Approved _____
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by Senator Paul Hess at
Chairperson

4:30 ~~a.m./~~p.m. on February 22, 1983, 19__ in room 123-S of the Capitol.

All members were present except:
Senator Doyen

Committee staff present:
Research Department: Sherry Brown, Mary Galligan, Ed Ahrens
Revisor's Office: Norman Furse
Committee: Mark Skinner, Doris Fager

Conferees appearing before the committee:

Dr. Robert Harder, Secretary, Department of Social and Rehabilitation Services
Ronald Todd, Assistant Commissioner of Insurance
Jerry Slaughter, Kansas Medical Society
Donald Wilson, President, Kansas Hospital Association
Harold Riehm, Kansas Association of Osteopathic Medicine
Homer Cowan, Western Insurance Companies, Fort Scott, Kansas

HB 2039 - SRS Wards' Trust Fund

Dr. Harder explained to the committee that HB 2039 is needed to make some technical adjustments in the statute. He stated that SRS now administers a wards' account, but that the statute is needed to assure its legality.

Motion was made by Senator Gaines and seconded by Senator McCray to report HB 2039 favorably for passage. The motion carried by roll call vote.

Sub. for HB 2084 - General Assistance

There were questions from committee members concerning the ramifications of Sub. for HB 2084, and Dr. Harder answered these questions to the committee's satisfaction.

Motion was made by Senator Gaines and seconded by Senator Talkington to report Sub. for HB 2084 favorably for passage. The motion carried by roll call vote.

SB 283 - Limiting the Liability of the health care provider insurance fund

Mr. Todd explained that this bill was introduced at the request of the Commissioner of Insurance. He gave a brief history of the health care provider insurance availability act. He explained that it was enacted in 1976 in order to solve an availability problem of medical malpractice insurance for doctors, hospitals, etc. Included in the act was a provision for excess insurance for claims over $100,000. Mr. Todd said that this type of claim takes several years to settle, and the losses are beginning to accumulate. He explained that SB 283 puts a cap of $1 million on the amount to be paid for any one loss.

Mr. Todd then requested on behalf of Commissioner Fletcher Bell that SB 283 be held in the committee until he can work with the people affected in exploring the area in order to find a premium to which there is no objection. Senator Hess asked if there was objection to SB 283 because there may be no way to get excess coverage above $100,000 or that the premiums are too high. Mr. Todd answered that both may enter into the problem. He noted that other problems are involved, and his office would like time to attempt to solve them.

SB 284 - Health Care Provider Insurance Availability Act

Mr. Todd distributed Attachments A and B for the committee's attention. He explained that the reason for SB 284 was to keep the fund solvent. There were questions from committee members following his explanation.

SB 283 and SB 284, Continued

Mr. Slaughter distributed his presentation to committee members. (See Attachment C) He suggested that the effective date of the act be changed to publication in the Kansas Register in order to get money in the fund at an earlier date. He stressed that it is appropriate to take action on SB 284 this year to guarantee the solvency of the fund. Committee members were given opportunity to question him following his presentation.

Mr. Wilson presented his written testimony (Attachment D). He suggested that new providers pay 45% surcharge for two years instead of one year. There were questions from committee members.

Mr. Riehm stated his support of all changes recommended with the exception of imposition of the cap. He added that he concurred with the recommendation of Mr. Todd that SB 283 be further examined before it is passed. Committee members were given opportunity to question him.

Mr. Cowan said he agreed with testimony presented at this meeting. He commented that he did not feel this was a panic situation; and asked the committee to look at it seriously. He said he felt the people involved have the expertise to find the best solution. He added that there must be a cap on the court liability. He said there is so much non-funded liability that it is difficult to go to the re-insurance market. Senator Gaines asked if there is any merit in the long-term to provide that the insurance commissioner establish a surcharge according to actuarial standards to maintain the fund. Mr. Cowan agreed that this would be a good idea. In answer to a further question from Senator Gaines, Mr. Cowan said it is his impression that the present law is not working very well.

Motion was made by Senator Talkington and seconded by Senator Gaines to amend SB 284 in Section 5 to provide that the act shall take effect after its publication in the Kansas Register. The motion carried by voice vote.

Motion was made by Senator Talkington and seconded by Senator Bogina to amend SB 284 by providing that the surcharge for new providers be 45% for two years rather than one year. The motion carried by voice vote.

Motion was made by Senator Gaines and seconded by Senator Bogina to amend SB 284 on line 75 by adding the words "including interest thereon" following the word "judgment." The motion carried by voice vote.

Motion was made by Senator Talkington and seconded by Senator McCray to report SB 284 as amended favorably for passage. The motion carried by roll call vote.

