Kansas Legislative Research Department July 16, 1985

MINUTES

SPECIAL COMMITTEE ON MEDICAL MALPRACTICE

July 1 and 2, 1985
Room 514-S, Statehouse

Members Present

Representative Joe Knopp, Chairman
Senator Jack Walker, Vice-Chairman
Senator Roy M. Ehrlich
Senator Paul Feleciano
Senator Frank D. Gaines
Senator Jeanne Hoferer
Senator Nancy Parrish
Senator Jack Steineger
Senator Robert Talkington
Senator Wint Winter, Jr.
Senator Eric Yost
Representative Marvin Barkis
Representative William Brady
Representative J. Frank Buehler
Representative Rex Hoy
Representative Ruth Luzzati
Representative Michael O'Neal
Representative Vincent Snowbarger
Representative John Solbach
Representative Dale Sprague
Representative Thomas Walker

Staff Present

Mike Heim, Kansas Legislative Research Department
Emalene Correll, Kansas Legislative Research Department
Melinda Hanson, Kansas Legislative Research Department
Mary Ann Torrence, Revisor of Statutes Office
Mary Hack, Revisor of Statutes Office
Bob Coldsnow, Legislative Counsel
Mary Jane Holt, Secretary

Others Present

Ron Todd, Kansas Insurance Department
Ted Fay, Kansas Insurance Department
Derenda J. Mitchell, Kansas Insurance Department
Bob Hayes, Kansas Insurance Department
Don Strole, Kansas State Board of Healing Arts
Ron Green, Legislative Post Audit
Jerry Slaughter, Kansas Medical Society
Richard C. Hite, Kansas Bar Association, Wichita, Kansas
Mike Mullen, Medical Protective Company, Ft. Wayne, Indiana
Tom Bell, Kansas Hospital Association
Harold Riehm, Kansas Association of Osteopathic Medicine
Sherman A. Parks, Jr., Kansas Chiropractic Association
Homer Cowan, Western Insurance Companies, Ft. Scott, Kansas
Kathleen Sebelius, Kansas Trial Lawyers
Lee Wright, Farmers Insurance Group, Mission, Kansas
Bill Henry, Kansas Engineering Society, Topeka, Kansas
David W. Wilson, Medical Protective Company, Ft. Wayne, Indiana
James L. Ketcherside, Kansas Health Care Provider Insurance Availability Plan, McPherson, Kansas
Richard Harmon, Domestic Insurance Companies

Others Present (con't.)

Elizabeth Carlson, Board of Healing Arts
Ralph O'Neal, Scott City, Kansas
David Litwin, Kansas Chamber of Commerce and Industry
Patricia Clark, Kansas Bar Association
Patricia Henshall, Office of Judicial Administrator
Bob Trunzo, St. Paul Companies, Inc., St. Paul, Minnesota
Mark Bennett, American Insurance Association
Walter Darling, Kansas Division of the Budget
Jim McBride, United Way of Topeka
Kathern Forest, American Association of Retired Persons, Wichita, Kansas
Larry Magill, Independent Insurance Agents of Kansas
Larry Buening, Board of Healing Arts
Beth Sheffel, League of Women Voters of Topeka
Dick Brock, Insurance Department
Verna Roberts, United Way of Topeka

July 1, 1985
Morning Session

Chairman Joe Knopp called the meeting to order at 10:00 a.m. He announced the Committee focus primarily would be on four areas: (1) the issue of tort law, the court system, and the determination of legal liability in medical malpractice cases; (2) peer review and action by the medical society and health care providers in preventing medical malpractice; (3) insurance — primary coverage by private companies; and (4) Health Care Stabilization Fund.

The Chairman introduced the staff and informed the Committee that the Legislative Coordinating Council had authorized the Committee to utilize subpoena powers and take testimony under oath, if needed.

Melinda Hanson, Kansas Legislative Research Department, reviewed for the Committee a Glossary of Terms, (Attachment I). The glossary is listed under two classifications; insurance terms and legal terms. Two additional terms under the insurance classification were added. "Loss development" was defined to mean an adjustment made to the claim reserve. As investigation begins and continues this amount may change. "Policy year loss ratio" means the figure that results after every claim against one policy year premium has been made and paid.

A Committee member requested information, to be provided at a later date, concerning how reserves are kept by insurance companies, particularly multi-line insurance companies.

Emalene Correll, Kansas Legislative Research Department, reviewed the 1975 legislative interim study of the Special Committee on Medical Malpractice. She said that the social and technological changes that have taken place in the last 20 years have contributed to the medical malpractice problem more than anything else. Mrs. Correll referred to a survey conducted by the former federal Department of Health, Education and Welfare (HEW) and reported in 1971, which found that 7.6 percent of the total patients discharged from the two hospitals involved in the survey suffered from medical injuries and 2.2 percent suffered medical injuries caused by negligence during hospitalization. Of the medical malpractice claims filed, 10 percent result in a finding against the defendant and about 75 percent never go to trial.

The Committee asked staff to check and see if an update on a survey by HEW had been made.

Mrs. Correll reviewed legislation introduced by the 1975 Special Committee on Medical Malpractice in 1976. Senate Bill No. 637 directed the Commissioner of Insurance to provide certain reports relating to medical malpractice claims or actions to the State Board of Healing Arts, and was enacted. House Bill No. 2726 concerned civil procedure and changed the statute of limitations for discovery of negligence in medical malpractice cases from ten years to four years, except for minors, prisoners and incapacitated persons, for whom it was changed to eight years from the time of occurrence for all negligence actions. This bill was passed by the 1976 Legislature. Senate Bill No. 639 changed the collateral source rule relating to health care providers and was enacted. House Bill No. 2721 granted immunity from civil actions for damages to persons reporting information to the various licensing boards and was enacted. House Bill No. 2724 permitted periodic payment of judgments and was enacted by the 1976 Legislature. House Bill No. 2725 would have limited the amount of damages awarded for pain and suffering to not to exceed $25,000. This bill was not enacted. House Bill No. 2723 amended various health care provider licensing acts to require continuing education and was enacted. Senate Bill No. 638 concerned rules of pleading and prohibited listing the specific amount of damages sought if over $10,000 was involved, and this bill was enacted. Senate Bill No. 640 required compensation for reasonable attorneys' fees in malpractice actions be approved by the court, and was enacted. And, Senate Bill No. 646, the Medical Professional Liability Insurance Availability Act, which created the Health Care Stabilization Fund, among other things, was enacted.

Mike Heim, Kansas Legislative Research Department, reviewed a memorandum regarding Kansas Law Relating to Medical Malpractice Actions (Attachment II). In 1985, the Legislature passed S.B. 267 which requires attorneys of record and the Insurance Commissioner, in medical malpractice actions, to submit to the Board of Healing Arts expert witness reports and other relevant information which was made available to opposing parties; and Sub. for S.B. 110, which put a cap on punitive damages and altered the collateral source rule. The provisions of this bill sunset on July 1, 1989.

Mr. Heim referred to State Policy Reports, April, 1985, page 30 and a study done by the American Medical Association (AMA) on the number of tort reform measures in effect in 1984. The AMA study shows Kansas ranks second (Attachment III) in the number of reforms enacted by the states.

Kathleen Sebelius, Kansas Trial Lawyers Association, informed the Committee that the Kansas Supreme Court, on June 21, 1985, struck down the old collateral source rule passed in 1976. The Committee questioned whether this would invalidate that part of Sub. for S.B. 110. Ms. Sebelius stated the Supreme Court decision does raise questions about the 1985 bill. Copies of the Wentling v Medical Anesthesia Services P.A., Kansas Supreme Court Opinion No. 56, 984, June 21, 1985, were made available to the Committee later in the day.

A Committee member asked how often screening panels had been used in Kansas and whether mandatory screening panel laws of other states had been challenged in the courts. Staff agreed to check on this.

The Committee recessed for lunch.

Afternoon Session

Mrs. Correll reviewed the provisions of the Health Care Provider Insurance Availability Act (Attachment IV), which was enacted by the 1976 Legislature and has been amended several times. The statutory minimum professional liability coverage has been raised from $100,000 per occurrence and $300,000 annual aggregate to $200,000 per occurrence and $600,000 annual aggregate.

In regard to the joint underwriting association (JUA) Plan, the Western Insurance Company is the administrative carrier of the Plan in Kansas. The Plan, sometimes referred to as an assigned risk pool, apportions among insurers the applicants for professional liability insurance who are unable to procure insurance through ordinary methods.

A Committee member asked for the names and minutes of the meetings of the 13-member Board of Governors that provides technical assistance in the administration of the Fund. Another Committee member asked for a list of the legal expenses of the Fund and the names of the attorneys who defended the Fund.

In regard to peer review, Mrs. Correll explained peer review is often confused with a disciplinary action by a regulatory licensing agency, for example, the Board of Healing Arts, which regulates and licenses practitioners of the healing arts. She said the function of these regulatory boards has traditionally not been looked upon as peer review, but rather, the regulating of practitioners' licenses by their respective boards. The Board of Healing Arts, for example, has the authority to revoke, suspend or limit the license of the practitioner if the practitioner is found to be in violation of the laws governing the practice or the rules and regulations adopted by the Board.

The traditional usage of the term "peer review" is when a health care provider is reviewed by his or her peers. A type of peer review most familiar is one that is conducted by the medical staff at a hospital which reviews the care provided by other members of the medical staff. A hospital that is accredited by the Joint Commission on Accreditation of Hospitals is reviewed by its peers. Some members of the accreditation commission would be administrators or persons involved with the operation of other hospitals.

A Committee member requested a table be prepared showing for the past five to ten years private carrier insurance premiums, Health Care Stabilization Fund surcharges, the amount in the Fund, claims filed against the Fund and the amount of the claims, settlements made from the Fund both in dollars and numbers, the number of trials the Fund was involved in, and the amount of judgments, as well as defense costs, each year.

Ron Todd, Assistant Commissioner, Kansas Insurance Department, introduced Ted Fay, Derenda Mitchell, and Bob Hayes of the Kansas Insurance Department. Mr. Fay is an attorney with the Insuance Department and has been assigned to work with the Kansas Citizens Committee on Tort Reform to study the medical malpractice liability situation in Kansas. Ms. Mitchell works with the Health Care Stabilization Fund and Mr. Hayes is the Supervisor of the professional liability section that reviews rates and policy forms for medical malpractice insurance.

Mr. Todd testified that the Insurance Department does not have the authority to make or set premium rates for insurance companies. The Kansas statutes require that premium rates must be reasonable, adequate, and not unfairly discriminatory. Investment income is not required by statute to be included or considered in the information or ratemaking procedures utilized by the insurance company to support proposed rate filings (Attachment V).

In answer to Committee questions, Mr. Todd replied some insurance companies state they do use investment income in setting rates. The Legislature has, in the past, considered requiring that investment income be included in the rate making process, and the Insurance Commissioner has supported this idea. The reason given by opponents of this idea is that income is considered separate and apart from underwiring. In response to a question, Mr. Todd said interest earned from a loss reserve account was not considered investment income. He noted the assigned risk plan rates are basically 20 percent above the St. Paul rates.

A Committee member requested the Insurance Department furnish the Committee with examples from the past few years of information provided by the St. Paul Companies and Medical Protective Company comparing their Kansas loss experience with their nationwide loss expeience, and also their average nationwide physician's rates.

Mr. Todd explained insurance companies have what is called the right of underwriting. They can insure or not insure whomever they choose. A person buys insurance in the assigned risk plan only when no insurance company will sell that person insurance and stays there until an insurance company agrees to sell insurance to that person. In order to purchase insurance from the assigned risk plan the applicant must furnish two written rejections from private insurers.

The Insurance Department conducts a review for all rate filings. They examine each company's Kansas earned premiums and incurred losses and their expenses. He stated the Medical Protective Company and St. Paul Fire and Marine write 85 percent of the medical malpractice insurance in Kansas.

A Committee member asked to what extent premiums were based on national investment earnings or losses and national earnings and loss experience in general. He also inquired whether insurers could review past years experience so they could show the justification for 1985 rates. Another question asked was how many settlements and for what amount had been made for various years.

A Committee member pointed out that information distributed by Mr. Todd (Attachment V) did not reflect the Fund surcharge which was 110 percent of the insurance premiums paid to their primary insurer.

Mr. Todd handed out to the Committee information on the Health Care Stabilization Fund (Attachment VI), Health Care Provider Insurance Availability Plan (Attachment VII), and a Summary of Kansas Citizens Committee Activities to July, 1985 (Attachment VIII).

Don Strole, General Counsel for the Kansas State Board of Healing Arts, testified before the Committee (Attachment IX). He explained the Board of Healing Arts is composed of 13 members and includes five medical doctors, three osteopathic doctors, three chiropractic doctors, one podiatrist, and one lay member. The Board's main function is the licensing and the disciplining of physicians. The Board also licenses podiatrists, physical therapists, physical therapy assistants, and physician assistants.

With respect to the disciplining of physicians, the Board receives and acts upon complaints submitted to it about certain licensees. These complaints can be categorized in four areas: (1) impaired physicians; (2) physicians who excessively prescribe or misprescribe drugs; (3) physicians who commit ethical violations; and (4) physicians who are incompetent.

Mr. Strole said vigorous peer reviews should be conducted by hospitals and other such institutions and when a doctor's competency is in question, the doctor should be required to attend courses to make the doctor competent.

The vice-chairman said peer review at a hospital is largely involved with looking at different paper reports that are required and is not directed at whether a doctor's action was right or wrong. He said this is basically because a malpractice action will likely arise 18 months after the incident occurred, when at the time there appeared to be no problem.

Mr. Strole stated the Board was not receiving records and reports from the Health Care Stabilization Fund as early as they should. He explained that three-member review committees that were established during the 1984 Legislature will be able to get cases worked up and decided a lot more quickly under the newly adopted Administrative Procedures Act that became effective July 1, 1985.

In answer to Committee questions Mr. Strole stated all information received by the Board of Healing Arts is confidential until disciplinary action is taken by the Board. He said 90 percent of the complaints handled by the Board are found to have no basis. He said he would like to have reports from insurers of health care providers about incidents where malpractice occurred. He said the attorney-client privilege should not apply in such cases. He said the procedure for revoking a health care provider's license may take one to two years since a person's right to practice a profession is considered a property right and is subject to certain due process requirements.

Ron Green, Legislative Post Audit, appeared before the Committee to review the status of the current audit of the Board of Healing Arts. He referred to the audit scope statement (Attachment X) which was approved by the Legislative Post Audit Committee on May 25, 1985. The audit was originally requested by Representative Barr. The audit addresses two major questions: (1) do current procedures for reporting cases of incompetent health care practitioners to the Board appear to be adequate; and (2) how effective is the Board in protecting the public against unprofessional, improper, unauthorized, and unqualified practice of the healing arts? The audit also

addresses the Health Care Stabilization Fund in terms of analyzing transfers and balances and what has affected the Fund in either a positive or negative way. The audit should be finished by the middle of July. The Board of Healing Arts should, at that time, be able to see the draft of the audit. The audit process should be completed by the end of July, at which time the Legislative Post Audit staff will be available to review the report with this Committee. He suggested if the Committee has any requests or suggestions on the audit they could inform the Legislative Post Audit Committee before its July 8 meeting.

The Chairman adjourned the Committee meeting until 9:00 a.m., Tuesday, July 2, 1985.

July 2, 1985
Morning Session

The meeting was called to order at 9:00 a.m. by the Chairman, Representative Joe Knopp. He introduced Jerry Slaughter of the Kansas Medical Society.

Mr. Slaughter testified the Kansas Medical Society represents approximately 3,400 physicians. He said the original $10,000,000 limit on the Fund was a mistake, as it was unrealistically low. He stated the Fund is functionally broke. There are 400 claims pending, of which he estimated the Fund will make payments on 100. In addition there are 250 to 300 additional claims expected to be made before the end of the year. With an average claim payment of $300,000, this would exceed the $10,000,000 limit. There are substantially more claims being filed with larger settlements or judgments which will result in increased premiums for physicians.

