annually to the plan or plans, any amount assessed or assessable from insurers under any plan or plans existing pursuant to K. S. A. 1976 Supp. 40-3413.

(*c*) All amounts for which the fund is liable pursuant to paragraphs (1), (2), (3) or (4) of subsection (*b*) of this section shall be paid promptly and in full if less than one hundred fifty thousand dollars ($150,000) or if one hundred fifty thousand dollars ($150,000) or more by installment payments of one hundred fifty thousand dollars ($150,000) per fiscal year, the first installment to be paid within sixty (60) days after the fund becomes liable and each subsequent installment to be paid annually on the same date of the year the first installment was paid, until the claim has been paid in full. Any attorney's fees payable from such installment shall be similarly prorated.

(*d*) A health care provider shall be deemed to have qualified for coverage under the fund: (1) On or after the effective date of this act if basic coverage is then in effect; (2) subsequent to the effective date of this act, at such time as basic coverage becomes effective; or (3) upon qualifying as a self-insurer pursuant to K. S. A. 1976 Supp. 40-3414. [L. 1976, ch. 231, § 3; July 1.]

40-3404. Levy of annual premium surcharge; amount; collection by insurer; penalty for failure of insurer to comply; reduction of surcharge, when. (*a*) The commissioner shall levy an annual premium surcharge on each health care provider who has obtained basic coverage and upon each self-insurer for each fiscal year. Such premium surcharge shall be an amount equal to a percentage of the annual premium paid by the health care provider for the basic coverage required to be maintained as a condition to coverage by the fund by subsection (*a*) of K. S. A. 1976 Supp. 40-3402. The annual premium surcharge upon each self-insurer shall be an amount equal to a percentage of the amount such self-insurer would pay for basic coverage as calculated in accordance with rating procedures approved by the commissioner pursuant to K. S. A. 1976 Supp. 40-3413. The commissioner shall determine the applicable percentage, not to exceed sixty-five (65%), to be used in computing the premium surcharge in each fiscal year. Such determination shall be based upon actuarial principles and calculated to accumulate approximately ten million dollars ($10,000,000) within a ten-year period following the effective date of this act. Such premium surcharge shall not be less than forty percent (40%) of the annual basic coverage premium for any fiscal year until the fund accumulates five million dollars ($5,000,000).

(*b*) In the case of a resident health care provider who is not a self-insurer, the premium surcharge shall be collected 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. 40-1113 and 40-2801 *et seq.* and K. S. A. 1976 Supp. 40-252. The amount of the 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, but in the event basic coverage is in effect at the time this act becomes effective, such surcharge shall be based upon the unearned premium until policy expiration and annually thereafter. Within fifteen (15) days immediately following the effective date of this act, the commissioner shall send to each insurer information necessary for their compliance with this subsection. 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. In the case of a nonresident health care provider or a self-insurer, the premium surcharge shall be collected in the manner prescribed in K. S. A. 1976 Supp. 40-3402.

(*c*) If the fund exceeds the sum of ten million dollars ($10,000,000) 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 ten million dollars ($10,000,000). [L. 1976, ch. 231, § 4; July 1.]

40-3405. Transfer of amount from state general fund to health care stabilization fund for insufficiency; appropriation for fiscal year of transfer; repayment; maximum premium surcharge for fiscal years when health care stabilization fund indebted to state general fund. Upon certification by the commissioner 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 transfer an amount equal to such insufficiency from the state general fund to the fund and the amount to be transferred is hereby appropriated for the fiscal year in which such amount is required to be transferred. Each amount transferred from the state general fund to the fund shall constitute a debt of the fund from the date transferred until repaid to the state general fund. An amount equal to such debt shall be transferred to the state general fund in the fiscal year following the fiscal year in which the transfer is made in amounts such that an insufficiency of the fund is not created, and if the full amount to be paid to the state general fund is not so transferred in one payment, the director of accounts and reports shall continue to transfer amounts not more frequently than one time per month until the full amount has been transferred to the state general fund. The commissioner shall levy the maximum premium surcharge authorized by subsection (*a*) of K. S. A. 1976 Supp. 40-3404 in any fiscal year in which the fund is indebted to the state general fund.

The provisions of this section shall expire on July 1, 1981. [L. 1976, ch. 231, § 5; July 1.]

40-3406. Investment of health care stabilization fund moneys. 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 fund. [L. 1976, ch. 231, § 6; July 1.]

40-3407. Payments from fund; claim payments. Except for investment purposes, all payments from the fund shall be upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the commissioner and, with respect to claim payments, accompanied by (1) a certified copy of a final judgment against a health care provider or inactive health care provider for which the fund is liable; or (2) a certified copy of a court approved settlement against a health care provider or inactive health care provider for which the fund is liable. For investment purposes amounts shall be paid from the fund upon vouchers approved by the chairperson of the pooled money investment board. [L. 1976, ch. 231, § 7; July 1.]

40-3408. Liability of insurer or self-insurer for injury or death arising out of act or omission of health care provider, limitation; fund coverage excess over liability insurance coverage. The insurer of a health care provider covered by the fund or self-insurer shall be liable only for the first one hundred thousand dollars ($100,000) of a claim for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider, subject to an annual aggregate of three hundred thousand dollars ($300,000) for all such claims against the health care provider. However, if any liability insurance in excess of such amounts is applicable to any claim or

would be applicable in the absence of this act, any payments from the fund shall be excess over such amounts paid, payable or that would have been payable in the absence of this act.

If any inactive health care provider has liability insurance in effect which is applicable to any claim or would be applicable in the absence of this act, any payments from the fund shall be excess over such amounts paid, payable or that would have been payable in the absence of this act. [L. 1976, ch. 231, § 8; July 1.]

40-3409. Service upon commissioner required in action filed in state for injury or death arising out of act or omission of health care provider, time, failure to make service; notification of commissioner required in action filed outside of state; defense of action. (*a*) (1) In any action filed in this state for personal injury or death arising out of the rendering of or the failure to render professional services by any health care provider covered by the fund or any inactive health care provider covered by the fund, the plaintiff shall serve a copy of the petition upon the commissioner by registered mail within ten (10) days from filing the same, and 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 or her insurer or the inactive health care provider or his or her insurer be liable for such amount that, if such service had been made, would have been paid by the fund; (2) in any action filed outside of this state for personal injury or death arising out of the rendering of or the failure to render professional services by any health care provider or any inactive health care provider covered by the fund, the inactive health care provider, the self-insurer or the insurer of a health care provider or an inactive health care provider shall notify the commissioner, as soon as it is reasonably practicable, that such summons or petition has been filed.

(*b*) Such action shall be defended by the insurer or the self-insurer, but if the commissioner believes it to be in the best interests of the fund, 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. The commissioner is authorized to employ independent counsel in any such action against an inactive health care provider covered by the fund. [L. 1976, ch. 231, § 9; July 1.]

40-3410. Negotiation of amount of claim to be paid from fund; settlement; procedure for court approval. When the insurer of a health care provider or inactive health care provider covered by the fund has agreed to settle its liability on a claim against its insured or when the self-insurer has agreed to settle liability on a claim and the claimant's demand is in an amount in excess of such settlement, or where a claim is against an inactive health care provider covered by the fund who does not have liability insurance in effect which is applicable to the claim, or where it would otherwise be in the best interest of the fund, the claimant and the commissioner may negotiate on an amount to be paid from the 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 the inactive health care provider, or if none is pending, in a court of appropriate 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 or inactive 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 K. S. A. 1976 Supp. 40-3411 shall be followed. [L. 1976, ch. 231, § 10; July 1.]