The Chairman suggested that the committee would expect reasonable action through the Insurance Commissioner's office to try to work out the problems in SB 283, and noted that it would be held in committee until the 1984 session of the Legislature, if necessary.

The meeting was adjourned by the Chairman.

REPORT ON THE HEALTH CARE PROVIDER INSURANCE AVAILABILITY ACT

FEBRUARY 18, 1983

Prepared By
Fletcher Bell
Commissioner of Insurance
Kansas Insurance Department
Topeka, Kansas

TABLE OF CONTENTS

SECTION I

INTRODUCTION

Since the effective date of the Kansas Health Care Provider Insurance Availability Act on July 1, 1976, this department has issued seven (7) reports which review the implementation and administration of the Act. Copies of previous reports are available from the Department upon request.

The purpose of this report is to provide a brief synopsis of the Health Care Stabilization Fund activities, the Health Care Provider Insurance Availability Plan and medical malpractice closed claims information.

SECTION II

THE HEALTH CARE STABILIZATION FUND

In accordance with the provisions of the Health Care Provider Insurance Availability Act, the Health Care Stabilization Fund was established for the purpose of paying damages for personal injury or death arising out of the rendering, or failure to render, professional services by a health care provider who has complied with the basic coverage requirements of the Act. The Fund is administered by the Commissioner of Insurance and the following annual Fund surcharges have been levied:

Fiscal Year	HCSF Surcharge Percentage	Ending Fiscal Year HCSF Balance
1977	45%	$ 2,555,055
1978	45%	$ 6,224,939
1979	40%	$ 9,253,570
*1980	15%	$ 12,331,606
1981	0%	$ 13,379,656
1982	0%	$ 12,417,869
1983 (Current)	0%	$ 11,640,296

*As of 12-31-82

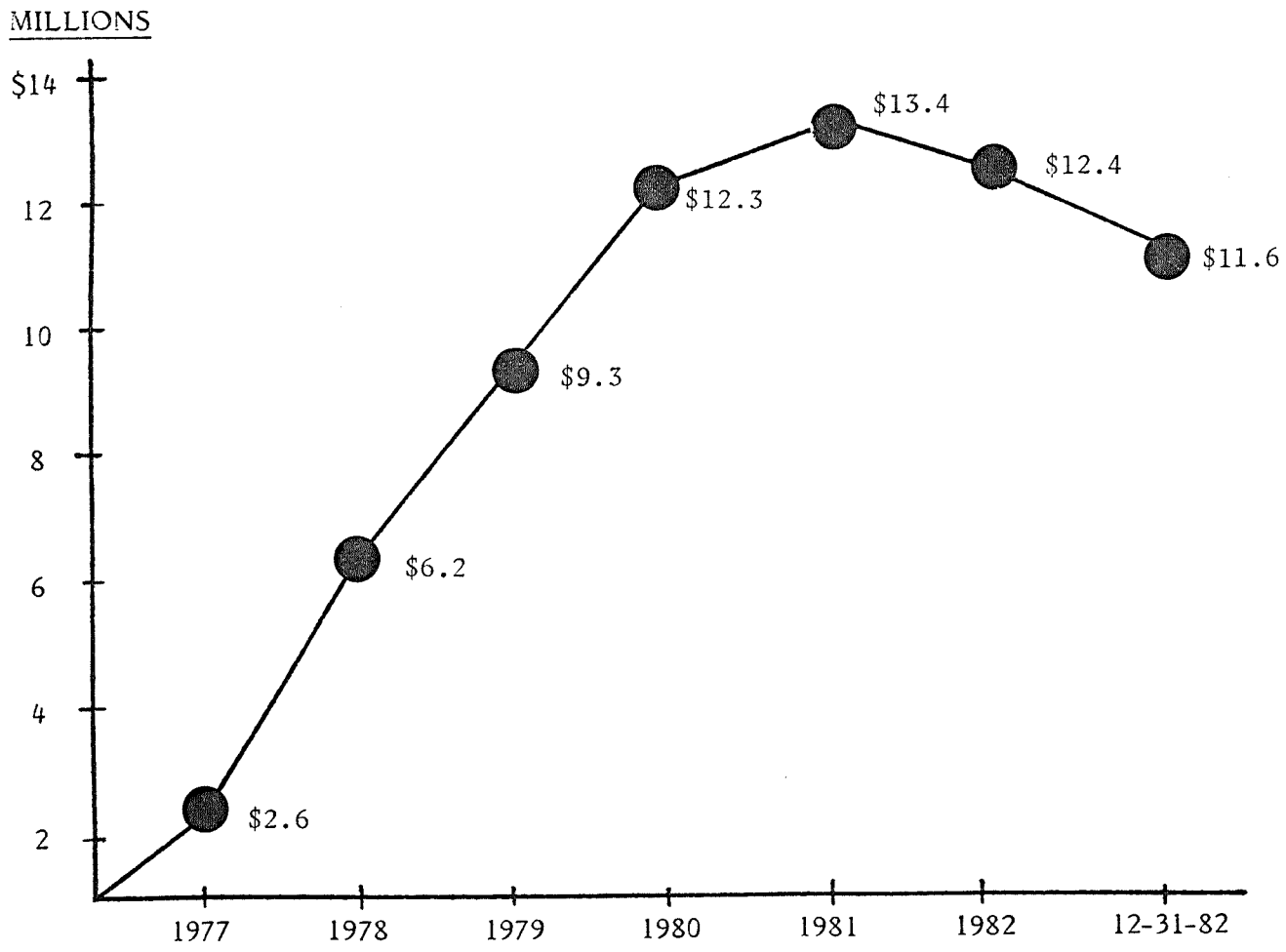
*During Fiscal Year 1980 (effective April 21, 1980) the Kansas Legislature amended the Health Care Provider Insurance Availability Act to provide that health care providers who are complying with this law for the first time shall be subject to a minimum annual surcharge of twenty five (25) percent for the first twelve (12) month compliance period.