He said increasing premiums are causing a problem in access to care, since many physicians are restricting their practices and many are retiring early. He noted that rural area family physicians cannot afford to deliver a small number of babies or perform anesthesia, and that statistics show about one-third of rural physicians are restricting their practices. Mr. Slaughter said insurance companies are underpricing their policies due to the open ended nature of the system.

The Kansas Medical Society, he said, plans to request the Legislature to require itemization of awards, consider limiting actual damage recoveries, and limiting nonpecuniary losses, the restructuring of the screening panel in Kansas by considering the Indiana or Nevada approach, requiring structured settlements of annuities when payments are made out of the Health Care Stabilization Fund, and to consider limiting attorney contingent fees.

Mr. Slaughter stated Providers Insurance Company does not write insurance for physicians. Primarily they write insurance for hospitals. Two relatively new companies are Pennsylvania Casualty Company and Medical Defense Company. The Pennsylvania Casualty Company will not write insurance if there are fewer than five doctors in a group and Medical Defense is very restrictive on physicians in insurance classes V and above. He listed St. Paul Fire and Marine and Medical Protective as viable insurance markets, as well as the joint underwriting plan (JUA) or the assigned risk pool. He cited the social climate, urbanization and claim frequency as factors affecting the current medical malpractice problems.

In response to Committee questions, Mr. Slaughter stated he feels the screening panel concept of three physicians would allow a quick look at a claim as it is filed and if there was merit to a claim it would encourage insurance companies to make a quick settlement which would get the money to the claimant earlier, and if the panel determined there was not any negligence, some of those cases might not go to court. Some states have found screening panels to be constitutional and some states have ruled they are unconstitutional.

A Committee member asked Mr. Slaughter to provide the Committee with the median age of physicians in Kansas. Another Committee member asked what the total dollars paid out in Kansas were for automobile insurance and for medical malpractice insurance and what the total number of claims was for each.

Mr. Slaughter said the costs of settling medical malpractice claims are going up and that the average national jury verdict is about $1 million.

A Committee member asked how many motions for summary judgment and directed verdict were overruled in cases when the judgment later was found in favor of the defendant. Another Committee member asked whether certain classes of health care providers were causing a greater proportion of the problems.

The question was asked whether the Kansas Medical Society was doing enough to police its own members. Mr. Slaughter replied that more could be done for self-policing.

A question was asked whether any state had revised the standard of care for physicians to make it a higher standard. Mr. Slaughter said he was not aware of any state doing this. He said nationally doctors are found not negligent in 70 percent of the cases that go to trial.

A question was asked whether physicians were being treated unfairly by Kansas juries. Mr. Slaughter said the idea that physicians have deep pockets has had an effect on jury awards. He cited a study by the Rand Corporation conducted in Cook County, Illinois, which showed awards in negligence suits for medical malpractice injuries were four times larger than for comparable injuries sustained in automobile accidents.

Mr. Slaughter said premiums range for rural family physicians from $3,000 to $12,000 a year, with those that do some obstetrics probably paying in the $7,000 to $10,000 range. He did not feel that adjusting the rate-making to spread the cost among all physicians equally would be feasible. In regard to a surcharge being assessed against each patient admitted to a hospital, Mr. Slaughter replied the medical society is looking at an alternative to this problem, but he did not feel a hospital admittance surcharge would be accepted by the public or by Medicare. He said St. Paul Fire and Marine Insurance Company had reduced its premium increase from 27 percent to 23 percent due to the passage of 1985 S.B. 110.

Richard C. Hite, Wichita attorney, appeared on behalf of the Kansas Bar Association. Mr. Hite is currently the Chairman of the Kansas Bar Association's Legislative Committee and is also a member of the Insurance Commissioner's Citizens Committee for Review of the Tort System. He stated that tort law and the adversary system is the best system known for resolution of disputes, and extreme care should be used before drastic changes are made. He made several suggestions the Committee should consider (Attachment XI). He said the Committee should focus on the causes and extent of higher premiums. He said the cause was that doctors have deviated from the standard of care. He said educational requirements should be reviewed. He suggested that the Committee explore the extent of the problem if the Health Care Stabilization Fund had been funded on an actuarial basis from the beginning. He also said the Committee should determine the impact of changes already made. He handed out charts comparing the 45 percent Health Care Stabilization Fund (HCSF) model surcharge to the actual HCSF surcharge imposed (Attachment XII).

In response to questions by the Committee, Mr. Hite responded he would not favor trying a case to a single judge or single master to determine damages. He said a screening panel adds another layer of bureaucracy when there is good counsel on both sides of the case who have done their homework. However, if counsel is inexperienced, a screening panel might be very good. He explained that Judge Kelley of Wichita uses a mediation panel of lawyers drawn from a list of lawyers selected by members of the Bar. The lawyers that have gone before the mediation panel have strongly approved of the procedure. Mr. Hite thought a panel of judges that would specialize in medical malpractice cases would merit consideration. He said he did not favor lowering the standard of care for physicians. He said there were sanctions now against lawyers for filing frivolous suits. In response to a question of whether the Patterned Jury Instructions for Kansas should be changed, Mr. Hite said jury instructions should be left general.

Mike Mullen, Medical Protective Company, testified that the medical malpractice problem not only affects the insurance industry but also the public and the state. Insurance companies are in business to make a profit and if a profit can no longer be made the insurance company has the choice of assisting in changing the environment or leaving the state. He said that in five years the problems in Kansas will force his insurance company to make a decision about leaving Kansas if no changes are made in the environment. The frequency of $1 million cases in Kansas is seriously impacting the viability of the Health Care Stabilization Fund. The size of claims within Medical Protection's retention, he said, has increased dramatically and the liability limit has increased from $100,000 to $200,000 per occurrence. He noted the costs of defense are up substantially over what they were ten years ago.

He said his company operates with 150 people in 14 states with a very low overhead of only 7.8 percent. About 30 percent of every dollar paid out goes to the defense bar which is the only party in this system that has no gamble. He said 70 percent of every dollar paid out goes to plaintiffs. Plaintiff attorneys get an average of 40 percent of this 70 percent or about 28 percent of the total.

Mr. Mullin said Medical Protective's ratemaking decisions involve many factors including its experience in Kansas and countrywide trend factors. He recommended that the Committee review the statute of limitations. He said Indiana has a two year statute of limitations. It was noted Kansas has a similar statute of limitations. He also recommended a law providing for mandatory effective screening panels and which would provide that the panel's recommendations be admissible in evidence at trials. Further, he recommended a $500,000 cap on awards. The state of Indiana has a $500,000 cap on awards. He said the plaintiffs' bar supported the cap. He said Indiana, Nebraska, and Louisiana have enacted laws which have been effective in dealing with rising medical malpractice insurance costs.

In answer to Committee questions, Mr. Mullen indicated his company has not made a profit in Kansas the last two years. His company writes medical malpractice insurance in Kansas only for medical doctors and dentists and to a limited extent osteopaths. He also replied that Indiana does not have prejudgment interest. Mr. Mullen stated the best way to insure professional liability is to pick a rate for a class that most accurately reflects the loss experience of the class, and all members of that class, and insure the doctors until such point in time they demonstrate they are less than an average risk in that class, at which time they will not be renewed. He said a surcharge on doctors based on their malpractice experience tends to alienate them. The screening panel encourages the plaintiff to explore his or her case, as the plaintiff gets virtually a free look at the case. He said he would not oppose a statutory requirement for insurers to report incidents of malpractice to the Board of Healing Arts if immunity were provided. A Committee member asked how many physicians insured by his company have had a malpractice suit filed against them and how many have resulted in a pay out. Mr. Mullen said he would provide this information at a later date.

The Committee recessed for lunch.

Afternoon Session

Tom Bell appeared as a representative of the Kansas Hospital Association and presented testimony to the Committee (Attachment XIII). He said currently Providers Insurance Company, St. Paul Fire and Marine Insurance Company, and Pennsylvania Casualty Company are writing medical malpractice insurance for hospitals in Kansas. The Kansas Hospital Association, he said, recommends that the Committee consider structured settlements and awards, mandatory screening panels and reasonable limitations on awards and attorney fees.

Mr. Bell said there are 165 hospitals in Kansas of various sizes, 70 of which are government-owned, eight of which are for-profit, and the rest are not-for-profit. He said medical malpractice premium costs range from $10,000 per year for smaller hospitals to $300,000 or more for larger hospitals.

He noted a new Illinois law that requires a plaintiff to attach to his petition a statement of a physician stating medical malpractice exists. He said that American Bar Association has made a number of recommendations for reform of the tort system.

A Committee member asked what the hospital view would be on the concept of trip insurance for patients and what the reaction of Blue Cross and other health insurers and Medicare would be to this idea.

Mr. Bell said hospitals should take a lead role in peer review. He said ultimately the hospital board of directors is responsible for effective peer review. He noted hospitals with over 60 beds follow specific standards for peer review and agreed to provide the Committee with a copy of these standards.

In answer to Committee questions, Mr. Bell replied that when a physician is sued for medical malpractice, usually the hospital is sued also, and different insurance companies are involved.

Harold Riehm testified before the Committee, representing the Kansas Association of Osteopathic Medicine (Attachment XIV). He informed the Committee his Association supports screening panels, structured settlements, and limits on contingency fees of attorneys, and an overall cap on damage awards. He said the practice of Medical Protective Insurance Company of only insuring osteopaths if they are in practice with a group of medical doctors should be reviewed. Mr. Riehm said most osteopaths have to pay the higher premium rates of St. Paul or buy insurance through the JUA Plan. He suggested the Committee look into how JUA Plan's claims history experience came about.

Sherman A. Parks, Jr., Executive Director, Kansas Chiropractic Association, presented testimony to the Committee (Attachment XV). The Chiropractic Association recommended limiting awards on both pecuniary and nonpecuniary damages to $500,000 and $100,000, respectively. They also recommend using the state of Indiana as a model for the screening panel system. They recommend structured awards and limit on attorney contingency fees established by statute.

Homer Cowan, Vice-President of Western Insurance Companies, recommended abolishing punitive damages, putting a cap of $500,000 on nonpecuniary damages, and no cap on actual damages. He further suggested attorney fees be at a contract price, agreed on between attorney and client, on all damages awarded at trial; tightening instructions to the jury; disclosing witness fees to the jury and restricting expert witnesses to the state of Kansas and surrounding areas and to physicians in like practices. He recommended the Indiana approach as Mr. Mullen outlined (Attachment XVI) and that the Oklahoma jury instructions be reviewed.

Mr. Cowan said insurers never wanted the state to become involved in the insurance business. He said during the first year of the JUA Plan 900 to 1,000 health care providers were covered by it. Now there are 270 providers covered by the Plan. He said the Fund needed to have the ability to become involved in cases more quickly where it may be liable.

Kathleen Sebelius, Executive Director, Kansas Trial Lawyers Association, said she represented 900 trial attorneys (Attachment XVII). The Trial Lawyers propose higher rated premiums for doctors who repeatedly commit acts of malpractice, oppose frivolous lawsuits, and support the discovery rules mandated by the Kansas Supreme Court. They also oppose unreasonable and excessive attorney fees, propose rebates be awarded if premium rates are not justified, support qualified immunity to doctors who are willing to testify at hospital hearings or before the Board of Healing Arts about malpractice of other physicians, propose that the Kansas Board of Healing Arts be given access to pertinent data on acts of malpractice, and support the automatic review of cases resulting in settlements or verdicts over $100,000 and of any doctor with more than two malpractice claims in a two-year period. She urged the Committee not to recommend any massive changes in the system. Time is needed to see what impact S.B. 507, passed in 1984, providing, among other things, for the appointment of an independent disciplinary administrator by the Board of Healing Arts, and 1985 Sub. for S.B. 110, which puts a cap on punitive damages for health care providers and changes the collateral source rule for them, will have on the problem. She said high jury awards reflect the high costs of medical care over the life of a patient.

Ms. Sebelius stated in 1983 there were 435,000 hospital admissions and 36,000 live births in Kansas. The Trial Lawyers Association reviewed 700 petitions in the Insurance Commissioner's office last winter and found 31 doctors were responsible for 16 percent of the malpractice cases filed, and estimated these 31 doctors would be responsible for 30 percent to 40 percent of the money paid out of the Fund.

She noted under the current system, the Fund is responsible for all malpractice awards against a physician who has left the state. She said the Committee should ask some basic questions, such as what has happened to medical malpractice premium rates in states where changes in tort law have been made, whether victims of malpractice are being adequately compensated, whether Kansas doctors are paying premiums based on Kansas or national malpractice experience, and what the effect of peer review systems in other states has had on malpractice.

The Chairman announced the next Committee meeting would be July 18 and 19, and it was decided to hear testimony from the insurance comapnies concerning rates and testimony from the Insurance Department on the Health Care Stabilization Fund and the JUA Plan. The Committee requested information be obtained from other states on how they were dealing with the problems facing Kansas and what their laws are. Specifically a request was made that someone from Indiana come to testify before the Committee. Other information requested included: changes that could be made in our insurance laws that would open competition in Kansas, evidence that capping awards would be helpful, insurance availability to physicians, a survey of all 50 states listing the number of companies writing insurance in each state, an analysis of governmental mechanisms operating in those states and any reforms to their tort systems. In reference to the Fund, some areas to be addressed are: whether the Fund should be administered by the Insurance Commissioner's Office or by some other office, how information from the Fund could be provided to the Board of Healing Arts, and whether separate counsel should be hired to represent the Fund.

The Chairman announced the meeting in August would be the 15th and 16th and would focus on tort reform and the Board of Healing Arts, as well as other topics.

The Chairman also announced that staff would prepare and distribute to the Committee a list of ideas, in broad categories, of issues to be addressed by the Committee.

The Committee adjourned.

Prepared by Mike Heim

Approved by Committee on:

July 19, 1985
(Date)

MEMORANDUM

June 28, 1985

TO: Special Committee on Medical Malpractice

FROM: Kansas Legislative Research Department

RE: Glossary of Terms

Insurance

Claim — A demand made against an insured for damages covered by a policy he or she holds. A claim is generally referred to the insurer for handling on behalf of the insured in accordance with the contract terms.

Claims Made Policy — Policy under which coverage purchased at the beginning of the year protects only against claims made during that year. (See "occurrence policy.")

Earned Premium — The part of an insurance premium that pays for the protection the insurer has already given on a policy.

Expense Ratio -- Percentage of the premium used to pay the costs of acquiring, writing, and servicing business.

HCPIA — Health Care Provider Insurance Availability Act (K.S.A. 40-3401 et seq.)

HCSF -- Health Care Stabilization Fund.

Indemnity — Restoration of the victim of a loss, in whole or in part, by payment, repair, or replacement.

ISO — Insurance Services Organization. This organization assists property and liability insurance companies by establishing underwriting rules and rates and by analyzing statistics.

JUA — Joint Underwriting Association or Authority (also called an assigned-risk pool) —a device for making insurance available to high-risk physicians by mandating a subsidy from other policyholders. (See K.S.A. 1984 Supp. 40-3413.)

Loss — Payment made in behalf of the insured.

Loss Ratio — Percentage of losses to premiums.

Loss Reserve — The portion of the assets of an insurer kept readily available to meet probable claims.

7-2-85 Attachment I

Losses Incurred — Total losses, whether paid or unpaid, sustained by an insurer under a policy or policies.

Occurrence Policy — Policy under which a physician purchases at the beginning of year one coverage against all claims (whenever they might be made) on incidents occurring during year one. The insurance, thus, would apply to a suit even if it were brought in year two. (See "claims made policy.")

Rate (also called premium rate) — The price per unit of insurance.