40-3411. Commencement of action upon failure to reach settlement or obtain court approval thereof on amount to be paid from fund; defense of action; attorneys' fees; costs. (*a*) In any claim in which the insurer of a health care provider or inactive health care provider covered by the fund has agreed to settle its liability on a claim against its insured or when the self-insurer has agreed to settle liability on a claim and the claimant's demand is in an amount in excess of such settlement, to which the commissioner does not agree, or where the claim is against an inactive health

care provider covered by the fund who does not have liability insurance in effect which is applicable to the claim and the claimant and commissioner cannot agree upon a settlement, an action must be commenced by the claimant against the health care provider or inactive health care provider in a court of appropriate jurisdiction for such damages as are reasonable in the premises. If an action is already pending against the health care provider or inactive health care provider, the pending action shall be conducted in all respects as if the insurer or self-insurer had not agreed to settle.

(*b*) Any such action against a health care provider covered by the fund or inactive health care provider covered by the fund who has liability insurance in effect which is applicable to the claim shall be defended by the insurer or self-insurer in all respects as if the insurer or self-insurer had not agreed to settle its liability. The insurer or self-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; except that if the insurer or self-insurer settles the claim for an amount less than one hundred thousand dollars ($100,000), the insurer or self-insurer shall be responsible for all defense costs until the insurer's or self-insurer's total combined payments equal one hundred thousand dollars ($100,000) with respect to such claim, and neither the health care provider, unless such provider is a self-insurer, or the fund shall be obligated to pay the difference between such settlement and one hundred thousand dollars ($100,000). The commissioner is authorized to employ independent counsel in any such action against a health care provider or an inactive health care provider covered by the fund.

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

(*d*) The costs of the action shall be assessed against the 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. [L. 1976, ch. 231, § 11; July 1.]

40-3412. Same; no direct action against fund or insurer; inadmissible evidence; fund not liable for certain damages. (*a*) Any action for personal injury or death arising out of the rendering of or the failure to render professional services by any health care provider or inactive health care provider shall be maintained against such health care provider or inactive health care provider. No claimant shall have any right of action directly against the 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 fund shall be inadmissible in any such action.

(*c*) Nothing herein shall be construed to impose any liability in 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.

(*d*) The fund shall have no obligations whatsoever for payment for punitive damages.

(*e*) The fund shall not be liable to pay amounts due from a judgment against an inactive health care provider arising from the rendering of professional services as a health care provider contrary to the provisions of this act.

(*f*) Any action for damages or for approval of a settlement as set forth in K. S. A. 1976 Supp. 40-3409, 40-3410 or 40-3411 shall be brought in a court of appropriate jurisdiction and venue. [L. 1976, ch. 231, § 12; July 1.]

40-3413. Apportionment of risk among insurers; preparation of plan; contents; approval or disapproval; amendment; preparation by commissioner of insurance, when; governing board, membership; order to discontinue unfair or unreasonable activities or activities inconsistent with act; commissions on insurance under plan; expiration of section. (*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, and such other liability insurance as may be included in or added to the plan, 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 including the authority to make assessments against the insurers participating in the plan or plans;

(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 fiscal year. If there is any suplus of premiums over losses and expenses received for that year such surplus shall be transferred to the fund. If there is any excess of losses and expenses over premiums earned such losses shall be transferred from the 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 K. S. A. 1976 Supp. 40-3402;

(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 subsection (*a*) of this section. 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 subsection (*a*) of this section, but only after a hearing held upon not less than ten (10) days' written notice to every insurer and rating organization affected 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.

(*c*) If no plan meeting the standards set forth in subsection (*a*) 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 after hearing, if necessary to carry out the purpose of this act, prepare and promulgate a plan meeting such requirements.

(*d*) 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.

(*e*) For every such plan or plans, there shall be a governing board which shall meet at least annually to review and prescribe operating rules. Such board shall consist of nine (9) members to be appointed by the commissioner as follows: Three (3) members shall be representatives of foreign insurers, two (2) members shall be representatives of domestic insurers, two (2) members shall be representatives of the general public, one (1) member shall be a licensed insurance agent actively engaged in the solicitation of casualty insurance and one (1) member shall be a health care provider. Said members shall be appointed for a term of two (2) years.

(*f*) 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.

(*g*) The provisions of this section shall expire on July 1, 1978. [L. 1976, ch. 231, § 13; July 1.]

40-3414. Qualification of health care provider as self-insurer; cancellation of certificate of self-insurance, grounds. (*a*) Any health provider whose annual insurance premium is or would be one hundred thousand dollars ($100,000) or more for basic coverage calculated in accordance with rating procedures approved by the commissioner pursuant to K. S. A. 1976 Supp. 40-3413, may qualify as a self-insurer by obtaining a certificate of self-insurance from the commissioner. Upon application of any such health care provider, on a form prescribed by the commissioner, the commissioner may issue a certificate of self-insurance if the commissioner is satisfied that the applicant is possessed and will continue to be possessed of ability to pay any judgment for which liability exists equal to the amount

of basic coverage required of a health care provider obtained against such applicant arising from the applicant's rendering of professional services as a health care provider. In making such determination the commissioner shall consider (1) the financial condition of the applicant, (2) the procedures adopted and followed by the applicant to process and handle claims and potential claims, (3) the amount and liquidity of assets reserved for the settlement of claims or potential claims and (4) any other relevant factors. The certificate of self-insurance may contain reasonable conditions prescribed by the commissioner. Upon not less than five (5) days' notice and a hearing pursuant to such notice, the commissioner may cancel a certificate of self-insurance upon reasonable grounds therefor. Failure to pay any judgment for which the self-insurer is liable arising from the self-insuror's rendering of professional services as a health care provider, the failure to comply with any provision of this act or the failure to comply with any conditions contained in the certificate of self-insurance shall be reasonable grounds for the cancellation of such certificate of self-insurance.

(*b*) Any health care provider who holds a certificate of self-insurance shall pay the applicable surcharge set forth in K. S. A. 1976 Supp. 40-3402 (*c*). [L. 1976, ch. 231, § 14; July 1.]

40-3415. Consultation and assistance in maintaining compliance with act. The commissioner, the attorney general and the officers and employees of the state agencies which license, register, certify or otherwise regulate health care providers are authorized and directed to consult with and assist each other in maintaining compliance with the provisions of this act. [L. 1976, ch. 231, § 15, July 1.]

40-3416. Report of suspected violations to regulatory agencies; investigation; report to attorney general; injunctive relief. Whenever the commissioner is informed or reasonably suspects that a health care provider is rendering professional services in violation of K. S. A. 1976 Supp. 40-3402, said commissioner shall report the suspected violation to the state agency which licenses, registers or certifies such health care provider. Upon receipt of such report or other evidence of a violation of K. S. A. 1976 Supp. 40-3402, said state agency shall make such investigation as it deems necessary and take such other official action as deemed appropriate. If a violation is found to exist, said state agency shall promptly notify the attorney general of this state. Upon such notice the attorney general or county attorney of the proper county shall, in the name of the state, institute and maintain an action to enjoin the health care provider from rendering professional services in this state in the district court of the district in which such health care provider is rendering professional services. [L. 1976, ch. 231, § 16; July 1.]

40-3417. Rules and regulations. The commissioner shall prescribe such rules and regulations as may be deemed necessary to carry out the purposes of this act. [L. 1976, ch. 231, § 17; July 1.]

40-3418. Severability of act. 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. [L. 1976, ch. 231, § 18; July 1.]

40-3419. Title of act. K. S. A. 1976 Supp. 40-3401 to 40-3419, inclusive, shall be known and may be cited as the health care provider insurance availability act. [L. 1976, ch. 231, § 19; July 1.]