As of December 31, 1982, there were 303 open claim files being monitored by the Department. The following charts and graphs present an overview of the HCSF's operations since the inception of the HCPIA Act.

TABLE 1
HEALTH CARE STABILIZATION FUND
CLAIM FILES OPENED AND CLOSED
(As of December 31, 1982)

Fiscal Year	Opened	Closed	Files Pending as of the end of each FY
1977	1	1	0
1978	5	2	3
1979	64	6	61
1980	81	16	126
1981	96	33	189
1982	120	66	243
1983 (First 6 months)	85	25	303 as of 12-31-82

GRAPH 1
GROWTH OF HEALTH CARE STABILIZATION FUND
(As of December 31, 1982)



HCSF Balances as of June 30 of each year

TABLE 2
STATUS OF HEALTH CARE STABILIZATOIN FUND
CUMULATIVE FROM JULY 1, 1976 THROUGH DECEMBER 31, 1982

HCSF Receipts:

Surcharge Payments Collected (less returns)	$ 11,233,061.31
Investment Income	5,792,504.21
HCPIA Plan Income	1,457,262.40
Reimbursements	17,677.04
Total Receipts	$ 18,500,504.96

HCSF Expenditures:

Claim Payments	$ 5,850,357.68
Attorney Fees (Claim Expenses)	493,824.65
Data Processing & Actuarial Services	79,542.81
Salaries & Wages	82,144.60
HCPIAP (Plan)	354,339.00
Total Expenditures	$ 6,860,208.74

HEALTH CARE STABILIZATION FUND BALANCE AS OF DECEMBER 31, 1982 $ 11,640,296.22

GRAPH 2
COMPARISON OF HCSF SURCHARGE
PAYMENTS BY TYPE OF
HEALTH CARE PROVIDER
(JULY 1, 1976 THROUGH DECEMBER 31, 1982)