Rate Filing — Submission to the Insurance Commissioner by an insurance company (or rating organization) of the per unit cost of insurance it plans to use as a base for the determination of premiums. The filing must contain supporting documentation adequate to justify the proposed rate.

Reinsurance — An agreement between two or more insurers by which risk of loss is apportioned. The goal is to spread the risk of loss so that a disproportionately large loss under a single policy does not fall on one company. The reinsurer is the one accepting all or part of the risk of loss of another insurer.

Reserves — Funds set aside by an insurer for the purpose of meeting obligations as they become due.

Underwriter — Person (or company) who selects risks for insurance and determines in what amounts and on what terms the insurer will accept the risks.

Unearned Premium — The portion of the original premium not yet earned by the insurance company. If the policy is cancelled, this amount is due the policyholder.

Legal

Additur — Power that the trial court has to increase the amount of a jury award in cases of inadequate compensation.

Collateral Source Rule — Under this rule, compensation received by a plaintiff for injury from sources other than the defendant should not be deducted from a jury award. This general rule was modified in Kansas in 1976 and again in 1985 with S.B. 110 regarding medical malpractice actions.

Compensatory Damages — Awarded to compensate the injured party for the injury sustained, to replace the loss caused by the harm or injury.

Contested Claims — Claims that will be litigated by the insurer.

Contingent Fee — Arrangement between client and attorney, frequently used in personal injury actions, by which the attorney agrees to represent the client with compensation to be a percentage of the amount recovered. Sometimes regulated by court rule or statute.

Nonpecuniary Damages (sometimes called "intangible damages") — Pain and suffering types of damages, as opposed to money damages.

Punitive Damages — Damages above and beyond compensatory damages; awarded against a person to punish for outrageous conduct.

Remittitur — Procedural process by which a judge may order a plaintiff to remit a portion of the award in cases when money damages awarded by a jury are grossly excessive as a matter of law.

Res Ipsa Loquitur — A rule of evidence that permits negligence of a defendant to be inferred from the mere fact that the injury occurred. The plaintiff must prove that the defendant was in exclusive control of whatever caused the injury and that the injury would not have occurred if reasonable care had been used.

Statute of Limitations — Sets a time limit within which the right to a cause of action exists.

MEMORANDUM

June 27, 1985

TO: Special Committee on Medical Malpractice

FROM: Kansas Legislative Research Department

RE: Kansas Law Relating to Medical Malpractice Actions

The Kansas law relating to medical malpractice actions is a mixture of judge-made or common law and statutory law. This memorandum reviews the general provisions of these two aspects of the Kansas law with the exception of the Health Care Provider Insurance Availability Act, which is covered in a separate memorandum.

Malpractice Case Law

It should be noted that negligence is an essential element of a medical malpractice action in Kansas. (See Natason v. Kline, 187 Kan. 186 (1960) and more recently Durflinger v. Artiles, 234 Kan. 484 (1983). It is possible for a physician or a hospital to enter into express contracts with patients by which they bind themselves to warrant the success of treatment or to otherwise obligate themselves. If this type of an agreement is found to exist then certain warranties and obligations are implied by law and if the results of medical treatment are not as promised then a breach of contract action may accrue. (See Malone v. University of Kansas Medical Center, 220 Kan. 371 (1976) and see Noel v. Proud, 189 Kan. 6 (1962).) Contract actions, however, against a medical professional for a failure to perform services as agreed are infrequent when compared with medical malpractice actions based on negligence and are not a subject of this memorandum and would appear to be beyond the scope of the Committee's study charge which refers only to medical malpractice.

Elements of Negligence

Preliminarily, a review of some of the fundamental principles of the law of negligence may be helpful. Negligence is simply one kind of conduct. The traditional formula for the elements of a negligence cause of action found in Prosser and Keeton on Torts 5th Ed., 1984, at page 164-5 are as follows:

1. A duty, or obligation, is recognized by law and requires a person to conform to a certain standard of conduct for the protection of others against unreasonable risks.

2. A breach of this duty or in other words a failure on the person's part to conform to the standard required must occur.

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3. There must be a reasonably close causal connection between the conduct and the resulting injury. The negligent conduct must be the "proximate cause" of the injury.

4. Finally, there must be actual loss or damages resulting to the interests of another.

At the center of negligence is the concept of the reasonable person. What would a reasonable and prudent person, confronted by like circumstances and exercising reasonable care, have done? Negligence involves acting other than a reasonable person would. The reasonable person has been observed to be the epitome of ordinariness, never reckless or absent minded yet neither with exceptional courage, foresight or skill. (See Mellor, The Law, p. 53 3rd Ed. 1966.)

Professional persons or any one who undertakes any work calling for special skill, are required not only to exercise reasonable care in what they do, but also to possess a standard minimum special knowledge and ability. Most of the cases have dealt with surgeons and other doctors but the same requirement of special knowledge and ability also applies to dentists, pharmacists, psychiatrists, lawyers, architects, engineers, accountants, and many other professionals. (See Prosser pp. 185-6.)

The Pattern Instructions For Kansas 2d or P.I.K. 15.01 dealing with malpractice and the duty of physicians or dentists states:

> "In performing professional services for a patient, a (physician) (dentist) has a duty to use that degree of learning and skill ordinarily possessed and used by members of his profession and of his school of medicine in the community in which he practices, or in similar communities, and under like circumstances. In the application of this skill and learning the (physician) (dentist) should also use ordinary care and diligence.
>
> "A failure to do so is a form of negligence that is called malpractice."

It should be noted that a revision is being considered to add to the notes which follow P.I.K. 15.01. The revision would state that when it is agreed that the standard of medical procedure is universal, consideration should be given to delete the reference to "similar communities" in P.I.K. 15.01 to avoid confusing juries who have heard experts from other states or areas. See also Prosser at page 188 which notes that improved facilities of communication, travel and availability of medical literature have led some courts to abandon a fixed locality rule in favor of treating the community as only one factor in applying the general professional standard. In some jurisdictions the locality rule has been outright discarded and a general national standard applied, especially in the case of medical specialists.

Kansas follows a national standard rule in regard to medical specialists. P.I.K. 15.12 states that a physician or surgeon who holds himself out to be a specialist must use his skill and knowledge in a manner consistent with the special degree of skill and knowledge ordinarily possessed by other specialists in the same field of expertise.

Evidence and Expert Testimony

Proof of malpractice in effect requires two evidentiary steps which include: (1) evidence as to the recognized standards of the medical community in the particular kind of case, and (2) a showing that the physician or surgeon negligently departed from the standard in his treatment of the patient. P.I.K. 15.10 which deals with a physician's standard of care and expert testimony states in part:

> ". . . On questions of medical or scientific nature concerning the standard of care of (physician) (dentist), only those qualified as experts are permitted to testify. The standard of care is established by members of the same profession in the same or similar communities under like circumstances. It follows, therefore, that the only way you may properly find that standard is through evidence presented by (physicians) (dentists) called as expert witnesses."
>
> [The above rule is limited to those matters clearly within the field of medical science. If what was done or not done in the treatment of a patient is within the common everyday knowledge of persons generally, such facts may be established from the general circumstances as shown by the evidence, which evidence may include testimony by persons other than experts.]

As P.I.K. 15.10 reflects, ordinarily expert medical testimony is required to establish negligence or lack of reasonable care on the part of a medical professional in the medical diagnosis, care, and treatment or performance of surgical procedures. The "common knowledge" exception to this rule is that if what is alleged to have occurred is so obviously lacking in reasonable care and the results are so bad that the lack of reasonable care is apparent, expert testimony is not required. The bracketed paragraph in P.I.K. 15.10 is given when evidence puts into issue the "common knowledge" rule. An example of this common knowlege rule occurred in Rule v. Cheeseman 181 Kan. 957 (1957), where a 12-inch square pad of gauze was left in the body of a patient after an operation requiring a second operation for its removal.

Best Judgement and Referrals

A physician is not a guarantor of good results, and civil liability does not arise merely from bad results, or if bad results are due to some cause other than treatment. In case of doubt as to which of two or more courses is to be pursued, the physican has the right to use his best judgment. The selection must be consistent with the skill and care which other physicians practicing in the same field or similar community would use. See Goheen v. Graber 181 Kan. 107 (1957) and P.I.K. 15.11.

A physician who undertakes the treatment of a patient and refers the patient to another physician for care is not legally responsible for any negligence on the part of the other physician unless he has failed to exercise reasonable care in selecting the other physician. (See P.I.K. 15.13.) A physician is liable for the negligence or malpractice of another physician where the latter acts as his agent, employee or assistant. (See Natanson v. Kline, 186 Kan. 393 (1960).)

Informed Consent

A physician may not perform any surgical operation or than treatment on a patient without the informed consent of the patient or without the consent of someone authorized to give consent when the patient is unable, due to incapacity. A physician or surgeon in the absence of an emergency has a legal obligation to make a reasonable disclosure of the nature and probable consequences of the suggested treatment and the dangers within his knowledge which are possible so a patient will have a basis to make an intelligent informed consent. The duty of the physician is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances. (See Funke v. Fieldman 212 Kan. 524 (1973) and P.I.K. 15.15 and 15.16.) For there to be liability, the unrevealed risk must materialize and there must be harm to the patient caused by this lack of information. A causal connection exists between the nondisclosure and the harm only when disclosure would have resulted in a decision against the treatment. A physician has no duty to apprise his patient of each infinitesimal, imaginative, or speculative element of such risks. Further, it is permissible to withhold certain information from a patient if, this information would harm the patient and the nondisclosure was considered reasonable. (See P.I.K. 15.16.) Consent though may be granted by conduct. Finally, it should be noted that when a patient fully appreciates the dangers involved in an operation, and there is a failure of a physician to disclose these dangers there would be no causal relation to the injury and the nondisclosure. (See Younts v. St. Francis Hospital and School of Nursing 205 Kan. 292 (1970).) (See Collins v. Meeker 198 Kan 390 (1967).)

In emergency situations requiring immediate surgery, when it is impossible or impractical to obtain consent because delay would endanger the patient's life or health, a physician is excused from obtaining consent and may proceed if he does so in accord with ordinary practice among members of his profession in the same or similar communities under like conditions. A similar exception applies to emergencies which arise during operations which a patient has consented to and unforeseen conditions are discovered which necessitate further or different treatment. (See P.I.K. 15.15.)

Presumption, Burden of Proof and
Res Ipsa Loquitur

In regard to presumptions and burden of proof in medical malpractice actions, the physician or surgeon is presumed to have carefully and skillfully treated or operated on his patient and there is no presumption of negligence from the fact of an injury or adverse result. (See Webb v. Lungstrum 223 Kan. 487 (1978).) The injured party has the burden of proof to produce evidence that the physician was negligent. (See Charley v. Cameron 215 Kan. 750 (1974).)

One type of circumstantial evidence, however, called res ipsa loquitur or the thing speaks for itself, has the effect of shifting the burden of proof from the injured plaintiff to the defendant physician who then must produce evidence his conduct was not negligent. In its inception according to Prosser at page 243, the principle was nothing more than a reasonable conclusion, from the circumstances of an unusual accident that the defendant was probably at fault. The phrase was coined in a case involving a pedestrian who was struck by a barrel of flour that rolled out of a warehouse window. In Kansas, the doctrine applies in a medical malpractice action only where a layman is able to say as a matter of common knowledge and observation, or from the evidence can draw an inference, that the consequences of professional treatment were not such as ordinarily would have followed if due care had been exercised. (See Funke

v. Fieldman 212 Kan. 524 (1973).) The conditions for this doctrine were stated in Voss v. Birdwell 188 Kan. 643 (1961) as threefold: the accident is a kind that ordinarily does not occur in the absence of someone's negligence, it is caused by an instrumentality within the exclusive control of the defendant, and there is no possibility the injured party could have contributed to the problem.

Comparative Negligence

Kansas is a comparative negligence state following the 49 percent rule, meaning the plaintiff or injured party cannot be found to be more than 49 percent negligent or he may not recover. In a 1983 case, Allman By and Through Walters v. Holleman 233 Kan. 781, the court rejected a number of claims by the defendant osteopathic physician that the deceased patient had been negligent in a number of actions including inadvertently removing life support equipment when she was in an intensive care unit of a hospital. Comparative negligence of a patient has been recognized in other cases, e.g., McGuire v. Sifers 235 Kan. 368 (1984).

P.I.K. 15.20 does state a physician has the right to expect a patient to follow advice. The failure to follow this advice does not relieve the physician from the results of earlier malpractice but absolves him from liability for any increased injury due to the patient's failure to accept reasonable treatment and advice.

Damages

Damages in medical malpractice action are covered in several sections of the P.I.K. For example, P.I.K. 9.01 provides that a plaintiff found entitled to recover for personal injury damages may recover for any of the following shown by evidence:

1. pain, suffering disabilities, or disfigurement, and any accompanying mental anguish suffered to date and reasonably certain to be experienced in the future;

2. reasonable expenses of necessary medical care, hospitalization, and treatment received and that reasonably expected to be incurred in the future;

3. loss of time or income to date and reasonably certain to be lost in the future; and

4. aggravation of any preexisting ailment or condition.

The instruction states that the plaintiff's age, condition of health before and after the injury, and the nature and extent and duration of the injury should be considered. It also states that the court cannot give a unit value or mathematical formula for computing pain and suffering, disability, and mental anguish and that the jurors should arrive at an amount that will adequately and fairly compensate the injured party.

P.I.K. 9.02 provides that a reasonable amount can also be awarded for the loss or impairment of the plaintiff's ability to perform services as a husband or wife resulting from the injury or the so-called loss of consortium. Factors to be considered include the loss or impairment of the plaintiff's ability to perform services in the

household and in the discharge of his domestic duties and the loss or impairment of the plaintiff's companionship, aid, assistance, comfort, and society.

P.I.K. 9.44 provides that punitive damages to punish the defendant are permitted if the defendant's conduct is found to have been willful, wanton, malicious, or fraudulent. In fixing the amount of punitive damages, a jury may consider the amount of actual damages recovered, defendant's financial condition, and probable litigation expenses. (See Ayers v. Christiansen 222 Kan. 225 (1977).)

Malpractice Legislation

A series of enactments dealing with medical malpractice issues were passed in 1976 as a result of an interim study by the 1975 Special Committee on Medical Malpractice on this topic. These laws are described under the "1976 Legislation" heading. A copy of that interim committee report has been made available to the Committee.

1976 Legislation

The Health Care Provider Insurance Availability Act (K.S.A. 1984 Supp. 40-3401 et seq, as amended) which resulted from the earlier study is a subject of another memorandum. The mandatory insurance provisions of this act were challenged in State ex rel. Schneider v. Liggett 223 Kan. 610 (1978), and upheld by the Kansas Supreme Court. The Court said that the Act did not violate the due process rights nor the equal protection rights of the defendant doctor who had refused to obtain liability insurance.

Statute of Limitations

The statute of limitations (K.S.A. 60-513) covering medical malpractice actions was amended in 1976 to place these actions in a special category and shorten the so-called "discovery period" from ten years beyond the time the negligent act gave rise to the injury to four years. The ten year discovery period still applies to other negligence actions. The 1976 amendments also contained a general limitation in regard to persons under a legal disability to provide an eight-year limit on bringing the action beyond the time when the Act causing the injury took place. The statute of limitations change regarding the four year discovery period was challenged in Stephens v. Snyder Clinic Association 230 Kan. 115 (1981) on the basis of violation of equal protection and special legislation violating a Kansas constitutional provision. The Court upheld the statute and rejected both arguments.