SENATE BILL No. 295

AN ACT concerning the health care provider insurance availability act; including certain mental health centers as health care providers thereunder; amending K.S.A. 1976 Supp. 40-3401 and repealing the existing section.

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

Section 1. K.S.A. 1976 Supp. 40-3401 is hereby amended to read as follows: 40-3401. As used in this act the following terms shall have the meanings respectively ascribed to them herein:

(a) "Applicant" means any health care provider;

(b) "Basic coverage" means a policy of professional liability insurance required to be maintained by each health care provider pursuant to the provisions of subsection (a) or (b) of K.S.A. 1976 Supp. 40-3402;

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

(d) "Fiscal year" means the year commencing on the effective date of this act and each year, commencing on the first day of that month, thereafter;

(e) "Fund" means the health care stabilization fund established pursuant to subsection (a) of K.S.A. 1976 Supp. 40-3403;

(f) "Health care provider" means a person licensed to practice any branch of the healing arts by the state board of healing arts, a person who holds a temporary permit to practice any branch of the healing arts issued by the state board of healing arts, a person engaged in a postgraduate training program approved by the state board of healing arts, a medical care facility licensed by the department of health and environment (excluding any medical care facility under the supervision and control of the state board of regents, within the department of social and rehabilitation services or within the department of human resources), a health maintenance organization issued a certificate of authority by the commissioner of insurance, an optometrist licensed by the board of examiners in optometry, a podiatrist registered by the state board of healing arts, a pharmacist registered by the state board of pharmacy, a licensed professional nurse who is licensed by the board of nursing and certified as a nurse anethetist by the American association of nurse anethetists, a professional corporation organized pursuant to the professional corporation law of Kansas by persons who are authorized by such law to form such a corporation and who are health care providers as defined by this subsection ~~or~~, *a dentist certified by the state board of healing arts to administer anesthetics under K.S.A. 1976 Supp. 65-2899,* a physical therapist registered by the state board of healing arts, *or a mental health center or mental health clinic licensed by the secretary of social and rehabilitation services*;

(g) "Inactive health care provider" means a person or other entity who purchased basic coverage or qualified as a self-insurer on or subsequent to the effective date of this act but who, at the time a claim is made for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider, does not have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider;

(h) "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;

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

(j) "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;

(k) "Rating organization" means a corporation, an unincorporated association, a partnership or an individual licensed pursuant to K.S.A. 40-930 or K.S.A. 40-1114, or both sections, to make

rates for professional liability insurance;

(l) "Self-insurer" means a health care provider who has qualified as a self-insurer pursuant to K.S.A. 1976 Supp. 40-3414.

Sec. 2. K.S.A. 1976 Supp. 40-3401 is hereby repealed.

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

I hereby certify that the above BILL originated in the SENATE, and passed that body.

_____

SENATE concurred in
HOUSE amendments _____

_____
President of the Senate.

_____
Secretary of the Senate.

Passed the HOUSE
as amended _____

_____
Speaker of the House.

_____
Chief Clerk of the House.

APPROVED _____

_____
Governor.

SENATE BILL No. 132

AN ACT concerning the health care provider insurance availability act; amending K.S.A. 1976 Supp. 40-3413 and repealing the existing section.

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

Section 1. K. S. A. 1976 Supp. 40-3413 is hereby amended to read as follows: 40-3413. (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, and such other liability insurance as may be included in or added to the plan, 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 plan shall provide:

(1) Reasonable rules governing the equitable distribution of risks by direct insurance, reinsurance or otherwise including the authority to make assessments against the insurers participating in the plan or plans;

(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 fiscal year. If there is any surplus of premiums over losses and expenses received for that year such surplus shall be transferred to the fund. If there is any excess of losses and expenses over premiums earned such losses shall be transferred from the 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 K.S.A. 1976 Supp. 40-3402;

(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 subsection (a) of this section. As soon as reasonably possible after the plan has been filed the commissioner shall in writing approve or disapprove th . 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 subsection (a) of this section, but only after a hearing held upon not less than ten (10) days' written notice to every insurer and rating organization affected 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.

(c) If no plan meeting the standards set forth in subsection (a) 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 after hearing, if necessary to carry out the purpose of this act, prepare and promulgate a plan meeting such requirements.

(d) 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.

(e) For every such plan or plans, there shall be a governing

board which shall meet at least annually to review and prescribe operating rules. Such board shall consist of nine (9) members to be appointed by the commissioner as follows: Three (3) members shall be representatives of foreign insurers, two (2) members shall be representatives of domestic insurers, two (2) members shall be representatives of the general public, one (1) member shall be a licensed insurance agent actively engaged in the solicitation of casualty insurance and one (1) member shall be a health care provider. Said members shall be appointed for a term of two (2) years.

(f) 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.

(g) The provisions of this section shall expire on July 1, ~~1978~~ *1980, but any plan created hereunder shall continue to exist for the purpose of allowing policies then in effect to expire, transferring surplus to the fund, completing the payment of claims and receiving reimbursement therefor.*

Sec. 2. K.S.A. 1976 Supp. 40-3413 is hereby repealed.

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

I hereby certify that the above BILL originated in the SENATE, and passed that body.

_____

SENATE concurred in HOUSE amendments _____

_____
President of the Senate.

_____
Secretary of the Senate.

Passed the HOUSE as amended _____

_____
Speaker of the House.

_____
Chief Clerk of the House.

APPROVED _____

_____
Governor.

KANSAS MEDICAL MALPRACTICE

CLOSED CLAIMS REPORTS

APPENDIX II

KANSAS MALPRACTICE CLOSED CLAIMS SUMMARY

MAY 1, 1977 to SEPTEMBER 30, 1977

(Reported in Accordance with K.S.A. 40-1126)

I. Settlements resulting from 114 claims which were closed during the period of May 1, 1977 through September 30, 1977:

Amount of Settlement	Number of Claims
No Payment	58
$1 - 9,999	36
$10,000 - 19,999	5
$20,000 - 29,999	2
$30,000 - 39,999	2
$40,000 - 49,999	3
$50,000 - 59,999	2
$60,000 - 69,999	1
$70,000 - 79,999	2
$80,000 - 89,999	1
$90,000 - 99,999	0

Claims Resulting in Settlements over $100,000

Incident Giving Rise to Claim	Settlement	Defense Costs	Settlement Costs	Other Costs
Administration of Oxygen Following Birth	$125,000	NA-Excess Carrier	NA-Excess Carrier	NA-Excess Carrier
Heart-Lung Machine Malfunction During Surgery	$215,625	---	$5,574.04	---

II. Distribution of Company Costs

Total Cost to Companies for all Closed Claims:	$1,468,220
a. Defense Costs for all Closed Claims:	265,363
b. Other Costs (including loss adjustment, interest expense, company expense, but excluding settlements or awards)	77,081
c. Total Settlements or Awards*	1,125,776
d. Average Settlement or Award Based on Closed Claims Producing Payment to Claimant:	20,103 (56 claims)
e. Average Claim Payment Based on Total No. of Closed Claims:	9,875 (114 claims)

*One claim resulted in an award from legal action. This was in the amount of $50,000.