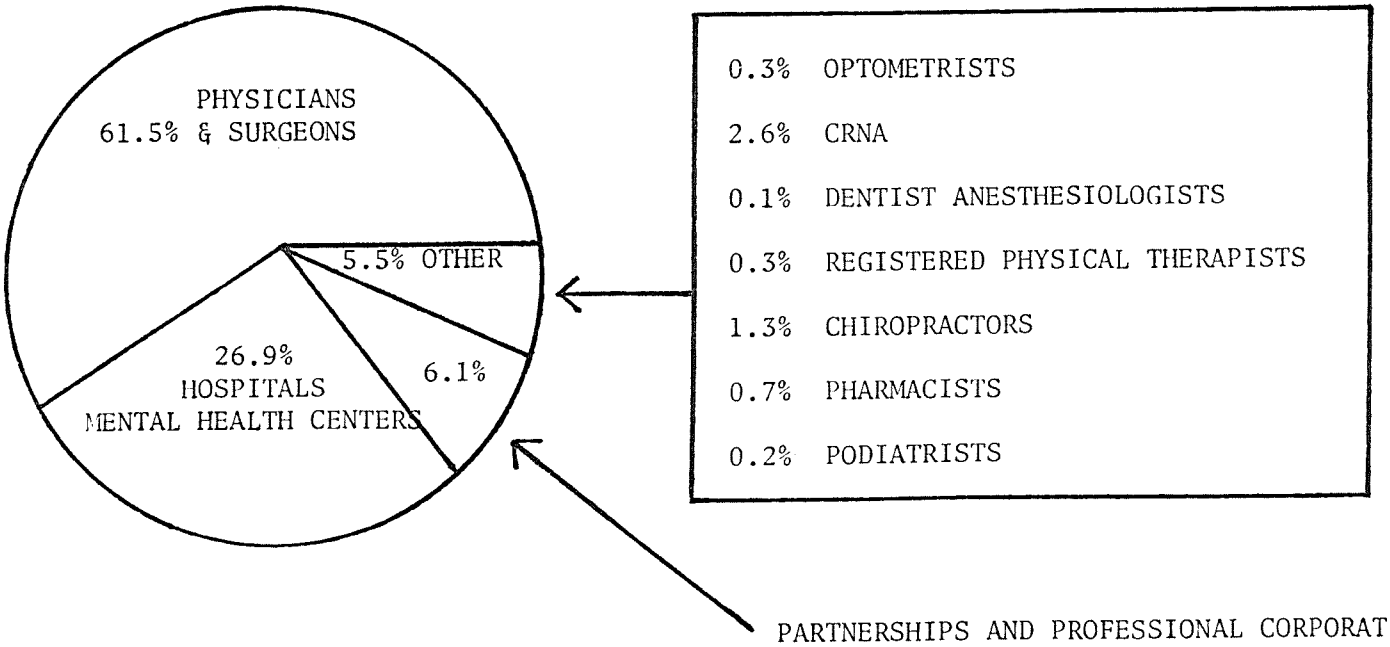


TABLE 3
HEALTH CARE PROVIDER COMPLIANCE
As of December 31, 1982

Type of Health Care Provider	Number in Compliance	Number in Non-Compliance: Number who were in Compliance at Some Time*	Number in Non-Compliance: HCPs which have Never Been In Compliance**
Physicians, Surgeons (including Post Graduate)	3,619	2,380	525
Osteopaths	218	116	46
Chiropractors	431	214	33
Podiatrists	69	17	2
Physical Therapists	356	249	79
DDS Anesthesiologists (Certified by Board of Healing Arts)	3	3	0
Medical Care Facilities	111	41	0
Mental Health Centers	33	11	2
Pharmacists	1,452	822	463
Optometrists	203	125	8
Certified Registered Nurse Anesthetists	246	159	45
Professional Corporations of HCP's	703	239	22
Partnerships of HCP's	75	90	7

*This column may include health care providers which have renewed the basic coverage, but the renewal notice had not yet been received by this department; inactive health care providers no longer required to maintain the basic coverage; or active health care providers which are no longer complying with the HCPIA Act.

**These health care providers may be residents of other states; inactive health care providers; or active health care providers which have not complied with the HCPIA Act.

SECTION III

THE KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN

The Health Care Provider Insurance Availability Plan (sometimes referred to as the Kansas JUA) was established in accordance with the provisions of the Health Care Provider Insurance Availability Act to provide professional liability insurance for health care providers who are in good faith entitled to such insurance but are unable to procure the required basic professional liability insurance from the normal markets.

The Plan is administered on a "no-profit/no-loss" basis by a nine member Board of Governors, who are appointed by the Commissioner. Insurance policies are issued and serviced by the Western Casualty and Surety Company of Fort Scott, Kansas.

The population of the Plan remained to be relatively stable during the first five years of operation. As noted in Table 4, however, the latest fiscal year experienced a sizeable decrease in the number of policies issued, most noteably for chiropractors which indicates an "opening up" of the insurance market for this type of provider.

TABLE 4
SUMMARIZATION OF THE HCPIA PLAN'S POLICIES ISSUED
TO HEALTH CARE PROVIDERS

Type of Health Care Provider	Last Completed Fiscal year FY 1982	Fiscal Year FY 1981	First Fiscal Year FY 1977
Physicians, Surgeons (includes Osteopaths)	257	326	398
Chiropractors	68	247	269
Podiatrists	62	57	36
Physical Therapists	0	0	14
Pharmacists	28	44	56
Optometrists	6	15	16
Certified Reg. Nurse Anesthetists	80	89	69
Medical Care Facilities	6	7	10
Mental Health Centers	6	8	0
Partnerships & Prof. Corp. of HCP's	83	105	0
	596	898	868

TABLE 5
SUMMARIZATON OF THE HCPIA PLAN'S LATEST FIVE YEARS OF OPERATION

		FY 1982	FY 1981	FY 1980	FY 1979	FY 1978
I.	Earned Premiums	$ 985,220	$1,168,717	$1,183,156	$1,414,784	$1,311,442
II.	Incurred Losses & Loss Reserves	1,309,095	500,974	501,308	715,288	277,568
III.	Excess of Earned Premiums*	(-) $1,063,015	$ 363,620	$ 285,349	$ 103,184	$ 565,240

From FY 1977 through FY 1981, the Plan transferred to the HCSF a total of $1,457,262 in "Profits." In FY 1982 the Plan experienced an operating deficit of $1,063,015 which is to be transferred from the HCSF to the Plan in three installments.