Collateral Sources

A special statute (K.S.A. 60-471) regarding the admissibility of evidence of certain collateral sources of reimbursement to injured parties in medical malpractice actions also was enacted in 1976. The statute permitted evidence to be admitted of reimbursements or indemnifications to the injured plaintiffs except for insurance payments and health maintenance organization benefits where the plaintiff or his employer had paid for the premiums in whole or in part. In the only reported case on

the statute, Doran v. Priddy, 534 F. Supp. 30 (1981), a federal district judge stated the Kansas Supreme Court if faced with a constitutional challenge would strike down this statute as a violation of equal protection and the federal court so held. The Court said the distinction between insured plaintiffs and ones who must rely upon kindness for some of their prelitigation care does not further the goal of limiting the size of malpractice verdicts. This statute was repealed by 1985 S.B. 110 but was replaced with a somewhat similar provision. S.B. 110 will be discussed in detail later.

Attorneys' Fees

K.S.A. 7-121b, enacted in 1976, requires that compensation for reasonable attorneys' fees shall be approved by the district court or appropriate appellate court in medical malpractice actions.

Screening Panels

K.S.A. 65-4901, et seq., enacted in 1976 and amended in 1979 authorizes the convening of screening panels in a claim for personal injury or death on account of the alleged malpractice of health care provider. The statute requires the district court to convene a screening panel when a petition has been filed if one of the parties to the action requests that such a panel be convened. If no petition has been filed, any party affected by a claim of alleged malpractice may request that a screening panel be convened by filing a memorandum with the court and, such a panel would have to be convened by the district court. In addition, a district court or administrative judge may convene a screening panel when a petition alleging malpractice has been filed even if none of the parties to the action requests a panel.

The membership of a medical malpractice screening panel is to be:

1. a health care provider designated by the defendant or by the person against whom the claim has been made if no petition has been filed;

2. a health care provider designated by the plaintiff or by the claimant if no petition has been filed;

3. a health care provider selected jointly by the plaintiff and defendant or by the claimant and the person against whom the claim is made; and

4. an attorney selected by the judge of the district court or administrative judge from a list of attorneys maintained for this purpose. The attorney is to serve as a nonvoting chairman of the screen panel. The act specifies the procedure to be followed in notifying the parties that a panel has been convened and provides for appointment of the jointly appointed health care provider member if the parties cannot agree.

The panel is to consider whether there was a departure from the standard practice of the health care provider specialty involved in the claim and whether a causal relationship existed between the damages suffered by the claimant and any such departure. In making its determination, the panel is to follow rules and procedure adopted by the Kansas Supreme Court. Within 90 days the panel is to make written recommendations on the issue of departure from the standard of care in a way which

caused the plaintiff or claimant damage. All parties, each attorney of record, the district court or administrative judge, and the Commissioner of Insurance are to be provided copies of the panel's recommendations within seven days of the handing down of the panel's decision.

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

The written report of the screening panel may not be admitted into evidence in any subsequent legal proceeding, but either party may subpoena any and all members of the panel as witnesses relating to the issues at trial.

State agencies which license, register, or certify health care providers are to maintain a current list of providers who are willing and available to serve on a screening panel.

Reporting of Malpractice Claims to Insurance Commissioner

K.S.A. 40-1126 and 40-1127 were amended in 1976, 1977, and 1978 to require insurers for health care providers, persons engaged in a technical profession, attorneys, and certified public accountants to report to the Insurance Commissioner any claim for damages due to negligence based on professional services, if the claim resulted in a final judgement or settlement in any amount, and the amount of premiums charged for the past year which latter report shall be filed annually.

Immunity for Reporting Malpractice to Board of Healing Arts, Others

K.S.A. 65-2898, 65-1515, 65-1462, 65-1127, and 65-1652 were enacted in 1976 to provide civil immunity to persons reporting alleged incidents of medical malpractice or reports regarding the qualifications, fitness, or character of a person licensed by the State Board of Healing Arts, the Board of Examiners in Optometry, the Kansas Dental Board, the State Board of Nursing, or the Board of Pharmacy. The legislation also provides that any state, regional, or local association composed of persons licensed to practice the healing arts, licensed optometrists, licensed dentists, registered professional nurses, licensed practical nurses, or registered pharmacists or any individual members of committees thereof which investigates and communicates information pertaining to alleged malpractice or the qualifications, fitness, or character of any licensee or registrant to the appropriate licensing board shall be immune from liability therefore in civil actions if the investigation and communication was made in good faith and did not represent as true matter not reasonably believed to be true.

Professional Incompetency

K.S.A. 65-2836 was amended to add "professional incompetency" as a basis for the Board of Healing Arts to suspend, revoke, or limit the license of a person licensed by them. The Board's ability to "limit" practice was also enacted in 1976.

Continuing Education

Various statutes were amended (K.S.A. 65-1117, 65-1431, 65-2809, and 65-2910) to require specific health care providers to comply with continuing education requirements as a condition of license renewal after July 1, 1978. These included nurses and licensed practical nurses, dentists, and dental hygienists and persons licensed by the Board of Healing Arts (was made mandatory, formerly it was discretionary with the Board).

Malpractice Study Commission

1976 S.B. 658 established an 11-member health care provider malpractice study commission which was to meet at least once annually but not more than six times a year to study health care provider malpractice problems and to report to the Governor and Legislature. Five members of the commission were to be appointed by the Governor, two members were to be appointed by the President of the Senate, two members were to be appointed by the Speaker of the House, and one member was to be appointed by the minority leader of the Senate and one by the minority leader of the House. The Governor was to designate a chairman from among the members of the commission.

Expenses of the commission were to be paid from appropriations to the Legislative Coordinating Council and staff was provided by the Legislative Research Department and the Office of Revisor of Statutes as authorized by the Council. The provisions of S.B. 658 expired December 31, 1978.

Damages Paid in Installments

K.S.A. 60-2609, enacted in 1976, allows the court to include a requirement that damages awarded to be paid in whole or in part by installment or periodic payments when a judgment is entered on a claim in any action for recovery of damages for personal injury or death arising out of or the failure to render professional services by a health care provider. Any installment or periodic payment becoming due and payable under the terms of the judgment constitutes a separate judgment upon which execution may issue.

Any judgment ordering installment or periodic payments is to specify the amount of each payment to be made. For good cause, the court may modify the judgment with respect to the amount, number of intervals between payments, but the total amount of damages award is not subject to modification.

Pleading Dollar Amounts

The rules of pleading under the code of civil procedure (K.S.A. 60-208) were amended in 1976 also to provide pleadings in all civil actions demanding damages over $10,000 shall so state but cannot specify the amount whereas pleadings demanding damages of $10,000 or less shall state the exact amount. A similar rule was enacted for punitive damages (K.S.A. 60-609(g)) and for limited actions (K.S.A. 61-1707).

1985 Legislation

S.B. 267 requires attorneys of record and the Insurance Commissioner in medical malpractice actions to submit to the Board of Healing Arts expert witness reports made available to opposing parties and, upon the Board's request, any depositions, interrogatories, admissions, or other relevant information made available to opposing parties. The Board is required to pay reasonable reproduction costs. The information submitted is subject to the confidentiality requirements of existing law.

Under the existing law the Commissioner of Insurance has to provide a copy of all malpractice lawsuit petitions to the Board of Healing Arts. The Commissioner receives these petitions as a result of his role as administrator of the Health Care Stabilization Fund.

Sub. for S.B. 110 makes several substantial changes in regard to medical malpractice liability actions under Kansas law. The bill puts a cap on punitive damages of either 25 percent of the annual gross income earned from professional services as a health care provider based upon their highest gross annual income from these services in any one of the past five years, or $3 million, whichever is less. A separate proceeding before the court is required for the awarding of punitive damages. The injured party must prove by clear and convincing evidence that the defendant acted with willful or wanton conduct or fraud or malice, which terms are defined. The plaintiff shall receive only 50 percent of any punitive damage award, with the remaining 50 percent to be placed in the Health Care Stabilization Fund. Punitive damages shall not be assessed against a principal, employer, or professional corporation for acts of an agent, employee, or shareholder unless the conduct was authorized or ratified. The above changes apply only to a cause of action accruing on or after July 1, 1985.

The bill alters the collateral source rule in the area of medical malpractice liability to permit the trier of fact (either a judge or jury) to hear evidence regarding indemnification or replacement of any damages or expenses incurred by the injured party from any insurance, except life insurance, or from workers' compensation, welfare payments, military benefits, employment wage continuation plans, or other benefit plans provided by law. The injured party may present evidence of any payments made to secure the insurance or benefits and the extent to which these benefits are subject to any lien or subrogation right. The collateral source amendments apply to any action regardless of when the cause of action accrued.

Finally, the provisions of the bill are sunsetted on July 1, 1989.

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(3) "Fairness" — how much local government aid is targeted to need,

(4) "Regulatory Burden" — how much state mandates affect local government, including mandates no longer required by the federal government but continued by states, and

(5) "Functional Assumption" — increasing state pick-up of costs now local.

Table 26: Indicators of State Institutional Modernization, 1960-1984

	1960	1984	Change
Constitutions			
Comprehensive revision	5	10	+5
Governors			
Two-year term of office	15	4	-11
Successive terms forbidden	16	4	-12
Short executive ballot (4 other statewide elected officials or less)	3	10	+7
Executive budget	40	44	+4
Legislatures			
"One person, one vote" apportionment	5	50	+45
Biennial Sessions	31	8	-23
60 day (or less) sessions	25	16	-9
Number of standing committees			
Senate	1082	730	-352
House	1331	917	-414
Professional staffing of all standing committees in both houses	0	38	+38
Legislative audits	9	20	+11
Judiciary			
Assignment of administrative and jurisdictional authority to highest state court	3	49	+46
Court administrators at appellate level	3	50	+47
Judicial qualifications commissions	3	41	+38

MEDICAL MALPRACTICE AND STATE POLICY

Introduction: State officials continue to face the issue of whether there should be limits on recoveries in tort actions in state courts. The subject covers auto accidents, on-the-job injuries and workers' compensation, product liability, and professional malpractice. Of these, the topic currently getting the most attention is professional malpractice, particularly medical malpractice.

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The situation is easier to understand than fix. When someone does something to another person which the law defines as wrong, the perpetrator is liable for civil damages. So when a driver recklessly hurts another driver, he is liable for damages. The courts have been gradually expanding this liability to errors made in the professional practice of lawyers, doctors, accountants, and others.

Assuming fault can be established, the question becomes one of damages for which the perpetrator is liable. These clearly include out-of-pocket costs of the person damaged — medical bills, for example — and lost income from being unable to work. They can also include less tangible costs such as "pain and suffering," loss of consort of one's spouse, and punitive damages, designed to discourage similar conduct in the future. There is a tendency for juries to make awards for some of these intangibles quite large — in the millions of dollars.

A substantial industry has developed around bringing and defending these claims. The plaintiffs are typically represented by trial lawyers on contingent fees. These trial lawyers have counterparts serving insurance companies representing defendants. Because most professionals purchase insurance against possible liability, the price of the judgments is reflected in prices for services, such as health care.

Malpractice, New York: The results are some big numbers. New York's Insurance Superintendent recently approved a 55% increase in medical malpractice rates by the state's largest medical malpractice insurer. The average doctor in New York will pay $19,000 a year for malpractice insurance. If the average doctor spends an average of 1,500 hours a year with patients, he or she must charge over $12 per patient-hour just to pay the malpractice insurance bill. Total premiums paid by New York doctors will exceed $400 million a year. The rates are higher for certain specialties than others and more in some geographic areas than others. The top rate in New York is over $80,000 — for an obstetrician on Long Island.

Governor Cuomo is recommending a plan to cut these costs — primarily by limiting what lawyers can recover in malpractice cases and strengthening peer review in hospitals.

The doctors aren't happy. A New York obstetrician commented in an OpEd (New York Times, April 8):

> Victims of clear-cut malpractice should be compensated. Unfortunately, today it is likely that even unavoidable complications will be turned into expensive lawsuits. What we now have is a perverse lottery that primarily enriches lawyers. Doctors are exploited to the point of extinction. The public purse is plundered. It is impossible to finance and deliver health care under these circumstances. Is this really the way we want to go?

Malpractice, Florida: In Florida, a neurosurgeon commented (Los Angeles Times, April 1):

> I think there is considerable risk that the services of neurological surgeons will no longer be available to the people in Florida after 1987.

> I now refuse to see patients referred by attorneys, insurance companies, other patients or self-referrals. I only see new patients who are bona fide emergencies in the emergency room and patients who are referred by other physicians.
>
> There are many neurosurgical procedures that I am capable of doing, which I will no longer do because I feel there is too much risk in doing these procedures in the state of Florida.

In 1975, Florida created a pre-trial process of screening cases by a panel of a judge, a lawyer, and physician. Someone whose claim was rejected by the screening could go to trial, but the results of the screening were admissible at the trial. The Florida Supreme Court declared this statute unconstitutional in 1980. Florida doctors then went back to the Florida legislature for relief, with the trial lawyers in opposition to the measures they proposed. The legislature did not act, so the doctors ran a petition drive to put a tort law reform measure on the 1984 ballot. This included a $100,000 ceiling on jury awards for mental anguish. The Florida Supreme Court rejected that measure before the vote could take place on the grounds that it covered more than one subject, contrary to the Florida constitutional requirement that such measures only cover one.

The AMA Position: The American Medical Association has a report on the subject (Professional Liability in the '80s, 1984). The report cites increasing costs for liability itself, plus:

> Apace with the multiplying claims and rising premiums, there is a growing awareness that many physicians are resorting to the practice of "defensive medicine" — ordering additional tests and procedures in diagnosing and treating — to protect against charges of omission and to justify their actions should any subsequent negligence claims be filed. Estimates are that defensive medicine may add anywhere from $15 billion to $40 billion annually to health care costs.

If one believes these numbers, defensive medicine costs from $63 to $170 per year per person in the United States, plus whatever pain and suffering is associated with the extra tests and procedures.

The AMA report documents a recent sharp increase in the number of malpractice claims and in the size of awards to plaintiffs. This has been noted elsewhere. For example, a recent issue of Time proclaims in a headline that "Malpractice Insurers are Ill."

But if there is a crisis in medical malpractice, it is not the nation's first. There was one in the 1970s that triggered state legislative action. The AMA report discusses the results:

> In one sense, the campaign for tort law reforms was immensely successful. Every state in the union, except West Virginia, enacted some reform proposals. Some states including those with the most serious professional liability problems ... enacted comprehensive packages of legislation over the vigorous and well-organized opposition of plaintiffs' trial lawyers.

But in another sense, the campaign appears to have failed.

> ... First, some of the reform measures have not been as effective in reducing litigation volume or severity as hoped ... Second, many of the potentially most effective reforms have been successfully challenged on constitutional grounds in the courts. With the exception — thus far — of contractual binding arbitration, every single major tort reform measure has been found unconstitutional by at least one state supreme court. In many states, lower courts have reached conflicting conclusions about the same statutes, and plaintiffs and defendants in many states are still awaiting higher court determinations on the validity of important provisions.

AMA's report reviews the status of widely adopted tort reform measures:

• **Pretrial Screening Panels:** Panel procedures were adopted by 30 states, have been upheld by supreme courts in ten, struck down in four, and repealed or permitted to sunset by legislatures in four — leaving 22 states with laws, 12 still subject to litigation.

• **Collateral Source Rules:** Although the subject is complicated, in many states juries consider how much a physician (actually the insurance company) should pay without being told how much the same person has recovered for the same damage from other sources, such as health insurance and workers' compensation. Nineteen states have changed this rule. This change has been rejected by courts in three and allowed to expire in one, leaving 15 where the new rules are still in effect.

• **Attorney Fee Regulation:** Twenty-three states have adopted some form of limitation of attorneys' fees in malpractice cases. These laws limit the freedom of the plaintiff and attorney to contract freely, which would permit fees of any level. Some states also allow the defendant to recover defense costs in cases where the loser did not appear to have a reasonable chance of winning. These statutes have survived legal challenges so far everywhere but New Hampshire. The AMA suggests that whether these regulations have had any effect on the number and severity of claims is "problematic."