III. Time of Incident to Time of Claim or Filing of Legal Action:

YEARS	NO. OF CLAIMS	% DISTRIBUTION
Over Six Years	1	0.9%
Six Years	0	0.0%
Five Years	1	0.9%
Four Years	2	1.8%
Three Years	11	9.8%
Two Years	35	31.3%
One Year	64	55.4%
TOTAL	114 Closed Claims	100.1%

IV. Principal causes and total costs of closed claims by type of alleged injury:

TYPE OF LOSS	TYPE OF INSURED				
	Hospitals	Physicians	Surgeons	Other	Total
FALLS					
Total Cost to Co.	6,806	0	4,345	0	11,151
# Claims Closed	3	0	1	0	4
ILLNESS FROM DRUGS					
Total Cost to Co.	0	0	1,264	0	1,264
# Claims Closed	0	3	1	0	4
ANESTHESIOLOGY					
Total Cost to Co.	0	0	5,114	101,482	106,596
# Claims Closed	0	0	1	3	4
BIRTH RELATED					
Total Cost to Co.	100	0	43,169	0	43,269
# Claims Closed	1	0	1	0	2
X-RAY THERAPY					
Total Cost to Co.	63	0	0	0	63
# Claims Closed	1	0	0	0	1
PHYSICAL THERAPY					
Total Cost to Co.	0	0	0	0	0
# Claims Closed	0	0	0	0	0
DOCTOR'S ADVICE					
Total Cost to Co.	0	0	0	0	0
# Claims Closed	0	0	0	0	0
PSYCHIATRIC					
Total Cost to Co.	777	0	0	0	777
# Claims Closed	1	0	0	0	1
PERSONAL INJURY					
Total Cost to Co.	0	0	0	1,507	1,507
# Claims Closed	1	0	0	1	2

	Hospitals	Physicians	Surgeons	Other	Total
P RIPTION ERROR					
.l Cost to Co.	6,900	23,135	19,398	86,329	135,76.
# Claims Closed	1	2	1	3	7
DENTAL					
Total Cost to Co.	0	0	0	22,289	22,289
# Claims Closed	0	0	0	10	10
OPTOMETRY					
Total Cost to Co.	0	0	0	0	0
# Claims Closed	0	0	0	0	0
VASECTOMY					
Total Cost to Co.	0	0	10,783	0	10,783
# Claims Closed	0	0	2	0	2
HYSTERECTOMY, D&C, BIRTH CONTROL					
Total Cost to Co.	0	250	0	65,534	65,784
# Claims Closed	0	2	0	3	5
INCORRECT DIAGNOSIS					
Total Cost to Co.	3,130	6,375	69,198	0	78,703
# Claims Closed	3	2	7	0	12
POST-OP INFECTIONS					
Total Cost to Co.	0	1,047	21,468	34,317	56,832
# Claims Closed	1	1	4	1	7
SURGERY (Directly Related Including Bandaging & Dressing)					
Total Cost to Co.	103,431	0	350,051	0	453,482
# Claims Closed	4	1	11	1	17
IMPROPER HOSPITAL CARE					
Total Cost to Co.	138,219	3,692	55,247	54,943	252,101
# Claims Closed	4	1	2	1	8
MISCELLANEOUS					
Total Cost to Co.	132,302	18,722	76,813	20	227,857
# Claims Closed	13	7	7	1	28
TOTAL					
Total Cost to Co.	391,728	53,221	656,850	366,421	1,468,220
# Claims Closed	33	19	38	24	114

Multiple closed claims arising from one incident: (The following provides breakdown of 12 separate incidents which resulted in 33 separate claims.

INCIDENT PRODUCING CLAIM	TYPE OF HEALTH CARE PROVIDER				
	Hospital	Physician	Surgeon	Other	Total
INCORRECT DIAGNOSIS					
Incident 1					
# Claims Closed	1	0	1	0	2
Incident 2					
# Claims Closed	0	0	3	0	3
Incident 3					
# Claims Closed	1	1	0	0	2
Incident 4					
# Claims Closed	0	0	2	0	2
SURGERY					
Incident 5					
# Claims Closed	1	0	0	1	2
Incident 6					
# Claims Closed	0	0	2	0	2
PRESCRIPTION ERROR					
Incident 7					
# Claims Closed	1	1	1	2	5
POST-OP INFECTION					
Incident 8					
# Claims Closed	0	1	1	0	2
ANESTHESIOLOGY					
Incident 9					
# Claims Closed	0	0	0	2	2
TEST PROCEDURE					
Incident 10					
# Claims Closed	0	5	0	0	5
BURN MANAGEMENT					
Incident 11					
# Claims Closed	0	0	4	0	4
IMPROPER HOSPITAL CARE					
Incident 12					
# Claims Closed	0	1	0	1	2
TOTAL	4	9	14	6	33

KANSAS MALPRACTICE CLOSED CLAIMS SUMMARY

JULY 1, 1975 to APRIL 30, 1977

(Reported in Accordance with K.S.A. 40-1126)

I. Settlements resulting from 375 claims which were closed during the period of July 1, 1975 through April 30, 1977: The following is a summary of those claims; however, due to the requirement of companies to report all closed claims to the Commissioner of Insurance, some of the claims included in this summary were closed prior to July 1, 1975.

Amount of Settlement	Number of Claims
No Payment	200
$1 - 9,999	131
$10,000 - 19,999	19
$20,000 - 29,999	3
$30,000 - 39,999	5
$40,000 - 49,999	2
$50,000 - 59,999	4
$60,000 - 69,999	1
$70,000 - 79,999	3
$80,000 - 89,999	0
$90,000 - 99,999	2

Claims Resulting in Settlements Over $100,000

Incident Giving Rise to Claim	Settlement	Defense Costs	Settlement Costs	Other Costs
Failure to Diagnose Illness Date of Incident--Dec. '73	$100,000 Date of Settlement--April '75	$ 0	$ 0	$ 0
Breech Delivery Causing Brain Damage to Infant Date of Incident--Dec. '71	110,000* Date of Award--Dec. '72	15,354	689	0
Hysterectomy. Date of Incident--June '74	250,000 Date of Settlement--March '75	0	650	0
Brain Damage to Infant During Delivery Date of Incident--Dec. '71	147,500 Date of Settlement--Nov. '72	30,671	0	2,500
IUD - Perforation of Uterus** Date of Incident--June '71	300,000 Date of Settlement--June '73	0	0	0

*Award through legal action.

**Further review of this claim indicates award paid by party other than insurance company.

	July 1, 1975 Dec. 31, 1975	Jan. 1, 1976 April 30, 1977	Total July 1975 April 30, 1977
Total Costs to Companies for All Closed Claims	$1,683,202	$1,439,918	$3,123,120
a. Defense Costs for all Closed Claims	186,609	319,726	506,335
b. Other Costs (including loss adjustment, interest expense, company expense, but excluding settlements or awards)	183,291	96,025	279,316
c. Total of Settlements or Awards	1,313,302	1,008,861	2,322,163
d. Average Settlement or Award Based on Closed Claims Producing Payment to Claimant	26,802 (# claims 49)	8,269 (# claims 122)	13,579 (# claims 171)
e. Average Claim Payment Based on Total Number of Closed Claims	12,049 (# claims 109)	3,792 (# claims 266)	6,192 (# claims 375)

Six claims resulted in awards from legal action, totaling $254,500.