IV. KANSAS MEDICAL MALPRACTICE CLOSED CLAIMS SUMMARY

This report summarizes the data submitted by 35 insurers in accordance with K.S.A. 40-1126 and K.S.A. 40-1127. There were 2,092 claims closed against Kansas health care providers during the seven year period beginning January 1976 and ending December 1982.

Total indemnity paid during this period was $17,921,800. Of the total claims closed, approximately 48% resulted in payments. The average indemnity paid, based on claims closed with payment, was $6,514 in 1976 and $25,564 in 1982, an increase of 292%. The greatest portion of this increase is attributed to the year 1977 where the average payment rose 161% over the prior year. The figure dropped in 1978 but has continued to rise in the past four years. These figures are presented on Graph I. Chart II provides a distribution of claims by dollar amount paid in indemnity.

On a total cost basis (i.e., indemnity, defense and all other costs), the distribution by type of health care provider is as follows: Physicians/Surgeons 68%, Medical Facilities 17%, Others 15%. Specific types of practitioners and claims costs for each are found on Chart IV.

By category of procedure or type of allegation producing claims, the greatest percentage of claims were attributed to surgery related procedures. Incorrect diagnosis was the second largest category, followed by improper care and birth related incidents. Although the incorrect diagnosis claims were second in number of claims, this category created the greatest cost in total dollars spent (indemnity, defense costs, etc.). Chart V provides further detail.

CHART I

Distribution of Company Costs By Percentage
of Total Costs for all Closed Claims
During Indicated Years

		Average 1976-1978	1979	1980	1981	1982
I.	Defense Costs	22%	24%	17%	18%	20%
II.	Other Costs (includes loss adj., interest, company expenses)	9%	4%	3%	5%	6%
III.	Indemnity Paid	69%	72%	80%	77%	74%
	ACTUAL TOTAL COSTS (I,II,III)	$ 7,132,104	$ 2,959,415	$4,219,783	$4,523,320	$5,326,953

GRAPH I

Severity of Claim Payments
(not Including Defense and Other Costs)