• **Statute of Limitation Changes:** These changes generally involve reducing the length of time during which a patient can assert a claim. Forty states have taken some action on this subject. These provisions have been partly invalidated (as they relate to minors) in three and AMA believes they have been construed by the courts in many states in ways that reduce their effectiveness.

• **Limitations on Liability:** Seventeen states have enacted some form of limitation on the amount of judgments, or portion of them that reflects pain and suffering as distinct from loss of employment income and actual outlays for medical care. Five state supreme courts have rejected these limits as arbitrary.

• **Periodic Payment of Damages:** Seventeen states have passed statutes which require or permit courts to award damage payments periodically, rather than in a lump sum.

• **Res Ipsa Loquitur:** Twelve states have abolished the res ipsa loquitur doctrine which, in some circumstances, shifts the burden of proof from the plaintiff to the defendant. AMA doesn't think these changes have had much effect.

AMA's staff has done a compilation of which states have enacted "tort reform" laws which are still in effect. **Reports** summed the number of measures in effect in each state, with results shown in Table 27.

Table 27: Number of Tort Reform Measures in Effect, 1984

Rank	State	Number	Rank	State	Number	Rank	State	Number
1	Florida	10	15	Maryland	6	35	Maine	3
2	Kansas	9	15	Oregon	6	35	Idaho	3
2	Delaware	9	15	New York	6	35	Georgia	3
2	California	9	21	South Dakota	5	35	Utah	3
2	Louisiana	9	21	Hawaii	5	35	Missouri	3
2	Nebraska	9	21	Massachusetts	5	40	Pennsylvania	2
7	Illinois	8	21	Virginia	5	40	New Jersey	2
7	Wisconsin	8	21	Oklahoma	5	40	Montana	2
9	Indiana	7	26	North Carolina	4	40	Kentucky	2
9	Arizona	7	26	Wyoming	4	40	Connecticut	2
9	Alaska.	7	26	Arkansas	4	40	Vermont	2
9	Ohio	7	26	Rhode Island	4	40	Mississippi	2
9	Tennessee	7	30	Nevada	4	47	New Hampshire	1
9	New Mexico	7	30	Colorado	4	47	North Dakota	1
15	Washington	6	30	South Carolina	4	47	Minnesota	1
15	Alabama	6	30	Iowa	4	50	West Virginia	0
15	Michigan	6	30	Texas	4			

Placement on this table indicates the degree of state participation in the wave of malpractice law reform that took place mostly in the 1970s, minus laws held invalid by state supreme courts. High placement on the chart indicates high state effort to hold down the costs of malpractice judgments, which not everyone considers a valid objective.

Legal Controversy: Generally, challenges to these statutes have not yet been decided by state supreme courts. Only in one state (Indiana) has a supreme court already heard challenges to every one of the "reforms" listed above. Thus the law is settled in Indiana (seven reforms) and West Virginia (no reforms to challenge) and unsettled in 48 states, as of late 1984.

A recent example of the court challenges occurred in California (Fein v. Permanente Medical Group, decided February 28, 1985).

The case involved a 34-year old employee of the California legislature who started feeling chest pains which, for roughly a day, his health maintenance organization misdiagnosed as muscular problems. He then had a heart attack. He returned to full-time work 11 months later and resumed jogging, bicycling, and swimming. However, assuming the findings at trial, his life expectancy was reduced significantly by failure to diagnose correctly on his initial visits.

Acting pursuant to California's tort reform law, the trial judge shifted a $63,000 award for future medical costs from a cash award to amounts to be paid if and when expenses were incurred and not reimbursed from other sources. The judge also reduced a pain and suffering award of half a million dollars to the statutory limit of $250,000 and deducted disability payments received from the State of California from the award for lost wages.

A majority of the California Supreme Court upheld the California legislation limiting pain and suffering damages. The majority noted that contrary conclusions had been reached by state courts in Illinois, North Dakota, New Hampshire, and Texas; but not in Indiana and Nebraska. However, some of the statutes rejected by the courts limited actual damage awards as well as pain and suffering awards, which the California law doesn't. The court also upheld considering income from other sources, such as the disability insurance.

California's Chief Justice Bird dissented. She commented:

> In order to provide special relief to negligent health care providers and their insurers, (the legislation) arbitrarily singles out a few injured patients to be stripped of important and well-established protections against negligently inflicted harm. Crisis (in malpractice insurance) or no crisis, this court is duty-bound to apply the constitutional guarantee against irrational and invidious legislative classifications. Today's majority opinion represents a sad departure from this court's previously proud tradition of fulfilling that important duty.

AMA's Proposed State Law Changes: The AMA committee that put its report together is looking for changes in state laws:

- Limit awards for pain and suffering;
- Eliminate punitive damages;
- Require that juries itemize how they arrived at damage awards;
- Encourage periodic, rather than lump sum payments;
- Establish state patient compensation funds to cover liability in excess of stipulated coverage amounts;
- Consider payments from other sources, such as health insurance;
- Limit lawyers' fees;
- Mandate pre-trial screening panels;
- Set standards for expert witnesses that would likely reduce the standards of care to which physicians are being held;
- Shorten the period between injury and when a suit must be filed;

- Make it harder for attorneys to sue persons other than primary defendants;
- Discourage frivolous suits; and
- Provide voluntary binding arbitration.

To get these enacted by the states, the AMA committee wants a federal law providing monetary incentives for the states to adopt them.

AMA also has recommendations on improving the quality of care including strengthening state licensing boards.

Virginia: In Virginia, malpractice insurance costs jumped by 32% in 1984 and are predicted to increase another 32% this year. The state medical society and one of the major malpractice insurers have adopted a proposal for "no fault" handling of certain claims. Someone suffering damage in medical treatment would notify the provider. Without any finding of who was at fault, the provider could offer to pay medical bills and any past and future loss of income. The patient would be free to accept the offer or to choose litigation, but the offer would not be admissible as evidence in litigation.

A similar plan has been adopted in 49 states for high school athletes who suffer catastrophic injuries. The school's insurer pays all economic losses without any argument over whether the school was at fault or not. Less than 10% of seriously injured students and their parents decline the offer.

Illinois: Citing a Department of Insurance study showing malpractice settlements and the size of awards tripling between 1980 and 1983, Governor Thompson has appointed a 17-member Blue Ribbon task force to develop recommendations on how to deal with the subject.

The Trial Lawyers' Perspective: The trial lawyers have been unimpressed with what they see as a stampede of medical professionals looking at ways to reduce their liability by limiting recoveries of victims, rather than improving medical practice to avoid negligent damage to patients. They suggest that state attention could better be devoted to dealing with negligent doctors (e.g., greater willingness to pull a physician's license) than dealing with innocent victims. They also argue that the malpractice lawsuit can be a potent force to encourage improvements in medical practice.

Some of them see some damage to innocent patients as an inevitable consequence of the operation of the health care system. The question is who should pay it? everyone who consumes medical care through malpractice insurance or just persons injured through limitations on awards?

Another line of attack has been to argue discrimination — that giving someone who loses a leg through the negligence of a driver a particular level of damages but limiting recovery if the same damage results from the negligence of a doctor is discriminatory.

PENSION AND HEALTH PLAN COVERAGE

Covering health care costs not covered by others is potentially one area of explosive growth of state spending. This explains both the desire of the Reagan Administration to reduce its involvement in Medicaid cost increases and the desire of

Kansas Legislative Research Department June 21, 1985

PROVISIONS OF THE HEALTH CARE PROVIDER INSURANCE AVAILABILITY ACT

The Health Care Provider Insurance Availability Act was developed by the 1975 Special Committee on Medical Malpractice and enacted in its original form by the 1976 Legislature. The Act, which is found at K.S.A. 40-3401 through 40-3420, has been amended several times in the last several years.

Definitions

K.S.A. 1984 Supp. 40-3401 defines terms used in the Health Care Provider Insurance Availability Act, including definitions of "basic coverage," "fund," "health care provider," "inactive health care provider," "plan," and "professional liability insurance." Of most significance in understanding the scope of the Act is the definition of the term, health care provider.

As used in the Health Care Provider Insurance Availability Act, health care provider means persons licensed to practice any branch of the healing arts (Medical Doctor, Doctor of Osteopathic Medicine, or Chiropractor) or person engaged in an approved postgraduate training program in the healing arts or holders of temporary permits to practice the healing arts; medical care facilities licensed by the Secretary of Health and Environment (general and special hospitals, recuperation centers, and ambulatory surgical centers); health maintenance organizations issued certificates of authority by the Commissioner of Insurance; licensed optometrists; registered podiatrists; registered pharmacists; licensed professional nurses who are certified as nurse anesthetists by the American Association of Nurse Anesthetists; professional corporations organized by persons who are by definition under this statute health care providers; not-for-profit corporations organized for the purpose of rendering professional services by persons who are health care providers under K.S.A. 1984 Supp. 40-3401; dentists certified to administer anesthetics in a medical setting; registered physical therapists; and mental health centers and mental health clinics licensed by the Secretary of ~~Health and Environment.~~ The term, health care provider does not include any state institution for the mentally retarded nor, after July 1, 1985, any state psychiatric hospital.* Other definitions utilized frequently in the Health Care Provider Insurance Availability Act are noted in the section summaries that follow.

SRS

Basic Coverage

K.S.A. 1984 40-3402 mandates that every resident health care provider maintain professional liability insurance approved by the Commissioner of Insurance and issued by an insurer authorized to transact business in Kansas in which the limit of the

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* State psychiatric hospitals were exempted in 1985 S.B. 362.

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insurer's liability is not less than $200,000 per occurrence, subject to not less than $600,000* annual aggregate for all claims made during the policy period. This mandated professional liability insurance is referred to in the Act as "basic coverage." The mandated coverage is to be maintained by all health care providers as a condition to rendering professional service in the state unless the health care provider is a self-insurer or, after July 1, 1985, is a resident practicing under the supervision of a clinical faculty member of the University of Kansas School of Medicine in a postgraduate training program approved by the Board of Healing Arts and operated by the University of Kansas Medical Center who is insured pursuant to K.S.A. 40-3414 as amended by 1985 S.B. 362. Policies mandated by this statute must, as a minimum, provide coverage for claims made during the term of the policy that were incurred during the term of the policy or during the prior term of a similar policy.

Pursuant to K.S.A. 1984 Supp. 40-3402 every insurer providing basic coverage must, within 30 days after receiving the premium for the policy, notify the Commissioner of Insurance that coverage is in or will be in effect in a form approved by the Commissioner. The statute specifies information that must be included in the notification, such as the name and address of the provider or providers covered by the policy, the amount of the annual premium, information identifying the policy, etc. The statute also requires the insurer to notify the Commissioner of Insurance in the event the required basic coverage is terminated for whatever reason, and all insurance contracts are to be construed to obligate the insurer to meet all mandatory requirements and obligations set out in the Act.

The statute also prohibits nonresident health care providers who are not self-insurers from providing professional services as a health care provider in Kansas unless such nonresident provider has professional liability insurance coverage as required by Kansas statutes although such coverage may be provided by an insurer that is not admitted to do business in Kansas.

K.S.A. 1984 Supp. 40-3402 further requires nonresident health care providers, self-insurers, and, after July 1, 1985, the University of Kansas Medical Center for medical residents engaged in covered postgraduate training operated by the Medical Center**, to submit the surcharge authorized by K.S.A. 40-3404 directly to the Commissioner of Insurance.

Health Care Stabilization Fund

K.S.A. 1984 Supp. 40-3403 creates a Health Care Stabilization Fund which is liable to pay excess amounts due from a judgment or settlement arising from damages for personal injury or death arising out of the rendering or failure to render professional services by a health care provider, self-insurer, or inactive health care provider who has qualified for coverage under the Fund. The Fund is liable for amounts in excess of the

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* Prior to the 1984 amendments to K.S.A. 40-3402 the statutory minimum professional liability coverage was $100,000 per occurrence and $300,000 annual aggregate. The liability of an insurer for claims made prior to July 1, 1984, may not exceed the limits of insurance provided by the policy prior to July 1, 1984.

** Added by 1985 S.B. 362.

basic coverage liability of (1) liable, resident health care providers or resident self-insurers for any injury or death arising out of the rendering of professional services or failure to render services either in Kansas or out-of-state, (2) for liable nonresident health care providers or self-insurers for any injury or death arising out of the rendering or failure to render professional services in Kansas, (3) for resident inactive health care providers, (4) for inactive nonresident health care providers for injuries or death arising out of professional services rendered in Kansas, and (5) for reasonable and necessary attorney fees incurred for defending the Fund, expenditures for reinsuring the Fund, actuarial expenses incurred in administering the Act, any amounts due to the assigned risk plan created by K.S.A. 40-3413, and necessary expenses. Inactive health care providers are providers who purchased basic coverage or qualified as self-insurers under the Act who, at the time a claim for personal injury or death is made, do not have basic coverage or self-insurance in effect solely because they are no longer engaged in rendering professional services as a health care provider.

Pursuant to K.S.A. 1984 Supp. 40-3403, all amounts for which the Fund is liable are to be paid in full if they are less than $300,000 or, if $300,000 or more, in installment payments of $300,000 or 10 percent of the amount of the judgment, including interest whichever is greater each fiscal year, with the first installment to be paid within 60 days after the Fund becomes liable and subsequent payments to be paid annually on the same date until the claim has been paid in full. The Fund's liability is limited to $3,000,000 in any one judgment or settlement against any one health care provider arising out of the rendering of professional services after July 1, 1984, and subject to an aggregate limitation for all settlements or judgments arising from claims made in any one fiscal year in the amount of $6,000,000 for each provider.

The 1984 Legislature amended K.S.A. 40-3403 by creating a 13-member board of governors to provide technical assistance in administration of the Fund, expertise in the evaluation of claims or potential claims and advice, information and testimony to the appropriate licensing agency regarding the qualifications of a health care provider. The members of the Board of Governors, who are appointed by the Commissioner of Insurance, include three doctors of medicine, three representatives of hospitals, two doctors of osteopathic medicine, one chiropractor, two members of other categories of health care providers, one member of the public who is not a health care provider, and the Commissioner of Insurance or the Commissioner's designee. If the Board of Governors of the Fund determines that an individual health care provider represents a material risk of significant future liability to the Fund by a majority vote and after notice and an opportunity for hearing, the liability of the Fund for claims against the individual provider may be terminated. The date of termination is 30 days after the determination is made by the Board. The appropriate licensing agency must be notified of the reasons for termination of coverage under the Fund.

Surcharge

K.S.A. 1984 Supp. 40-3404 requires the Commissioner of Insurance to levy an annual premium surcharge on each health care provider who has obtained basic coverage and each self-insurer for each fiscal year. After July 1, 1985, an annual surcharge is to be levied against the University of Kansas Medical Center for residents engaged in approved postgraduate training operated by the Medical Center on the basis of an assumed aggregate premium of $600,000.* The surcharge is an amount equal to a

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* Added by 1985 S.B. 362.

percentage of the annual premium paid by the health care provider for basic coverage or, in the case of a self-insurer, on the amount such self-insurer would pay for basic coverage calculated in accordance with approved rating procedures. Premium surcharges are collected by the insurer in addition to the annual premium for basic coverage collected from resident health care providers and are remitted to the Commissioner of Insurance by the insurer. Nonresident providers and self-insurers pay the surcharge directly to the Commissioner.

The premium surcharge authorized by the Health Care Provider Insurance Availability Act is to be in an amount deemed sufficient by the Commissioner of Insurance to fund anticipated claims against the Health Care Stabilization Fund. In setting the surcharge, the Commissioner may require a health care provider who has paid the surcharge for less than 24 months to pay a higher surcharge and to amortize any anticipated deficiencies in the Fund over a reasonable period of time.