III. Time of Incident to Time of Claim or Filing of Legal Action:

Years	7-1-75 thru 12-31-75 No. of Claims	1-1-76 thru 4-30-77 No. of Claims	Total 7-1-75 thru 4-30-77	% Age Distribution
Over Six Years	2	9	11	2.9%
Six Years	1	1	2	0.5%
Five Years	1	2	3	0.8%
Four Years	0	1	1	0.3%
Three Years	4	9	13	3.5%
Two Years	43	86	129	34.4%
One Year	58	158	216	57.6%
TOTAL	109	266	375	100.0%

IV. Principal causes and total costs of closed claims by type of alleged injury for period from July 1, 1975 to April 30, 1977:

TYPE OF LOSS	TYPE OF INSURED				
	Hosptials	Physicians	Surgeons	Other	Total
FALLS					
Total Cost to Co.	$ 37,318	$ 966	$ 0	$ 1,674	$ 39,958
# Claims Closed	20	2	0	1	23
ILLNESS FROM DRUGS					
Total Cost to Co.	9,687	12,116	48,793	18,406	89,002
# Claims Closed	6	6	6	6	24
ANESTHESIOLOGY					
Total Cost to Co.	0	0	2,044	16,754	18,798
# Claims Closed	0	0	6	6	12

TYPE OF LOSS	TYPE OF INSURED				
	Hosptials	Physicians	Surgeons	Other	Total
BIRTH RELATED					
Total Cost to Co.	188,373	54,172	412,531	0	655,076
# Claims Closed	6	2	7	0	15
X-RAY THERAPY					
Total Cost to Co.	0	3,516	0	10,055	13,571
# Claims Closed	0	3	1	2	6
PERSONAL INJURY					
Total Cost to Co.	777	9,954	32,246	0	42,977
# Claims Closed	1	2	3	0	6
PRESCRIPTION ERROR					
Total Cost to Co.	0	10,979	0	0	10,979
# Claims Closed	0	1	0	0	1
DENTAL					
Total Cost to Co.	0	0	0	37,078	37,078
# Claims Closed	0	0	0	14	14
OPTOMETRY					
Total Cost to Co.	0	0	0	711	711
# Claims Closed	0	0	0	1	1
VASECTOMY					
Total Cost to Co.	0	10,247	11,884	0	22,131
# Claims Closed	0	1	2	0	3
HYSTERECTOMY, D&C, BIRTH CONTROL					
Total Cost to Co.	32,360	12,322	722,705	0	767,387
# Claims Closed	7	5	18	0	30
INCORRECT DIAGNOSIS					
Total Cost to Co.	36,387	62,611	253,142	2,187	354,327
# Claims Closed	13	17	14	2	46
POST-OP INFECTIONS					
Total Cost to Co.	8,660	704	123,357	0	132,721
# Claims Closed	8	2	14	1	25
SURGERY (DIRECTLY RELATED INCLUDING BANDAGING & DRESSING)					
Total Cost to Co.	58,642	9,452	250,657	30,137	348,888
# Claims Closed	17	8	36	3	64
IMPROPER HOSPITAL CARE					
Total Cost to Co.	115,308	5,000	132,603	1,210	254,121
# Claims Closed	23	3	13	1	40
PHYSICAL THERAPY					
Total Cost to Co.	2,600	0	0	1,911	4,511
# Claims Closed	2	0	0	1	3
DOCTOR'S ADVICE					
Total Cost to Co.	0	0	5,269	0	5,269
# Claims Closed	0	1	6	0	7
PSYCHIATRIC					
Total Cost to Co.	5,263	7,148	0	12,000	24,411
# Claims Closed	8	2	0	1	11
MISCELLANEOUS					
Total Cost to Co.	65,038	173,532	63,318	100	301,988
# Claims Closed	18	8	15	3	44
TOTAL					
Total Cost to Co.	560,413	372,719	2,058,549	132,223	3,123,904
# Claims Closed	129	63	141	42	375

V. Multiple Closed Claims Arising From Alleged Injury to One Party

The following chart provides a breakdown of 20 incidents resulting in 48 separate claims during the period from 7-1-75 through 4-30-76.

	CLAIMS FILED AGAINST				
	Hospitals	Physicians	Surgeons	Other	Total
HYSTERECTOMY					
Incident 1 # Closed Claims	1		1		2
Incident 2 # Closed Claims	1		1		2
Incident 3 # Closed Claims			2		2
BIRTH RELATED					
Incident 4 # Closed Claims	1	1	1	1	4
Incident 5 # Closed Claims			2		2
IMPROPER HOSPITAL CARE					
Incident 6 # Closed Claims	1	1			2
INCORRECT DIAGNOSIS					
Incident 7 # Closed Claims	1		2		3
Incident 8 # Closed Claims	1	2			3
Incident 9 # Closed Claims			2		2
Incident 10 # Closed Claims			2		2
ILLNESS FROM DRUGS					
Incident 11 # Closed Claims				2	2
Incident 12 # Closed Claims	1			1	2
SURGERY					
Incident 13 # Closed Claims	1	1			2
Incident 14 # Closed Claims		1	3		4
Incident 15 # Closed Claims			3		3
POST-OP					
Incident 16 # Closed Claims			2		2
Incident 17 # Closed Claims			2		2
Incident 18 # Closed Claims	2				2
Incident 19 # Closed Claims			2		2
ANESTHESIOLOGY					
Incident 20 # Closed Claims	1		1	1	3

MEDICAL MALPRACTICE CLAIMS - PETITIONS SENT TO COMMISSIONER

DATE OF PETITION	DATE OF OCCURRENCE	ALLEGED NATURE OF INJURY	DEPARTMENT DISPOSITION
8-76	6-75/1-76	therapeutic abortion did not work; had baby	No Basis (occurrence prior to Act
9-76	7-76	in open heart surgery, damage to motor nerves, etc.	Settled Claim - $137,500 from Health Care Stabilization Fund
11-76	2-76	death - in Kansas Reception and Diagnostic Center - withheld insulin - sued doctors	No Basis (occurrence prior to Act
12-76	8-73	baby (delivery) brain damage	No Basis (occurrence prior to Act
12-76	9-74 & 5-75	negligence in surgery	No Basis (occurrence prior to Act
12-76	10-75	therapeutic abortion - too late - damage to reproductive organs	No Basis (occurrence prior to Act
1-77	10-72	negligence in surgery	No Basis (occurrence prior to Act
1-77	1-76	negligence in surgery (laparoscopic tubal ligation)	No Basis (occurrence prior to Act
1-77	2-76	wrist; osteopath didn't observe fracture in x-ray	No Basis (occurrence prior to Act
2-77	10-72	hip replacement surgery	No Basis (occurrence prior to Act
2-77	2-75	negligence in surgery	No Basis (occurrence prior to Act
2-77	2-75	negligence in surgery - later lost spleen	No Basis (occurrence prior to Act
2-77	2-75	hysterectomy/perforated uterus (didn't want either)	No Basis (occurrence prior to Act
2-77	2-75	death - anesthetic and surgery on eye	No Basis (occurrence prior to Act
2-77	2-76	fell from hospital bed; broke femur	No Basis (occurrence prior to Act
3-77	3-75	negligence in surgery	No Basis (occurrence prior to Act
3-77	3-75	bad nail (pin) for leg bone	No Basis (occurrence prior to Act
4-77	4-75	negligence in surgery	No Basis (occurrence prior to Act
4-77	4-75	got disease after injection	No Basis (occurrence prior to Act

Atch. C

EDICAL MALPRACTICE CLAIMS - CONTINUED

ATE ETITION	DATE OF OCCURRENCE	ALLEGED NATURE OF INJURY	DEPARTMENT DISPOSITION
5-77	5-75	negligence in surgery - resulted in thrombosis; damaged nerves	No Basis (occurrence prior to Act)
5-77	5-75	death; no reason given	No Basis (occurrence prior to Act)
5-77	7-75	hysterectomy - died from pneumonia	No Basis (occurrence prior to Act)
5-77	9-76	pain in pelvic examination	Active
6-77	11-75	sterility (boy)	No Basis (occurrence prior to Act)
6-77	12-76	perforated uterus and hysterectomy in abortion	Active
7-77	8-73	baby delivered/brain damage	No Basis (occurrence prior to Act)
7-77	8-75	loss of sight; left eye	No Basis (occurrence prior to Act)
7-77	4-76	didn't remove all of ovarian mass; second time, surgical injury	No Basis (occurrence prior to Act)
8-77	8-75	wrist fracture - deformed	No Basis (occurrence prior to Act)
9-77	5-75	torn sphincter (in pregnancy case)	No Basis (occurrence prior to Act)

Insurance Department

Attachment D

FLETCHER BELL
Commissioner

State Office Building—First Floor
Topeka 66612 913-296-3071

STATE OF KANSAS

October 1, 1977

The Honorable Wesley H. Sowers
State Senator, 31st District
234 South Brookside Drive
Wichita, Kansas 67213

Request for Legislative Revision K.S.A. 40-1126; Definition of "health care providers"

Dear Senator Sowers:

The purpose of this letter is to request legislative revision of the definition of "health care provider" currently contained in the third paragraph of K.S.A. 1976 supp. 40-1126, to include "mental health centers, mental health clinics, and health maintenance organizations". This proposed revision would bring the definition of health care providers into agreement with the definition of health care providers contained in the Health Care Provider Insurance Availability Act.