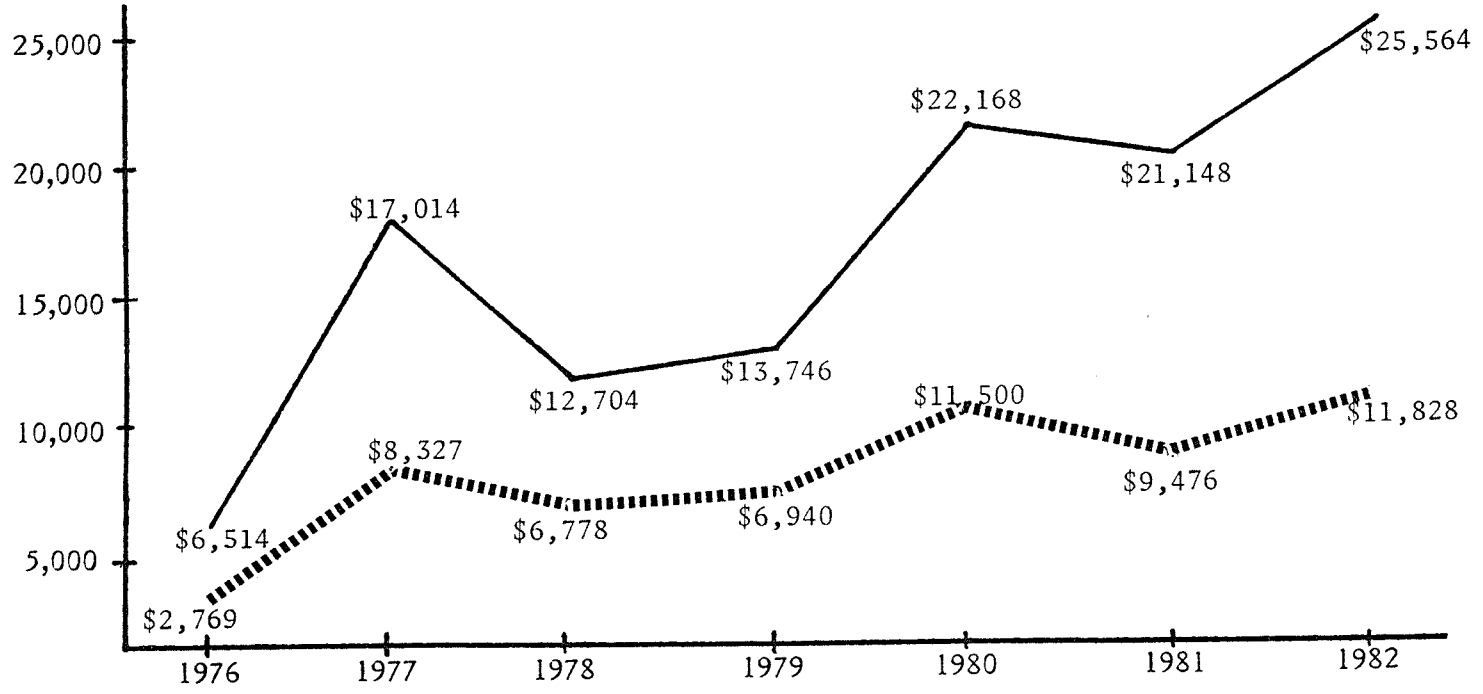


CHART II

Distribution of Claims by Range of Indemnity
Payment By Percentage of Total Claims

Amount of Payment	Average 1976-1978	1979	1980	1981	1982
No Payment	51.7%	49.5%	48.1%	55.2%	53.7%
$1-$9,999	34.2%	36.2%	34.1%	29.5%	23.9%
$10,000-$19,999	6.2%	6.1%	8.9%	6.3%	7.5%
$20,000-$29,999	2.0%	2.3%	4.1%	1.9%	3.9%
$30,000-$39,999	1.1%	1.0%	1.0%	1.4%	.6%
$40,000-$49,999	.7%	.6%	.7%	.5%	1.5%
$50,000-$59,999	.8%	1.3%	.7%	1.1%	1.2%
$60,000-$69,999	.4%	0%	0%	1.1%	.9%
$70,000-$79,999	1.0%	.3%	0%	0%	.3%
$80,000-$89,999	.1%	0%	0%	.5%	.6%
$90,000-$99,999	.1%	0%	0%	.5%	1.2%
Over $100,000	1.7%	2.6%	2.4%	1.9%	4.8%
TOTAL	100%	100%	100%	100%	100%
# of Claims	789	309	293	366	335

CHART III

Date of Incident to Date Claim was Filed

Years	Average 1976-1978	1979	1980	1981	1982
Over 6	3.3%	2.3%	1.7%	1.4%	1.5%
5 to 6	.7%	4.2%	2.0%	2.2%	1.8%
4 to 5	2.0%	3.6%	2.4%	1.1%	1.8%
3 to 4	2.2%	5.5%	7.5%	6.8%	6.6%
2 to 3	8.3%	23.3%	23.5%	21.6%	18.8%
1 to 2	29.2%	29.8%	24.9%	25.4%	24.5%
Under 1	54.3%	31.4%	37.9%	41.5%	45.1%

CHART IV

Distribution of Total Costs and Total Claims by Type of Insured
(July 1978 through December 1982)

Types of Insured	# Claims	% Total Claims	Total Costs	%Total Costs
*Physicians & Surgeons				
Group I	154	10.7%	$ 2,734,484	14.6%
Group II	184	12.8%	3,403,943	18.2%
Group III	91	6.3%	1,676,274	8.9%
Group IV	206	14.3%	2,295,858	12.3%
Group V	73	5.0%	2,162,594	11.5%
Group VI	27	1.9%	$ 477,269	2.5%
Subtotal - Physicians and Surgeons	735	51.0%	$12,750,422	68.1%
Hospitals	428	29.7%	$ 3,041,928	16.2%
Clinics	7	.5%	84,897	.5%
Mental Health Centers	12	.8%	63,373	.3%
Subtotal - Medical Facilities	447	31.0%	$ 3,190,198	17.0%
Dentists	83	5.8%	$ 395,537	2.1%
Chiropractors	12	.8%	240,326	1.3%
Podiatrists	5	.3%	72,977	.4%
Physical Therapists	1	.1%	100,000	.5%
Nurses	22	1.5%	61,489	.3%
Pharmacists	14	1.0%	75,796	.4%
Optometrists	8	.6%	12,329	.1%
Nurse Anesthetists	6	.4%	110,398	.6%
Prof.Corps./Partnerships	108	7.5%	1,721,415	9.2%
Subtotal - Others	259	18.0%	$ 2,790,267	14.9%
TOTAL	1,441	100%	$18,730,887	100%

*Physicians and Surgeons Grouped as Follows:

Group I - No Surgery
Physicians - No Surgery, Psychiatry, Pulmonary Diseases, Family Practice

Group II - No Major Surgery
General Practitioners or Specialists Performing Acupuncture, Arteriography, Catheterization, Radiation Therapy, Shock Therapy, Geriatrics, Pediatrics, Family Practice