Transfer from General Fund

K.S.A. 40-3405 allows a transfer of money from the State General Fund to the Health Care Stabilization Fund in the event the latter is insufficient to pay the Fund's liabilities. Any amount transferred from the General Fund constitutes a debt of the Health Care Stabilization Fund until the full amount of the transfer is repaid in the next fiscal year. The maximum surcharge authorized by K.S.A. 1984 Supp. 40-3404 must be imposed in any fiscal year in which the Fund is indebted to the State General Fund. The provisions of K.S.A. 40-3405 expired in 1981.

Investment of Fund Moneys

K.S.A. 40-3406 authorizes the Pooled Money Investment Board to invest and reinvest money in the Health Care Stabilization Fund as specified in the statute.

Payments From Fund

K.S.A. 40-3407 specifies that all payments made from the Health Care Sabilization Fund are to be made upon warrants of the Director of Accounts and Reports issued pursuant to vouchers approved by the Commissioner of Insurance accompanied by a certified copy of a final judgment against a health care provider or a certified copy of a court-approved settlement.

Liability of Insurer or Self-Insurer

Pursuant to K.S.A. 1984 Supp. 40-3408, the insurer of a health care provider covered by the Fund or a self-insurer is liable only for the first $200,000 of a professional liability claim, subject to an annual aggregate of $600,000 for all claims against the provider. Liability for claims made prior to July 1, 1984, is $100,000, subject to an annual aggregate of $300,000. If an inactive health care provider has liability insurance in effect which would be applicable to a claim in the absence of the Health Care Provider Insurance Availability Act, any payments from the Health Care Stabilization Fund are to be excess coverage over the amount that is paid or is payable in the absence of the Health Care Provider Insurance Availability Act.

Procedure in Actions Arising Under the Act

K.S.A. 1984 Supp. 40-3409 requires the plaintiff in any action for personal injury or death arising out of the rendering or failure to render professional services by a health care provider covered by the Health Care Stabilization Fund to serve a copy of the petition on the Commissioner of Insurance by registered mail. If such service is not made, the Fund is not liable for any amount due from a judgment or settlement nor is the health care provider or the provider's insurer to be liable for any amount that would have been a liability of the Fund. In the case of an action filed outside Kansas, notice must be given the Commissioner as soon as practicable that a summons or petition has been filed. If the petition names a health care provider credentialed by the Board of Healing Arts as a defendant, the Commissioner of Insurance must forward a copy of the petition to the Board.

Any action must be defended by the insurer of a health care provider or self-insurer, but the Commissioner may employ independent counsel to represent the Fund and may employ independent counsel in any action against an inactive health care provider covered by the Fund.

After July 1, 1985, the attorneys of record and the Commissioner of Insurance must submit reports of expert witnesses which have been made available to the opposing parties in an action to the Board of Healing Arts and, at the Board's request, any depositions, interrogatories, admissions, or other relevant information concerning the action which has been made available to opposing parties. Any report or information made available to the Board is subject to the confidentiality provisions of K.S.A. 65-2898a.*

Negotiation of Claims

K.S.A. 40-3410 allows the claimant and the Commissioner of Insurance to negotiate the amount to be paid from the Health Care Stabilization Fund when a settlement has been agreed to by an insurer or self-insurer or when a claim is against an active health care provider covered by the Fund who does not have liability insurance in effect that is applicable to the claim. The procedure to be followed in such instances is set out in the statute which also authorizes the Commissioner to employ independent counsel to represent the Fund in negotiations.

Actions in Which the Commissioner Does Not Agree to Settle

Under the provisions of K.S.A. 1984 Supp. 40-3411, in actions in which the insurer of a health care provider, a self-insurer, or an inactive provider covered by the Fund has agreed to settle a claim and the claimant's demand is in excess of the amount of the settlement, to which the Commissioner does not agree, an action must be commenced by the claimant against the health care provider or inactive health care provider. Such action is to be conducted as if the insurer or self-insurer had not agreed to settle the claim. An insurer or self-insurer must defend the action as if no agreement to settle the insurer's or self-insurer's liability had occurred, but the insurer

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* Added by 1985 S.B. 267.

or self-insurer must be reimbursed for the costs of the defense from the Fund. The health care provider or inactive health care provider against whom the claim is made is obligated to attend hearings and trials and give evidence in such actions. Any costs of an action arising pursuant to K.S.A. 40-3411 are to be assessed against the Fund if recovery is in excess of the amount offered by the Commissioner to settle the case or against the claimant if recovery is less than the settlement offer.

Certain Actions Prohibited

Pursuant to K.S.A. 40-3412 any action for personal injury or death arising out of the rendering or failure to render professional services by a health care provider or inactive health care provider must be maintained against the provider, and no claimant has a right of action against the Health Care Stabilization Fund nor directly against an insurer. Evidence that a portion of any verdict would be payable by insurance or the Fund is inadmissible. No additional liability may be imposed on the Fund for negligent failure to settle a claim or to settle a claim in good faith, nor may the Fund be liable for any punitive damages under K.S.A. 40-3412. The Fund is not liable for any judgment against an inactive health care provider arising from the rendering of health care services contrary to the provisions of the Health Care Provider Insurance Availability Act.

Apportionment of Risk

K.S.A. 1984 Supp. 40-3413 requires every insurer (corporation, association, reciprocal exchange, inter-insurer or other legal entity authorized to write bodily injury or property damage insurance in Kansas, including workmen's compensation and auto insurance) and every rating organization (corporation or association, partnership, or individual licensed to make rates for professional liability insurance) to cooperate in the preparation of a plan or plans for the apportionment among insurers of applicants for professional liability insurance who are unable to procure such insurance through ordinary methods. The plan (sometimes referred to as a joint underwriting association or JUA or an assigned risk pool) must provide: reasonable rules for the equitable distribution of risks by direct insurance or reinsurance including authority to make assessments against participating insurers; rates which are reasonable, adequate, and not unfairly discriminatory; a method for an annual comparison of the losses and expenses experienced by the plan and the premiums earned; the limits of liability the plan is required to provide; and a method for hearing grievances and for appeal to the Commissioner of Insurance. The plan required by K.S.A. 1984 Supp. 40-3413 must be approved by the Commissioner and the Commissioner may develop a plan if no satisfactory plan for the apportionment of risk is created by insurers. A board of governors, consisting of nine members appointed by the Commissioner and including three members representing foreign insurers, two members representing domestic insurers, two members representing the public, one licensed casualty insurance agent, and one health care provider, constitute the governing authority of the plan.

The provisions of K.S.A. 1984 Supp. 40-3413 expire on July 1, 1987, but any plan in existence on that date continues to exist for the purpose of allowing existing policies to expire and completing the payment of claims.

Self-Insurers

K.S.A. 1984 Supp. 40-3414 allows any health care provider whose annual insurance premium would be $100,000 or more for basic coverage to qualify as a self-insurer. The Kansas Soldiers' Home and, after July 1, 1985, the University of Kansas Medical Center for medical residents,* are, by statute, self-insurers and subject to the surcharge set out in K.S.A. 40-3402(c) but not to other provisions of K.S.A. 1984 Supp. 40-3414.

On application to the Commissioner of Insurance, by a health care provider, the Commissioner may issue a certificate of self-insurance if satisfied that the applicant has the ability to pay any judgment equal to the basic coverage required of health care providers after consideration of the guidelines set out in the statute. The Commissioner may also cancel a certificate of self-insurance, after notice and an opportunity for hearing, on the grounds set out in the statute.

Assistance in Complying With Act

K.S.A. 1984 Supp. 40-3415 directs the Board of Governors of the Plan, the Commissioner of Insurance, the Attorney General, and the officers and employees of state agencies that license, register, certify, or regulate health care providers to consult with and assist each other in maintaining compliance with the Health Care Provider Insurance Availability Act.

Reports of Suspected Violations

K.S.A. 40-3416 requires the Commissioner of Insurance to report any reasonable suspicion that a health care provider is rendering professional services without having the required professional liability insurance to the state agency which credentials such provider. The state agency, if it finds that a violation exists, must notify the Attorney General or appropriate county attorney who must initiate an action to enjoin the practice of the health care provider.

Rules and Regulations

The Commissioner of Insurance is required to promulgate any necessary rules and regulations to carry out the provisions of the Health Care Provider Insurance Availability Act under K.S.A. 40-3417.

Severability

K.S.A. 40-3418 is a general severability clause.

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* As provided in 1985 S.B. 362.

Title

K.S.A. 40-3419 names the act the Health Care Provider Insurance Availability Act.

Reorganization of Professional Corporations

Pursuant to K.S.A. 1984 Supp. 40-3420, any professional corporation that reorganizes as a Kansas not-for-profit corporation is to be considered a continuing concern for the purposes of obtaining basic coverage pursuant to the Health Care Provider Insurance Availability Act and shall not be considered an inactive health care provider. Any insurer issuing basic coverage to such a corporation must provide coverage for all claims made during the term of the policy issued while the not-for-profit corporation was operating as a professional corporation.

(3) "Fairness" — how much local government aid is targeted to need,

(4) "Regulatory Burden" — how much state mandates affect local government, including mandates no longer required by the federal government but continued by states, and

(5) "Functional Assumption" — increasing state pick-up of costs now local.

Table 26: Indicators of State Institutional Modernization, 1960-1984

	1960	1984	Change
Constitutions			
Comprehensive revision	5	10	+5
Governors			
Two-year term of office	15	4	-11
Successive terms forbidden	16	4	-12
Short executive ballot (4 other statewide elected officials or less)	3	10	+7
Executive budget	40	44	+4
Legislatures			
"One person, one vote" apportionment	5	50	+45
Biennial Sessions	31	8	-23
60 day (or less) sessions	25	16	-9
Number of standing committees			
Senate	1082	730	-352
House	1331	917	-414
Professional staffing of all standing committees in both houses	0	38	+38
Legislative audits	9	20	+11
Judiciary			
Assignment of administrative and jurisdictional authority to highest state court	3	49	+46
Court administrators at appellate level	3	50	+47
Judicial qualifications commissions	3	41	+38

MEDICAL MALPRACTICE AND STATE POLICY

Introduction: State officials continue to face the issue of whether there should be limits on recoveries in tort actions in state courts. The subject covers auto accidents, on-the-job injuries and workers' compensation, product liability, and professional malpractice. Of these, the topic currently getting the most attention is professional malpractice, particularly medical malpractice.

Professional Liability Insurance

K.S.A. 40-1112 and K.S.A. 40-1113 require all rates to be submitted for the Commissioner's prior approval. These statutes are applicable to all kinds of casualty insurance, except aircraft insurance and title insurance. Rates approved for use in Kansas must be justified by the insurance company (or rate making organization). These statutes allow companies to utilize past and prospective premium and loss experience derived from their Kansas or countrywide statistical records in justification of their proposed rate filings. This department does not have authority to make or set premium rates for insurance companies. In reviewing proposed rate filings the department determines compliance with the requirements of these statutes which are that premium rates must be reasonable, adequate and not unfairly discriminatory. Investment income is not required by these statutes to be included or considered in the information or rate making procedures utilized by the insurance company to support proposed rate filings.

Since 1976, health care provider professional liability insurance proposed rate filings have been reviewed and found to be acceptable for use in the state of Kansas. The results of the approved rate filings for physicians, surgeon's and hospitals are displayed on Exhibits 1 and 2 (attached).

Premium rates for doctors have been progressively increasing and the premium rates for the two major insurance companies have been demonstrating a widening premium rate differential since 1979. (See Exhibit 1) This rate differential between St. Paul and Medical Protective is due to the fact that each company utilizes its own premium and loss statistics to determine their own premium rate levels. The statistical supporting information does include both Kansas and countrywide premium and loss data; however, the Kansas data provides the basis for rate level determination, with the countrywide data being relied upon to establish certain rate making factors. If only Kansas data were utilized, the resulting premium rate levels would vary greatly from year to year.

St. Paul Fire and Marine Insurance Company premium rate levels for Kansas Hospitals are displayed on Exhibit 2. As reflected on this chart Kansas premium rates were reduced in 1977 and 1978. These premium rate reductions were the result of favorable prospective premium and loss projections for Kansas. The chart also reflects a level of stability in premium rates for the years of 1978, 1979 and 1980.

Physicians, Surgeons and Hospital Professional Liability Rate Making Procedures

Physicians, surgeons and hospital professional liability rate filings are customarily submitted on an annual basis; however, individual insurance companies are not required by statute to submit an annual filing. There have been times when the department requested that individual insurance companies submit a rate evaluation filing even though the insurance company was not requesting a rate adjustment. In other situations the department has been able to review premium and loss data submitted in connection with insurance companies' Annual Statements.

7/1-2/85 ATTACHMENT V

Rate making procedures utilized by individual insurance companies are not required to be in a standard format, even though the department conducts a review which incorporates a standard evaluation process for all rate filings. Certain insurance companies have developed a more complex rate making approach than other companies; however, the department's evaluation process incorporates the same standards for all companies.

The basis of the department's "standard evaluation" is each company's Kansas earned premiums and incurred losses. More specifically, the ratio of how many premium dollars were taken from Kansas to how many loss dollars have been or will be paid out in Kansas. The resulting ratio is then compared to the company's expected Loss ratio to determine if a rate adjustment is needed. At this point in the department's evaluation process, consideration has not yet been given to any form of trending or adjustments for future predictable changes. It is also at this point that "actuarial principles" and the inclusion of countrywide data become important considerations in the determination of any rate level change that may be requested by the company.

As the department continues to review the rate filing, previous rate filings are also reviewed to determine any significant changes in the rate making methods, as well as to determine the effect of trending and other prospective rate making procedures. Reviews are also conducted on other relevant areas of the rate filing. These include, for example, reviewing company expense ratios to other insurance companies' expense ratios, continuity of premium and loss data with prior rate filings and Annual Statement data, accuracy of the company's loss reserving practices and the credibility of Kansas verses countrywide data.

Insurance companies utilize a weighted combination of Kansas and countrywide experience data in order to avoid any widely fluctuating premium rates from one year to another year. This procedure is reviewed to determine if the effect is reasonable.

In addition to the department's review, professional liability rate filings are also reviewed by the independent actuarial firm which provides the Health Care Stabilization Fund's annual review. This review is conducted after the department takes final action on the filings; however, we have not been advised that the rate levels approved for use in Kansas were inaccurate, excessive or inadequate.

Additional Information Attached

1. Copy of K.S.A. 40-1112 and K.S.A. 40-1113, Exhibit 3 (2 pages).

2. Kansas Physicians and Surgeons Professional Liability Insurance Rate Comparison - The Medical Protective Company and St. Paul Fire and Marine Insurance Company, Exhibit 4.

3. Kansas Professional Liability Insurance Rates, Effective 7-1-85, Exhibit 5.

4. Insurance Company Distribution of Physicians and Surgeons By Percentage of Medical Doctors Written, Exhibit 6 (2 pages).