Although the definition in subsection (f) of K.S.A. 40-3401 is more specific with regard to Certified Registered Nurse Anesthetists and Dentists certified by the Board of Healing Arts to administer anesthetics, it is not believed that these two specific designations need to be added to the definition of K.S.A. 1976 supp. 40-1126.

If the above request is adopted by the legislature, a degree of continuity will be established in the closed claims reporting requirements and the Health Care Provider Insurance Availability Act.

Very truly yours,

Fletcher Bell
Commissioner of Insurance

Ron Todd

Ron Todd

RT:RDH:kmh

Atch. D

LAW OFFICES OF
FISHER, PATTERSON, SAYLER & SMITH
820 FIRST NATIONAL BANK TOWER
TOPEKA, KANSAS 66603

DAVID H. FISHER
DO PATTERSON
C. SAYLER
ED. UDLEY SMITH
LARRY G. PEPPERDINE
JAMES P. NORDSTROM

DENNIS R. TAYLOR
JUSTICE B. KING

PHONE
ODE 913
2-7761

September 23, 1977

Senator Wesley H. Sowers, Chairman
Health Care Provider Malpractice Study Commission
527 Union Center
Wichita, Kansas 67202

Dear Senator Sowers:

I regretfully find that I will be unable to attend the next meeting of the Health Care Provider Malpractice Study Commission on October 4, 1977. From my experience in attending and participating in the Commission meetings I have found a sincere desire on the part of the Chairman and the members of the Commission to cope with the problems under study by the Commission.

For the reason that I cannot attend personally I am writing this letter to set out some of my comments with regard to the matters which are under study and to be considered at your October meeting.

1. State of Kansas, ex rel, Curt T. Schneider, Attorney General, Petitioner, vs. Byron Timothy Liggett, M.D., No. 27,154, In the District Court of Barton County, Kansas. - I have carefully studied the court's opinion in this case. Assuming that an appeal will be taken from the court's opinion, I feel that the Commission should request the Attorney General to petition the Kansas Supreme Court for an early hearing on the appeal as a matter of extreme importance to the State of Kansas. Until the Supreme Court has passed on the appeal the Commission does not have a binding decision on which to rely as to whether or not K.S.A. 1976 Supp. 40-3402 and K.S.A. 1976 Supp. 40-3404 are enforceable and K.S.A. 1976 Supp. 40-3401 through 40-3419 are constitutional. The Health Care Providers as a group have relied on the constitutionality of this law and the great majority are complying with the Health Care Stabilization fund. Many problems will arise unless the legislation is held to be constitutional. The problems facing Health Care Providers and the public, if the legislation is held to be unconstitutional, cannot be foreseen at this time, but extensive legislation would be necessary to rectify the problems.

2. "Tail" coverage for those who did not have a claims-made policy from an admitted company when the law went into effect creates a burden on the Health Care Provider and no protection for the public during the period of time in which the Health Care Provider carried that type of policy. The Board of Governors of the Kansas Health Care Provider Insurance Availability Plan might be asked for proposals to cover this problem as well as the problem created if K.S.A. 1976 Supp. 40-3401 through 40-3419 is declared unconstitutional.

Atch. E

3. Information has been given to me indicating that several of the filed carriers previously writing malpractice coverage, and since the enactment of the Kansas Health Care Provider Insurance Availability Act, writing the base coverage, have withdrawn from writing medical malpractice coverage in the state. Several reasons have been given, in that with a maximum coverage of $100,000.00 the premiums chargeable do not justify their continuing to write this kind of insurance in Kansas when the cost of defense is included within the premium for base coverage. A reasonable request of the Insurance Commissioner as to whether or not such companies are withdrawing from writing in the State of Kansas should be made. If this is correct, then I believe the Commission should ask for a report as to what insurance companies are still writing the base coverage required to fulfill the requirements of the Health Care Provider Insurance Availability Act; the number of companies which have withdrawn since the Act was passed; and the reason for such withdrawal. I am certain that Commissioner Bell can obtain this information, which should be studied by the Commission. In the not too distant future the Commission may well face the problem that there is not sufficient coverage on the open market. This would require more coverage to be provided under JUA. The Commission might then want to study the effect on JUA as to when the JUA provisions of the Act would terminate.

4. While it is not a primary concern of your Study Commission as to availability to other professions of malpractice coverage, certain trends seem to indicate that the Health Care Providers are not the only profession facing a shortage in the insurance market. Mr. Edwin Dudley Smith, for the Kansas Bar Association, filed a recommendation at the May 18, 1977 meeting, suggesting that the statute of limitations, K.S.A. 60-513 (7) be amended to cover other professions generally, and giving as his reason that the same might strengthen the constitutionality of the 1976 amendment. Undoubtedly other professional groups will seek to have K.S.A. 60-513 (7) (c) amended to include their professions, and the Commission might wish to study whether or not such amendment would be recommended.

Again, I am sorry that I will not be present for the October 4, 1977 meeting, which I am sure will be very enlightening, and I look forward to receiving a copy of the minutes of that meeting.

Yours very truly

David H. Fisher

David H. Fisher
Commission Member

DHF:jv

cc: Emalene Correll, Kansas Legislative Research Department

September 29, 1977

The Honorable Wesley H. Sowers
State Senator, 31st District
234 South Brookside Drive
Wichita, Kansas 67218

Dear Wes:

I have reviewed your note dated September 26, 1977 and Mr. D. Fisher's letter of September 23, 1977.

The following are my responses to Mr. Fisher's comments:

1. The Dr. B. T. Liggett action: Section 18 (K.S.A. 40-3418) provides for the severability of the Act and it is my opinion that the basic structure of the Health Care Stabilization Fund could continue to operate if, for example, the mandatory insurance requirement was found to be unconstitutional. Although I have not requested any actuarial study of the impact on the surcharge percentage if the mandatory insurance requirement was found unconstitutional, if this example situation did occur, it would probably be necessary to increase the maximum Fund surcharge requirement permitted by the Act. In essence, the mandatory insurance requirement which is patterned after the basic insurance principle of spreading the loss exposure of a few over as many similar homogenous risks as possible, is a key provision of the Act to keep the Fund surcharge percentage at the lowest possible level.

2. "Tail" coverage for non-admitted companies: Adoption of this proposal would result in the Plan and the Fund potentially exposed to claims arising from professional services which occurred prior to the effective date of the Act. Those health care providers insured by non-admitted companies prior to the effective date of the Act are in somewhat of an adverse situation; however, the Act did not, in and of itself, create the problem, and neither should it nor the Plan be expected to resolve such problem.