Group III - No Major Surgery
General Practitioners or Specialists Performing Colonscopy, Laparoscopy, Needle Biopsy, Broncho-Esophagology, Emergency Medicine

Group IV - Surgery
Obstetrics-Gynecology, Emergency Medicine, Abdominal, Hand, Neck

Group V - Surgery

Group VI - Anesthesiology
General Practitioners or Specialists Performing General Anesthesia or Acupuncture Anesthesia (Not Nurse Anesthetists)

Chart V

Distribution of Total Company Costs
and Total Claims by Type of Alleged Injury
(July 1978 through December 1982)

Type of Injury	# Claims	% Total Claims	Total Costs	%Total Costs
Surgery	248	17.2%	$ 4,314,782	23.0%
Incorrect Diagnosis	210	14.6%	4,566,927	24.4%
Improper General Care	183	12.7%	1,401,323	7.5%
Birth Related	100	6.9%	2,563,760	13.7%
Falls	88	6.1%	329,755	1.8%
Dental	75	5.2%	349,679	1.9%
Miscellaneous	63	4.4%	302,881	1.6%
Birth Control, Abortions	56	3.9%	302,349	1.6%
Anesthesiology	51	3.5%	939,516	5.0%
Illness from Drugs	50	3.5%	664,336	3.5%
Prescription Error	48	3.3%	435,911	2.3%
Post-Op Infection	43	3.0%	674,142	3.6%
Doctor's Advise	38	2.6%	372,663	2.0%
Personal Injury	37	2.6%	120,972	.6%
Hysterectomy	34	2.4%	302,723	1.6%
X-Ray Therapy	31	2.2%	248,771	1.3%
Psychiatric	28	1.9%	335,445	1.8%
Improper Consent	22	1.5%	95,152	.5%
Vasectomy	13	.9%	89,056	.5%
Physical Therapy	12	.8%	214,088	1.1%
Optometry	11	.8%	106,656	.6%
TOTAL	1,441	100%	$18,730,887	100%

SB 284

EXPLANATORY MEMORANDUM FOR
LEGISLATIVE PROPOSAL NO. 12

Legislative Proposal No. 12 amends the Kansas Health Care Provider Insurance Availability Act to maintain the financial integrity of the Health Care Stabilization Fund and to address some administrative matters.

This proposal seeks to amend subsection (b) of K.S.A. 40-3403 of the Health Care Provider Insurance Availability Act so as to allow for the reasonable and necessary expenses incurred by the Commissioner in administering the Health Care Stabilization Fund to be paid from the Health Care Stabilization Fund. At the present time, these expenses are charged to the Kansas Insurance Department Budget, and eventually the State General Fund. The cost of those reasonable and necessary expenses is tentatively estimated to be approximately one hundred thousand dollars ($100,000) and include the payment of approximately four salaried personnel and the incidental expenses of filing, mailing, computer time, etc., necessary to manage the Fund.

Subsection (c) is amended to authorize a payment by the Fund of more than three hundred thousand dollars ($300,000) per year by the Fund when a judgment is rendered against it is so large that ten percent (10%) of it is greater than the three hundred thousand dollars ($300,000) figure. The basis for this proposal is to assure the Fund will be able to pay whatever judgments are rendered against it, thereby avoiding the dilemma of being unable to pay the judgment principal and post judgment interest of a large judgment.

Legislative Proposal No. 12 seeks to amend K.S.A. 40-3404(a) and (c) to eliminate the ten million dollars ($10,000,000) balance of the Fund and add new subsection (c) to require a minimum annual surcharge on all health care providers.

Proposed subsection (c) will require the assessment of annual surcharges of forty-five percent (45%) on all health care providers complying with the Health Care Provider Insurance Availability Act for the first time and twenty-five percent (25%) thereafter. If the balance of the Fund is projected to fall below ten million dollars ($10,000,000) during any fiscal year, the Commissioner would be authorized to assess surcharges in excess of those minimum prescribed amounts, not to exceed sixty-five percent (65%). This proposal would provide for the gradual growth of the balance of the Fund which is essential to assure solvency and avoid the imposition of assessment of an excessively large surcharge in any given year. The forty-five percent (45%) surcharge figure for first time compliers is based upon the surcharge figure imposed on health care providers at the initiation of the Act. The twenty-five percent (25%) figure reflects a modest annual surcharge to maintain a reasonably reliable flow of money into the Fund to help offset the increased obligations that have arisen and will probably continue to arise as the Fund continues to mature.