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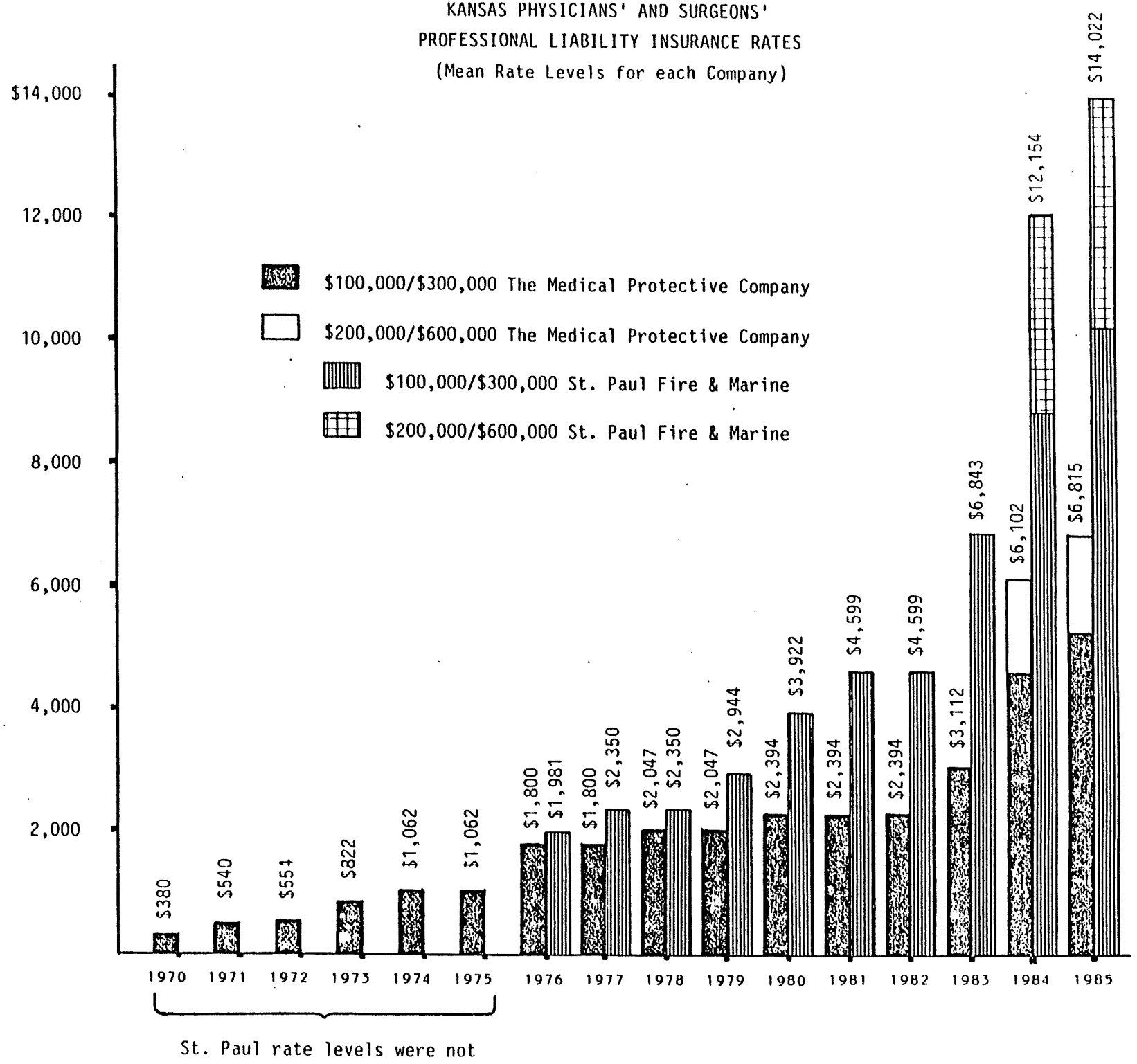
EXHIBIT I


KANSAS PHYSICIANS' AND SURGEONS'
PROFESSIONAL LIABILITY INSURANCE RATES
(Mean Rate Levels for each Company)
$14,000
12,000
10,000
8,000
6,000
4,000
2,000
$100,000/$300,000 The Medical Protective Company
$200,000/$600,000 The Medical Protective Company
$100,000/$300,000 St. Paul Fire & Marine
$200,000/$600,000 St. Paul Fire & Marine
$380
$540
$554
$822
$1,062
$1,062
$1,800
$1,981
$1,800
$2,350
$2,047
$2,350
$2,047
$2,944
$2,394
$3,922
$2,394
$4,599
$2,394
$4,599
$3,112
$6,843
$6,102
$12,154
$6,815
$14,022
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
St. Paul rate levels were not

KANSAS HOSPITAL PROFESSIONAL
LIABILITY INSURANCE RATES
FOR ST. PAUL FIRE & MARINE INS. CO.

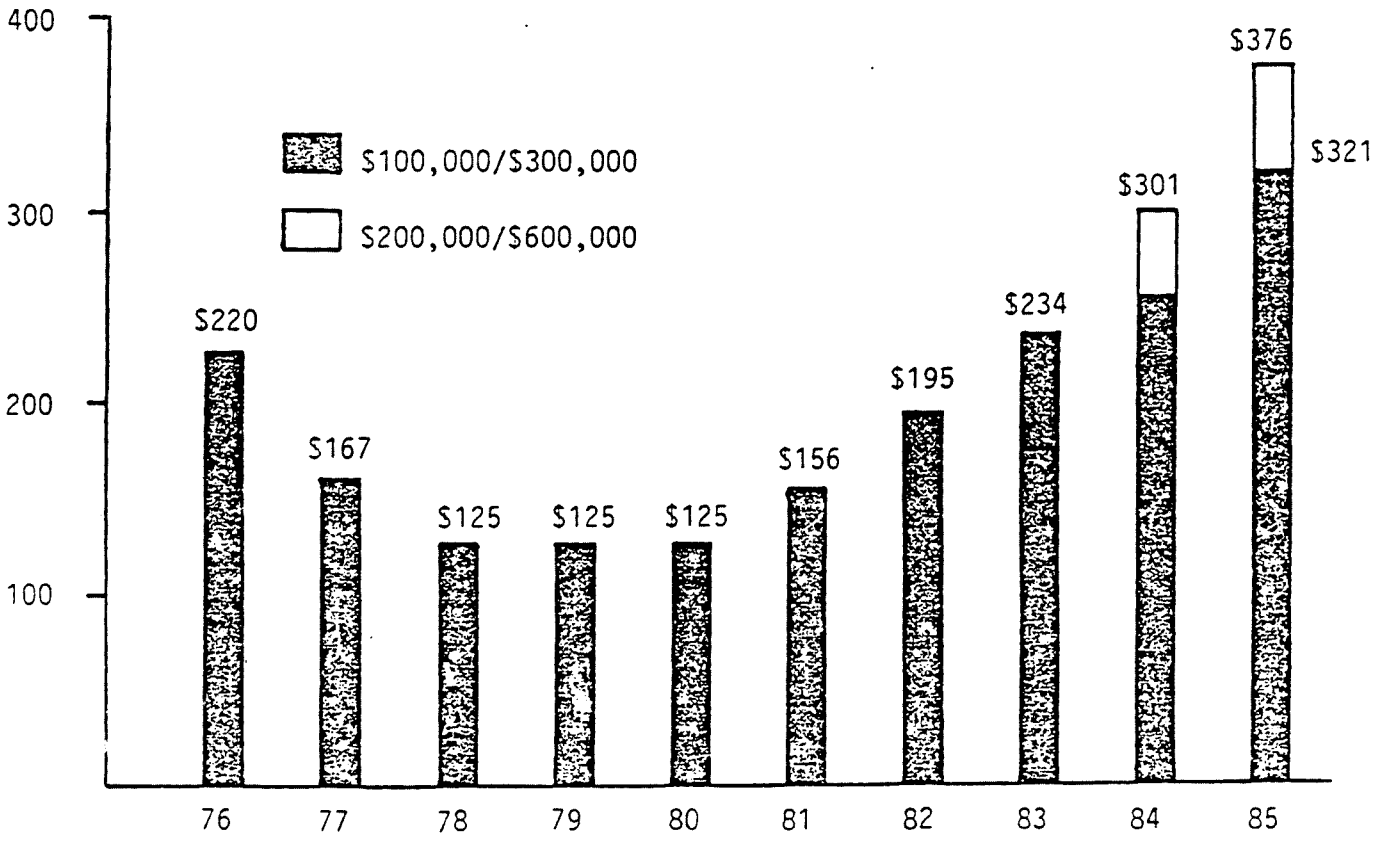


EXHIBIT II

40-1112. Same; making of rates. All rates shall be made in accordance with the following provisions:

(1) Due consideration may be given to past and prospective loss experience within and outside the state, to catastrophe hazards, if any, to a reasonable margin for profit and contingencies, to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, to policyholders' dividends in the case of participating insurers, and to all other relevant factors within and outside the state; (2) the systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination the commissioner of insurance, hereinafter referred to as commissioner, approves the application of separate expense provisions; but this subdivision shall not be construed to require uniformity among all insurers with respect to the application of other subdivisions of this section; (3) risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both; (4) rates shall be reasonable, adequate and not unfairly discriminatory.

History: L. 1945, ch. 215, § 2; Jan. 1, 1946.

Research and Practice Aids:

Hatcher's Digest, Insurance §§ 4, 10, 66, 67

40-1113. Filing of rates and rating information; approval or disapproval; notice and hearings; orders. (a) Every insurer shall file with the commissioner every manual of classifications, rules and rates, every rating plan and every modification of any of the foregoing which it proposes to use. Every such filing shall indicate the character and extent of the coverage contemplated and shall be accompanied by the information upon which the insurer supports the filing. A filing and any supporting information shall be open to public inspection after it is filed with the commissioner.

(b) An insurer may satisfy its obligation to make such filings by authorizing the commissioner to accept on its behalf the filings made by a licensed rating organization or another insurer. Nothing contained in this act shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization.

(c) Any filing made pursuant to this section shall be approved by the commissioner unless the commissioner finds that such filing does not meet the requirements of this act or establishes an unreasonable or excessive rate. As soon as reasonably possible after the filing has been made the commissioner shall in writing approve or disapprove the same, except that any filing shall be deemed approved unless disapproved within thirty (30) days.

(d) Any such filing with respect to a fidelity, surety or guaranty bond shall be deemed approved from the date of filing to the date of such formal approval or disapproval.

(e) In the event that the commissioner disapproves a filing, the commissioner shall specify in what respect he or she finds that such filing does not meet the requirements of this act.

(f) If at any time the commissioner finds that a filing so approved no longer meets the requirements of this act, the commissioner may, after a hearing held on not less than twenty (20) days' written notice, specifying the matters to be considered at such hearing, to every insurer and rating organization which made such filing, issue an order withdrawing his or her approval thereof. Said order shall specify in what respects the commissioner finds that such filing no longer meets the requirements of this act and shall be effective not less than thirty (30) days after its issuance. Copies of such order shall be sent to every such insurer and rating organization.

(g) Any person or organization aggrieved by the action of the commissioner with respect to any filing may, within thirty (30) days after such action, make written request to the commissioner for a hearing thereon. This section shall not apply to any insurer or rating organization with respect to a withdrawal of a filing made by it. The commissioner shall hear such aggrieved party within thirty (30) days after receipt of such request and shall give not less than ten (10) days' written notice of the time and place of the hearing to the insurer or rating organization which made the filing and to any other aggrieved party. Within thirty (30) days after such hearing the commissioner shall affirm, reverse or modify his or her previous action specifying the reasons therefor. Pending such hearing and decision thereon the commissioner may suspend or postpone the effective date of his or her previous action.

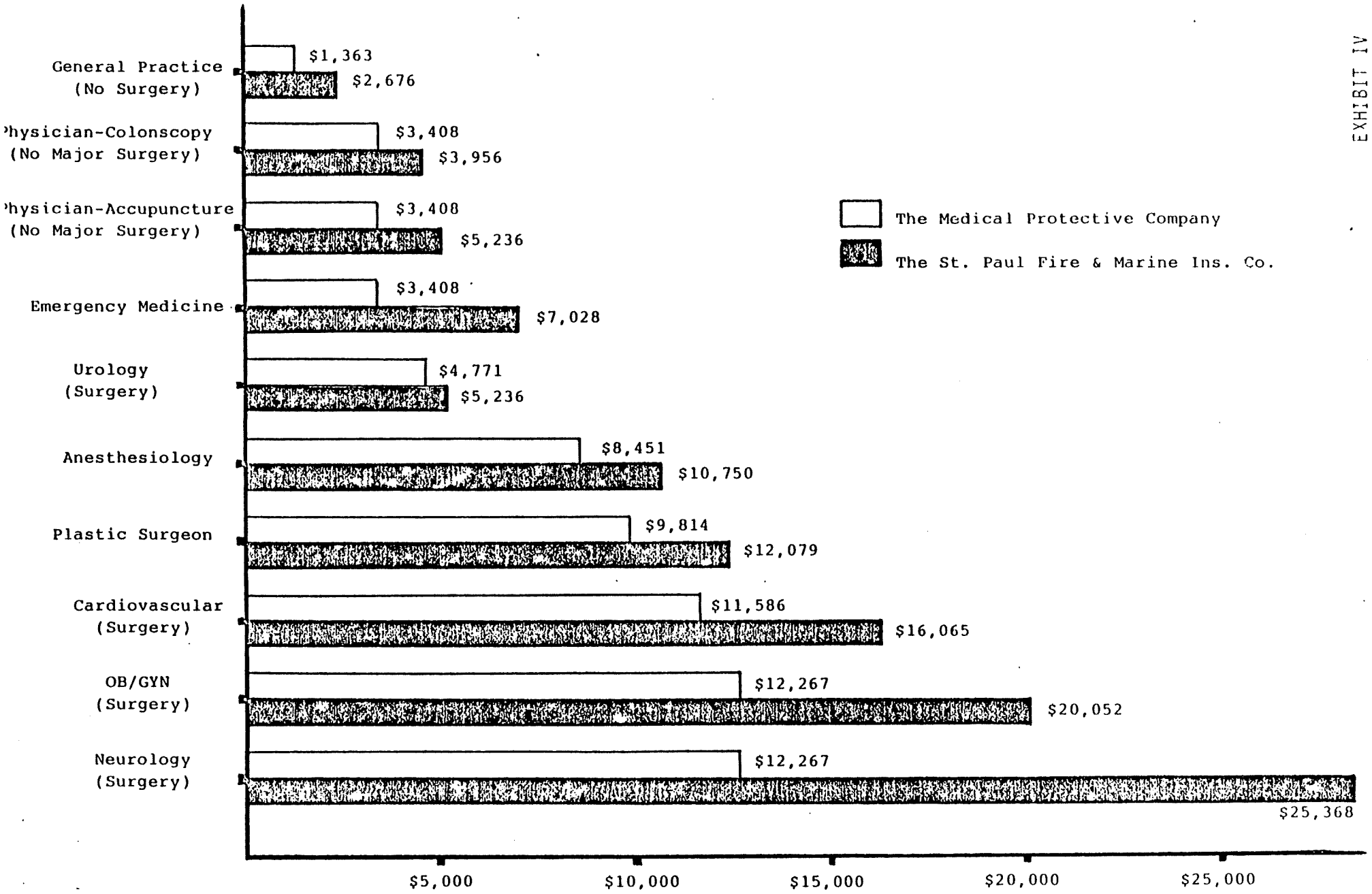
(h) No insurer shall make or issue a contract or policy except in accordance with filings which have been approved for said insurer as provided in this act.

History: L. 1945, ch. 215, § 3; L. 1978, ch. 177, § 2; L. 1979, ch. 141, § 2; July 1.