3. Withdrawal of insurance companies from the Kansas market: Presumably, Mr. Fisher has reference to physicians, surgeons, and hospital professional liability insurance companies. If this is true, my department's records indicate only one unexpected company withdrawal, which was the Pacific Indemnity Company that was insuring Osteopathic doctors. Although this was unexpected, I do want to advise you that another admitted Osteopathic insurance company offered to replace the expiring coverage to prevent any critical problem from developing. Unfortunately, only a small percentage of the withdrawing company's insureds sought coverage from the other admitted market. Other companies which withdrew or are in the process of withdrawing are the Hartford and Aetna Companies. As you may recall, these companies advised my office prior to the legislative development of the Act, of their intended withdrawal. One of these companies also indicated that if they were to remain in the Kansas Hospital Professional Liability Insurance market, it would be necessary to implement a $25,000 minimum premium requirement for any hospital they insured; i.e., the $25,000 minimum premium per hospital was for only $100,000/$300,000 limits. Certainly these withdrawals have occurred; however, the impact has been minimal and often the insureds reduced their premium costs by seeking coverage elsewhere.

4. Extension of reduced statutes of limitations to other professional services: No comments to offer.

Hopefully, these quick responses to Mr. Fisher's comments will be of assistance to you. If your committee desires additional testimony on comments 2 or 3, I am certain my staff can respond to the committee questions on October 4, 1977.

Very truly yours,

Fletcher Bell
Commissioner of Insurance

RDH
FB:kmh

STATE OF KANSAS

WESLEY H. SOWERS
SENATOR 31ST DISTRICT
SEDGWICK COUNTY
527 UNION CENTER
WICHITA, KANSAS 67202

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
CHAIRMAN: PUBLIC HEALTH AND WELFARE
MEMBER: ASSESSMENT AND TAXATION
ELECTIONS
LABOR AND INDUSTRY
LOCAL GOVERNMENT

October 18, 1977

The Honorable Curt Schneider
Attorney General of the State of Kansas
First Floor, Statehouse
Topeka, Kansas 66612

Dear General Schneider:

The Health Care Provider Malpractice Study Commission, at the last meeting of the Commission on October 4, 1977, requested that I write this letter to you on behalf of the Commission expressing the concern of the Commission in regard to the case of State of Kansas v. Liggett, Docket No. 27154, in the District Court of Barton County, and now on appeal to the Supreme Court of the State of Kansas.

Since this case involves matters of great concern and importance to the people of the State of Kansas, I request, on behalf of the Health Care Provider Malpractice Study Commission, that you take every action necessary to expedite the docketing and hearing before the Kansas Supreme Court of the Liggett case.

I hope that you will give this matter your serious and prompt consideration.

Sincerely,

Wesley H. Sowers

Wesley H. Sowers

WSH:dh
cc: Honorable Alfred G. Schroeder,
Chief Justice of the Supreme Court of Kansas

Michael F. Holland, Esq.
618 Main, P. O. Box 206
Russell, Kansas 67665

Atch. F

SUPREME COURT OF KANSAS
TOPEKA, 66612

ALFRED G. SCHROEDER
CHIEF JUSTICE

(913) 234-5057

November 8, 1977

Hon. Wesley H. Sowers
Senator 31st District
Sedgwick County
527 Union Center
Wichita, Kansas 67202

Dear Senator Sowers:

Re: State v. Liggett

Your letter of October 18, 1977, addressed to the Attorney General regarding the above styled case has been considered by the Court.

Pursuant to your request this case will be given preferential setting and assigned for hearing when the case is ready.

Respectfully,

Alfred G. Schroeder

ALFRED G. SCHROEDER
Chief Justice

AGS:ph

cc: Hon. Curt T. Schneider
Attorney General-State of Kansas

Mr. Michael F. Holland, Esq.
618 Main, P. O. Box 206
Russell, Kansas 67665

Mr. Lewis Carter, Clerk
Kansas Supreme Court

Atch. G

STATE OF KANSAS

Office of the Attorney General

1st Floor, State Capitol Bldg. (913) 296-2215 Topeka, Kansas 66612

Curt T. Schneider
Attorney General

June 28, 1977

ATTORNEY GENERAL OPINION NO. 77-216

Mr. Frank L. Johnson
Attorney for the Board
Board of Healing Arts
503 Kansas Avenue - Suite 500
Topeka, Kansas 66603

Re: Physicians--Professional Liability Insurance--Requirements

Synopsis: Physicians who are employed on a full-time basis by the Veterans Administration in Kansas and who hold a Kansas license issued by the State Board of Healing Arts, but who do not practice outside the scope of their federal employment, are not required to obtain the professional liability insurance required by K.S.A. 1976 Supp. 40-3402(a) unless such physicians engage in the practice of the healing arts in this state outside of the scope of their federal employment.

* * *

Dear Mr. Johnson:

K.S.A. 1976 Supp. 40-3402(a) provides in pertinent part thus:

> "A policy of professional liability insurance approved by the commissioner . . . shall be maintained in effect by each resident health care provider as a condition to rendering professional service as a health care provider in this state, unless such health care provider is a self-insurer."

Atch. H

The term "health care provider" is defined by K.S.A. 1976 Supp. 40-3401 to include, among others, "a person licensed to practice any branch of the healing arts by the state board of healing arts . . . ."

You advise that, although not required to do so, many physicians who are employed full time by the Veterans Administration maintain a Kansas license. K.S.A. 65-2872(i) exempts from licensure "[p]ractitioners of the healing arts in the United States army, navy, air force, public health service, or other military service when acting in the line of duty."

You inquire whether physicians who are employed full time by the Veterans Administration who choose to maintain a Kansas license, but who do not engage in the practice of medicine other than within the course of their federal employment, are required to furnish professional liability insurance, as provided in K.S.A. 1976 Supp. 40-3402. As you point out, the Federal Tort Claims Act prohibits medical malpractice suits against such physicians for any act or omission occurring in the course of their federal employment.

The state could not, of course, constitutionally impose its licensing requirements upon federally-employed physicians as a prerequisite for the practice of medicine in the course of their federal employment. The statutory exemption is but a recognition of the constitutional limits on the power of the state. By obtaining and maintaining a license from the Kansas Board of Healing Arts, such physicians enjoy the privilege of practicing medicine in this state outside of the scope of their federal employment, whether that privilege is ever exercised. Under K.S.A. 1976 Supp. 40-3402, the requisite insurance must be obtained "as a condition to rendering professional service as a health care provider in this state." A "health care provider," i.e., a person licensed to practice a branch of the healing arts by the Kansas Board of Healing Arts, is not required to obtain the requisite insurance unless he or she proposed to furnish professional services as a health care provider in the state.

The decision of a Veterans Administration physician to obtain a Kansas license does not bring his or her professional services in the course of that employment within the scope of the Kansas Healing Arts Act. It remains exempt by operation of law, by the statutory exclusion of such services from the act, and not by virtue of the personal wish of the physician to maintain or not to maintain Kansas licensure. Thus, in my judgment, a Veterans Administration physician who maintains Kansas licensure is not required to obtain the professional liability insurance required

by K.S.A. 1976 Supp. 40-3402(a) unless and until that physician renders professional health care services in this state which are subject to licensure by the State Board, i.e., services outside the scope of the practice conducted in the course of his or her federal employment.

Yours truly,

CURT T. SCHNEIDER
Attorney General

CTS:JRM:kj

Attachment I

7 RS 16

_____ BILL NO. _____

By

AN ACT relating to open public meetings; amending K.S.A. 75-4319 and repealing the existing section.

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

Section 1. K.S.A. 75-4319 is hereby amended to read as follows: 75-4319. (a) Upon formal motion made, seconded and carried, all bodies and agencies subject to this act may recess, but not adjourn, open meetings for closed or executive meetings. Any motion to recess for a closed or executive meeting shall include a statement of (1) the justification for closing the meeting, (2) the subjects to be discussed during the closed or executive meeting and (3) the time and place at which the open meeting shall resume. Such motion, including the required statement, shall be recorded in the minutes of the meeting and shall be maintained as a part of the permanent records of the body or agency. Discussion during the closed or executive meeting shall be limited to those subjects stated in the motion.