Finally, this proposal seeks to delete language of K.S.A. 40-3411 to limit a primary insurance carrier's right of settling claims under their one hundred thousand dollars ($100,000) coverage and exposing the Fund to further liability. On occasion, plaintiffs have attempted to settle with primary carriers in amounts less than their limits on the condition that plaintiffs can then proceed against the Fund. Plaintiffs have argued that the language (to be deleted) authorizes such settlement by the primary carrier. It is the Fund's position that such a settlement violates the intent of the Kansas Health Care Provider Insurance Availability Act which requires the primary carrier to be responsible for the first one hundred thousand dollars ($100,000) of any claim or settlement. If plaintiffs are authorized to settle with the primary carrier on this basis, the primary carriers will, in essence, be providing funds to finance plaintiffs lawsuit against the Fund. This, in turn, exposes the Fund to greater liability. Further, the language seems to remove any motive for the primary carrier to observe its obligation to the Fund to attempt to settle the case within the primary insurer's policy limits.

~~The Senate Committee on Public Health and Welfare will be requested to introduce this~~ proposal.

AHB 2-22-83
4:30

Kansas Medical Society

Incorporated 1859

February 22, 1983

TO: Senate Ways and Means Committee

FROM: Jerry Slaughter
Director of Governmental Affairs

SUBJECT: SB 283 and SB 284: Relating to Professional Liability

The Kansas Medical Society supports passage of SB 284; but opposes passage of SB 283.

SB 284 takes a step towards insuring the solvency of the Health Care Stabilization Fund by strenghtening the periodic payments provision, imposing a minimum surcharge of 25% and increasing the first-time surcharge to 45% of the basic premium cost. These changes are all necessary, and we are in full support of them.

We oppose SB 283 because it represents a drastic change in policy, without sufficient time to study the effects of the change. Limiting the Fund's exposure to one million dollars per claim will have the effect of requiring physicians in high-risk specialties to purchase excess coverage from an uncertain professional liability market. Our preliminary estimates indicate that the cost of such coverage would more than double the cost for professional liability protection for many physicians, while providing less coverage than they currently have in force. There is no doubt that the concept of limiting the Fund's exposure needs further study, but we feel it is premature to enact this provision with so little information at hand.

There are other alternatives which may need to be considered as we take a continuing look at the professional liability situation. For example, increasing the primary limits of required insurance is one such alternative that needs further investigation. Possibly a special study committee would be an appropriate forum for a complete overview of the professional liability environment in Kansas. There has not been such a comprehensive evaluation of the situation since the study committee of 1975 completed its work. We would look forward to an opportunity to cooperate in any study relating to professional liability during the coming interim. Thank you.

1300 Topeka Ave. • Topeka, Kansas 66612 • (913) 235-2383

AHC 2-22-83
4:30

TESTIMONY OF THE KANSAS HOSPITAL ASSOCIATION

ON THE HEALTH CARE STABILIZATION FUND

The Kansas Hospital Association appreciates the opportunity to testify on the bills before you relating to the Health Care Stabilization Fund.

Senate Bill 283

Senate Bill 283 limits the liability of the Fund to $1,000,000 for any one claim. While KHA supports limiting the Fund's exposure, we believe this legislation needs further study. Further study should include looking at other options such as splitting the Fund, so that each group of providers pay into their own fund, as has been done in Wisconsin, and investigating the feasibility of increasing the primary limits.

We would therefore encourage this committee to table Senate Bill 283 for further study until next year

Senate Bill 284

The Kansas Hospital Association supports Senate Bill 284. We have no problem with the amendment in section 1(b) which makes the Fund liable for the Insurance Department's expenses incurred through administration of the Fund. Historically these expenses have been paid by the State as part of the budget of the Insurance Department. There is no reason why the Fund should not pay for itself.

The bill amends section 1(c) to require payments of $300,000 or 10% of the judgment, whichever is greater, per fiscal year. We support this language as it guarantees continuity and

AH D 2-22-83 4:30

promptness in the payment of claims. It benefits no one to have the Fund's annual payment limit so low that it is in effect only paying off the interest, and not the principal, of a claim.

We support the 25% annual surcharge, as long as the Fund equals or exceeds the $10,000,000 Fund limit, set out in section 2(c). Our members would prefer to pay a reasonable annual surcharge which assures the viability of the Fund, rather than be assessed an extremely large surcharge in a year when the Fund has paid out many large claims.

We also support the 45% surcharge on new providers. We ask the committee to consider applying this 45% surcharge to new providers for their first two years of coverage under the Fund, rather than the first twelve months as set out in line 144. There are numerous providers who have been paying into the Fund since its inception and it seems only equitable that new providers pay a larger amount in the first two years to add to the amount established providers have already paid into the Fund.

With this one suggested change, we are fully in support of passage of Senate Bill 284.