(b) No subjects shall be discussed at any closed or executive meeting, except the following: (1) Personnel matters of nonelected personnel;

(2) consultation with an attorney for the body or agency which would be deemed privileged in the attorney-client relationship;

(3) consultations with the representative of the body or agency in employer-employee negotiations;

(4) confidential data relating to financial affairs or trade secrets of corporations, partnerships, trusts, and individual proprietorships;

(5) matters relating to actions adversely or favorably affecting a person as a student, patient or resident of a public

Atch. I

institution, except that any such person shall have the right to a public hearing if he or she so requests; ~~and~~

(6) preliminary discussions relating to the acquisition of real property~~.~~; and

(7) matters concerning licensure, registration, certification or other authorization, however denominated, required by law as a condition to the practice within this state of any branch of the healing arts, optometry, dentistry, podiatry, pharmacy, professional nursing, practical nursing or physical therapy.

(c) No binding action shall be taken during closed or executive recesses, and such recesses shall not be used as a subterfuge to defeat the purposes of this act.

Sec. 2. K.S.A. 75-4319 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the official state paper.

MEDICAL MALPRACTICE SCREENING PANELS
Pursuant to K.S.A. Supp. 65-4901 Et. seq.
and Supreme Court Rule number 142

Duties of Judge:

1. Decide if a screening panel should be convened.

2. Pick an attorney as chairperson.

3. Notify attorneys for all parties that a panel has been convened, the name of the chairperson, and the duty of the parties to each select other members of the panel within 10 days.

4. Appoint the third Health Care Provider to the panel if the parties have not agreed within 10 days on such an individual.

Duties of Chairperson:

1. Collect $100 from each party (c) (3).

2. Convene panel promptly at an agreed time and place for a preliminary conference (b) (3).

3. Notify attorneys for all parties of the date that the panel will have its preliminary conference, notify them that plaintiffs attorney must furnish at least 20 days prior to the preliminary conference all medical records, contentions, etc. as required by rules (d) (4) and (7); and that 10 days after plaintiffs filing of the above the defendant must file its contentions, added records, etc. (d) (5).

4. Conduct preliminary conference (d) (8) and (d) (10).

5. Notify parties if additional material is needed (d) (8).

6. Schedule and conduct final conference of screening panel (d) (9) and (d) (10).

7. Prepare written opinion (d) (11) within 90 days of convening (K.S.A. Supp. 65-4904).

8. Determine final compensation and expenses (c) (3) and collect prior to release of opinion.

9. Within 7 days provide copy of opinion and concurring or dissenting opinion to parties, Judge and Insurance Commissioner (K.S.A. Supp. 65-4904).

Duties of Health Care Provider Members of Screening Panel:

1. Cooperate with chairperson to agree on a time for a preliminary conference (d) (3).

2. Notify chairperson and parties if unable to serve on screening panel because of knowledge of material facts of the case or lack of expertise in the subject matter of the claim (d) (2).

3. Attend preliminary conference and review medical records, X-Rays, contentions of the parties, etc, and decide if a decision can be made and whether additional information is necessary. (d) (4)

4. Cooperate in agreeing on a time for a final conference to make decisions and cooperate with chairperson in preparing a written opinion.

Att. J

Attachment K

Session of 1977

SENATE BILL No. 367

By Committee on Public Health and Welfare

2-21

AN ACT relating to confidentiality of records and proceedings of a medical staff committee of a medical care facility.

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

Section 1. Records and proceedings of any committee of the medical staff of a licensed medical care facility shall be confidential and shall be used by such committee and the members thereof only in the exercise of the proper functions of the committee and shall not be public records. The records and proceedings of any such committee shall not be subject to discovery under the Kansas code of civil procedure, shall not be admissible in evidence in any court proceeding and shall be exempt from court process or subpoena. No person in attendance in any meeting of any such committee shall be required to testify as to what transpired at such meeting. The exemptions from discovery, admissibility, process and testimony contained in this subsection shall not be applicable to any proceeding brought by a health care facility or a member of the medical staff thereof and relating to the discipline of a staff member. Nothing in this subsection shall restrict the release of medical records of a patient.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

Atch. K

Session of 1977

Supplemental Information on SENATE BILL 367

AS REPORTED BY SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

Brief of Bill *

SB 367 would enact a new statute which would make the records and proceedings of any medical staff committee of a medical care facility confidential. Under the provisions of SB 367, the records and proceedings of a medical staff committee would not be subject to discovery in civil proceedings, would not be admissible as evidence in any court proceeding and would be exempt from court or subpoena. No person in attendance at a meeting would be required to testify as to what transpired at the meeting. The exemptions from discovery, admissibility, process and testimony would not be applicable to any proceeding brought by a medical care facility or a member of the medical staff of such facility if such proceeding relates to the discipline of a staff member.

Background

SB 367 was introduced at the request of the Kansas Hospital Association.

* Bill briefs do not express legislative intent. They give general information about the bill, not details or expected effects. They are prepared by the Legislative Research Department. The sponsors have not reviewed the briefs.

Attachment - 2

AN ACT RELATING TO MEDICAL MALPRACTICE ACTIONS; REQUIRING A NOTICE OF INTENT TO SUE PRIOR TO INSTITUTING A MEDICAL MALPRACTICE ACTION AND PRIOR TO NAMING ANY PERSON AS AN ADDITIONAL DEFENDANT OR THIRD PARTY DEFENDANT AFTER THE FILING OF ANY SUCH ACTION.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:
New Section 1.

(a) No person shall be permitted to file a medical malpractice action in any court within this state until 30 days after such person has served, by restricted mail, a notice of intent to sue on all persons to be named as defendants in such action.

(b) No party in a medical malpractice action brought in any court within this state shall be permitted to name any person as an additional defendant or as a third party defendant in such action unless, at least 30 days prior to doing so, such party serves, by restricted mail, a notice of intent to sue on the person to be named as an additional defendant or as a third party defendant.

(c) The notice of intent to sue required by this section shall state the name of the injured party, the name of the plaintiff's attorney or the third party plaintiff's attorney, whichever is applicable, the date or dates of the occurrence or occurrences complained of, the nature of the injury or injuries complained of, and the amount of damages to be sought.

(d) Mailing of such notice of intent to sue shall toll the applicable statute of limitations for 30 days.

New Section 2.

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

Atch. 2

AN ACT RELATING TO MEDICAL MALPRACTICE ACTIONS; PROVIDING FOR COURT AUTHORITY TO AWARD ATTORNEYS FEES TO PREVAILING DEFENDANTS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:

New Section 1.

(a) The court may award a reasonable attorneys fee to any prevailing defendant in a medical malpractice action if the court finds that the action against such defendant was brought or maintained without probable cause as to its merit.

(b) For the purposes of this section, the term "prevailing defendant" shall mean any defendant who is absolved from liability by verdict, summary judgment, or dismissal of the action against him by the court or by the plaintiff.

New Section 2.

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

Atch. M

AN ACT RELATING TO MEDICAL MALPRACTICE ACTIONS; PROHIBITING RECOVERY UPON AN ORAL CONTRACT.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:
New Section 1.

No liability shall be imposed upon any defendant in a medical malpractice action on the basis of an alleged breach of contract, express or implied, assuring results to be obtained from any procedure undertaken in the course of health care, unless such contract is expressly set forth in writing and signed by such defendant or by an authorized agent of such defendant.

New Section 2.

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

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