Source or prior law:
40-1106

KANSAS PHYSICIANS AND SURGEONS
PROFESSIONAL LIABILITY INSURANCE RATES
AS OF 7-1-85

EXHIBIT IV

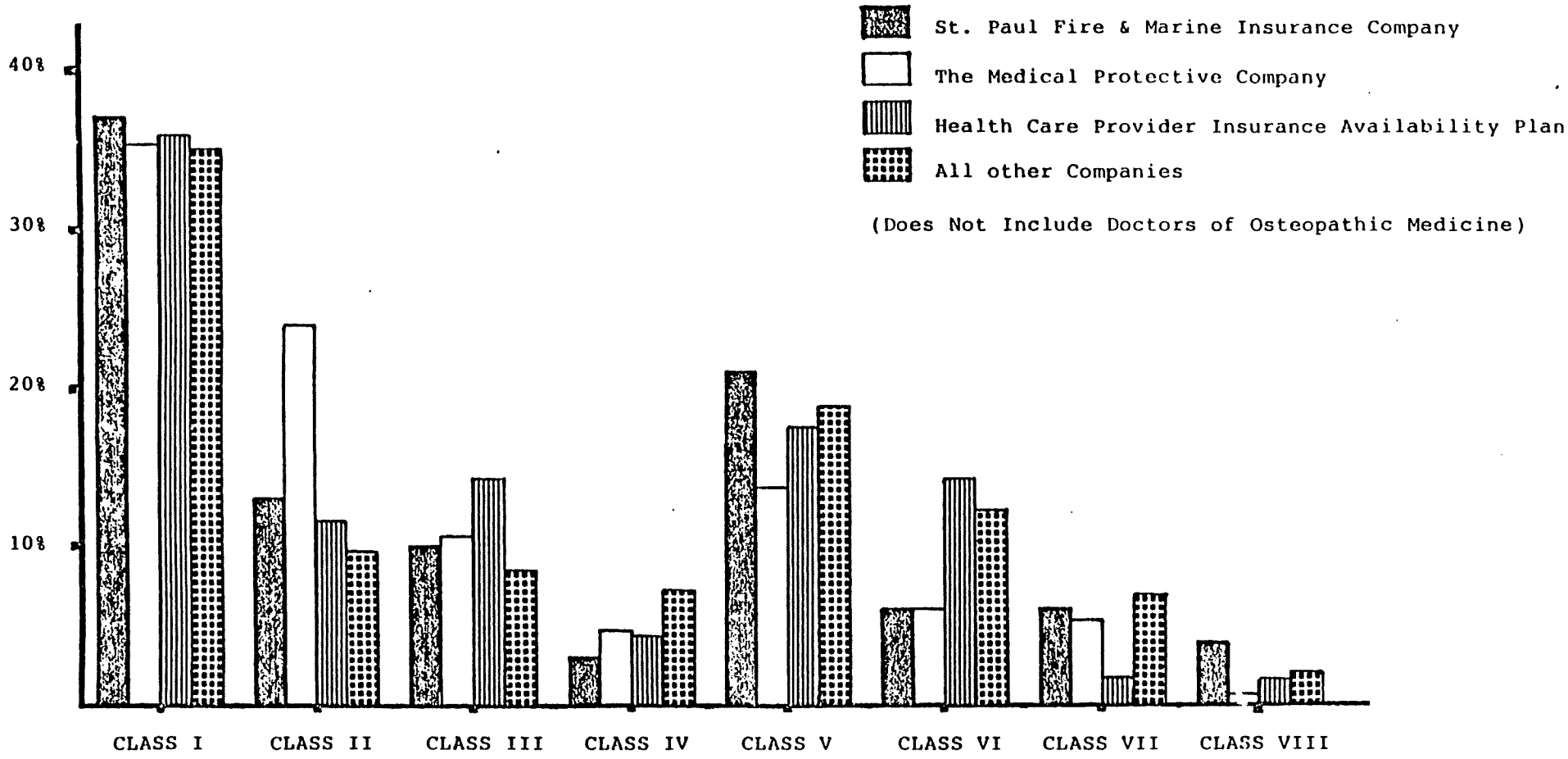


KANSAS PROFESSIONAL LIABILITY
INSURANCE RATES
EFFECTIVE 7-1-85

Class of General Practitioner	St. Paul Companies	Pennsylvania Casualty Co.	Providers Insurance Co.	Medical Prot. Insurance Co.	Medical Defense Co.
Physician - No Major Surgery/ Colonscopy	3,956	2,639	4,585	3,408	2,461
Family Physician or General Practitioner	2,676	1,649	1,507	1,363	1,330
Physician - No Major Surgery/ Accupuncture	5,236	4,947	4,585	3,408	3,325
Emergency Medicine	7,028	4,947	4,585	3,408	3,325
Surgery - Urological	5,236	6,184	6,527	4,771	4,655
Anesthesiology	10,750	8,430	10,102	8,451	11,970
Surgery - Plastic	12,079	10,116	11,656	9,814	9,576
Surgery - Cardio-Vascular	16,065	10,116	13,210	11,586	11,305
Surgery - Cardiac	16,065	10,116	13,210	11,586	11,305
Surgery - Obstetrics/Gynecology	20,052	11,802	11,656	12,267	11,970
Surgery - Neurology	25,368	13,488	14,764	12,267	11,970

EXHIBIT V

INSURANCE COMPANY DISTRIBUTION OF PHYSICIANS AND SURGEONS
BY PERCENTAGE OF MEDICAL DOCTORS WRITTEN
(Source: HCSF Compliance Records as of 6/6/85)



(See Attached Exhibit for Descriptions of Classes)

	St. Paul Fire and Marine	The Medical Protective	KHCPIA Plan	Other Companies
CLASS I: Physicians - No Surgery	548 / 37%	297 / 35.4%	25 / 36%	216 / 35%
CLASS II: Physicians, Minor Surgery	194 / 13%	201 / 24%	8 / 11.4%	58 / 9.5%
CLASS III: Family Practice or General Practice Surgery, Catherization, Laser Therapy, Shock Therapy	146 / 10%	90 / 10.7%	10 / 14.2%	51 / 8.3%
CLASS IV: Opthamology (surgery), Neo-plastic (surgery), Colon & Rectal (surgery), Endocrinology (surgery), Physicians (minor surgery), Emergency Medicine (no major surgery)	48 / 3%	40 / 4.8%	3 / 4.2%	41 / 7.2%
CLASS V: Surgical Specialties of Cardiac, General, Urology, Anesthesiology, Otorhino, Otology, Abdominal	304 / 21%	114 / 13.6%	12 / 17.2%	114 / 18.7%
CLASS VI: Surgical Specilties of OB/GYN, Hand, Neck, Plastic	95 / 6%	50 / 6%	10 / 14.2%	75 / 12.3%
CLASS VII: Surgical Specialties of Tramtic, Thoracic, Vascular, Cardio-Vascular, Orthopedic	88 / 6%	44 / 5.2%	1 / 1.4%	40 / 7%
CLASS VIII: Neurological Surgery	7 / 4%	3 / 0.3%	1 / 1.4%	11 / 2%
TOTAL NUMBER OF M.D.'s:	1,430 / 100%	839 / 100%	70 / 00%	606 / 100%

Basic Rate Making Requirements Professional Liability Insurance

K.S.A. 40-1112 and K.S.A. 40-1113 require all rates to be submitted for the Commissioner's prior approval. These statutes are applicable to all kinds of casualty insurance, except aircraft insurance and title insurance. Rates approved for use in Kansas must be justified by the insurance company (or rate making organization) and are requested to be reasonable, adequate and not unfairly discriminatory. These statutes allow companies to utilize past and prospective premium and loss experience derived from their Kansas or countrywide statistical records. Investment income is not required to be included or considered in the information or rate making procedures utilized by the insurance company to support proposed rate filings.

Physicians, Surgeons and Hospital Professional Liability Rate Making Procedures

Physician, surgeons and hospital professional liability rate filings are customarily submitted on an annual basis; however, individual insurance companies are not required by statute to submit an annual filing. There have been times when the department requested that individual insurance companies submit a rate evaluation filing even though the insurance company was not requesting a rate adjustment. In other situations the department has not been able to review premium and loss data submitted in connection with insurance companies' Annual Statements.

Rate making procedures utilized by individual insurance companies are not required to be in a standard format, even though the department conducts a review which incorporates a standard evaluation process for all rate filings. Certain insurance companies have developed a more complex rate making approach than other companies; however, the department's evaluation process incorporates the same standards for all companies.

The basis of the department's "standard evaluation" is each company's Kansas earned premiums and incurred losses. More specifically, the ratio of how many premium dollars were taken from Kansas to how many loss dollars have been or will be paid out in Kansas. The resulting ratio is then compared to the company's expected loss ratio to determine if a rate adjustment is needed. At this point in the department's evaluation process consideration has not yet been given to any form of trending of adjustments for future predictable changes. It is also at this point that "actuarial principles" and the inclusion of countrywide data become important considerations in the determination of any rate level change that may be requested by the company.

As the department continues to review the rate filing, previous rate filings are also reviewed to determine any significant changes in the rate making methods, as well as to determine the effects of trending and other prospective rate making procedures. Reviews are also conducted on other relevant areas of the rate filing. These include, for example, reviewing company expense ratios to other insurance companies' expense ratios, continuity of premium and loss data with prior rate filings and Annual Statement data, accuracy of the company's loss reserving practices and the credibility of Kansas verses countrywide data.

Insurance companies utilize a weighted combination of Kansas and countrywide experience data in order to avoid any widely fluctuating premium rates from one year to another year. This procedure is reviewed to determine if the effect is reasonable.

In addition to the department's review, professional liability rate filings are also reviewed by the independent actuarial firm which provides the Health Care Stabilization Fund's annual review. This review is conducted after the department takes final action on the filings; however, we have not been advised that the rate levels approved for use in Kansas were inaccurate, excessive or inadequate.

RDH:sdf
5895

Claims Made Policy Terminology

Claims Made Liability Insurance Policy: A liability insurance policy which provides coverage for those insured loss exposures for claims or suits which are made against the insured during the policy period, regardless of the date the loss was created or occurred. In this type of claims made liability insurance policy there is no contractual limitation on when the prior loss occurred; however, any claims or suits resulting from known loss occurrences will not be covered.

Modified Claims Made Liability Insurance Policy: Any claims made liability insurance policy which has been modified to incorporate one or both of the following features:

a. **Retroactive Date** provisions which limit the policy's coverage to only those claims or suits made against the insured during the claims made policy period that were caused by an occurrence after some specified date. The retroactive date provision allows the insured to purchase the length of the claims made policy's prior acts coverage needed for their individual situation.

b. **Extended discovery or reporting period** means that the claims made policy's provisions may be extended beyond the termination date to permit coverage of future claims or suits made after the termination date, provided that the occurrence which caused the claim to be made took place during the period the claims made policy was in effect. New events or occurrences created by the insured during the extended period are not covered. These extended discovery or reporting periods are commonly referred to as "tail coverage".

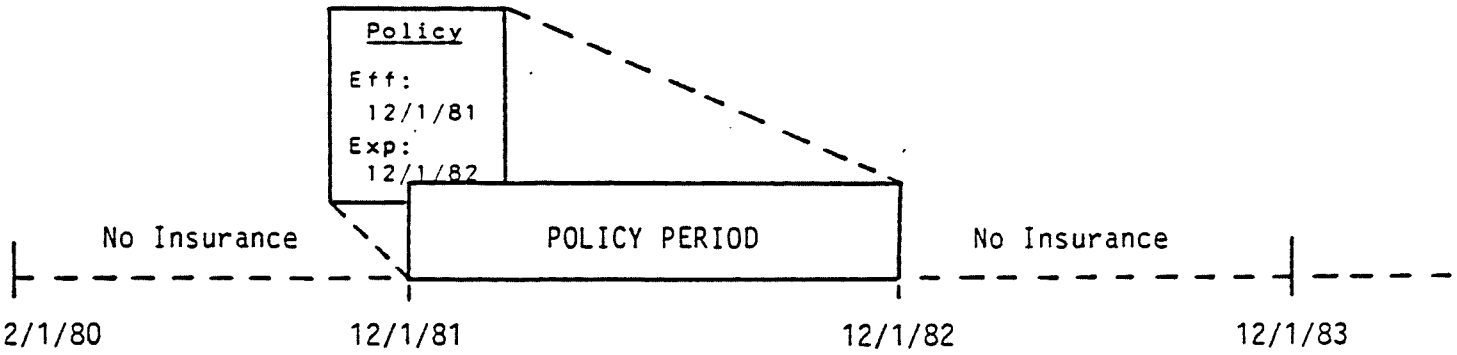
Mature v. Immature Claims Made Rates: When a claims made policy incorporates a retroactive active date provision (limiting the prior acts coverage period), the accompanying premium rate structure also reflects the length of the prior acts coverage being afforded to each individual insured. For example, a newly insured professional may be establishing their practice for the first time and therefore, does not have any need for prior acts coverage. This newly insured will obtain a claims made policy with a retroactive date concurrent with the inception date of the first policy issued and the premium amount paid will be the least mature claims made rate. This least mature claims made rate is a percentage of the mature rate level. As this example insured continues to renew the claims made policy the retroactive date will remain constant, increasing the length of prior acts coverage being afforded and the premium amount will increase until the prior acts coverage reaches a "mature level". The maturity period for claims made policies differs based on the type of risk that is being insured. For medical doctors the maturity period is reached on the fifth renewal of the claims made policy. For attorneys the maturity period is eight years.

Medical Malpractice Claims Made for Kansas Health Care Providers: As required by the Kansas Health Care Provider Insurance Availability Act (HCPIA Act, K.S.A. 40-3401, et seq.) specific provisions must be incorporated in the claims made professional liability insurance programs. These specific provisions are:

1. Prior acts for those claims made during the term of the policy which were incurred during the prior term of a similar policy must be incorporated for each applicable health care provider's previously insured professional practice in Kansas. This requirement eliminates the need for the active health care provider to purchase extended reporting coverage (tail coverage) when changing their basic coverage insurance companies.

2. Extended reporting coverage (tail coverage) for health care providers no longer rendering professional services in Kansas is not required since the Kansas Health Care Stabilization Fund provides the first dollar defense and first dollar loss payment for qualified inactive health care providers.

HOW OCCURENCE POLICIES COVER LOSSES

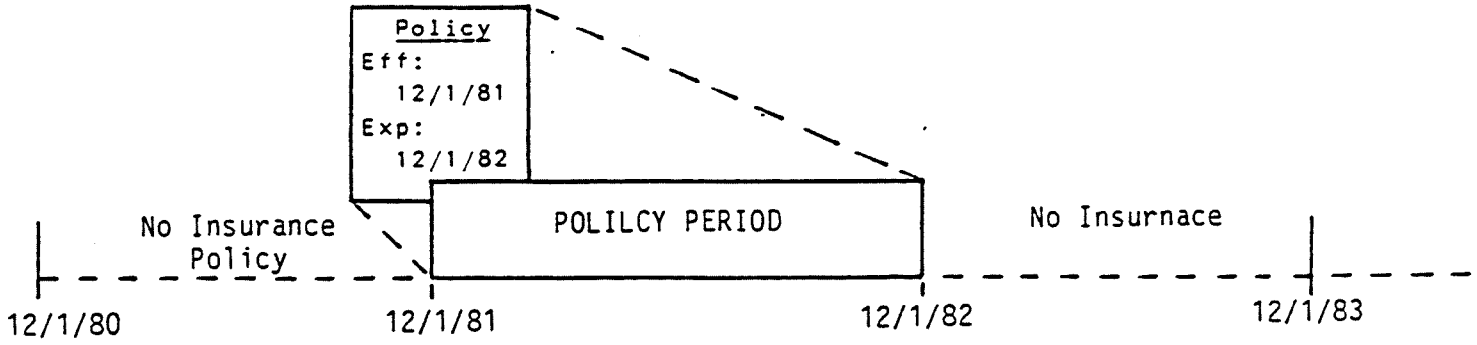


I. Any occurrence (injury to a third party) which takes place during the policy period is covered by the policy.

II. It does not mattter when the injured party actually makes a claim or files suit against the insured. For example, the insured's negligence caused another person to be injured on June 1, 1982. The insured does not realize or know of the injury. On April 1, 1983, the injured party files a claim of legal action. The insured, even though presently uninsured, has coverage for this claim under the occurrence policy because the injury took place during the policy period. Discovery period is subject to statutory limitations and court decisions.

The main advantage of the occurence policy is if the insured is held to be legally liable for any injury sustained (occurred) during the policy period that loss will be covered subject to the limit of liability of that policy. This advantage can also be viewed as a disadvantage, since once the occurrence policy limits are purchased those limits cannot be increased. In other words, the occurrence policy limits purchased in 1981, when $500,000 limits were thought to be adequate, would apply to today's claim from the 1981 injury, even though the insured now purchases $5,000,000 occurrence limits.

HOW CLAIMS MADE POLICIES COVER LOSSES



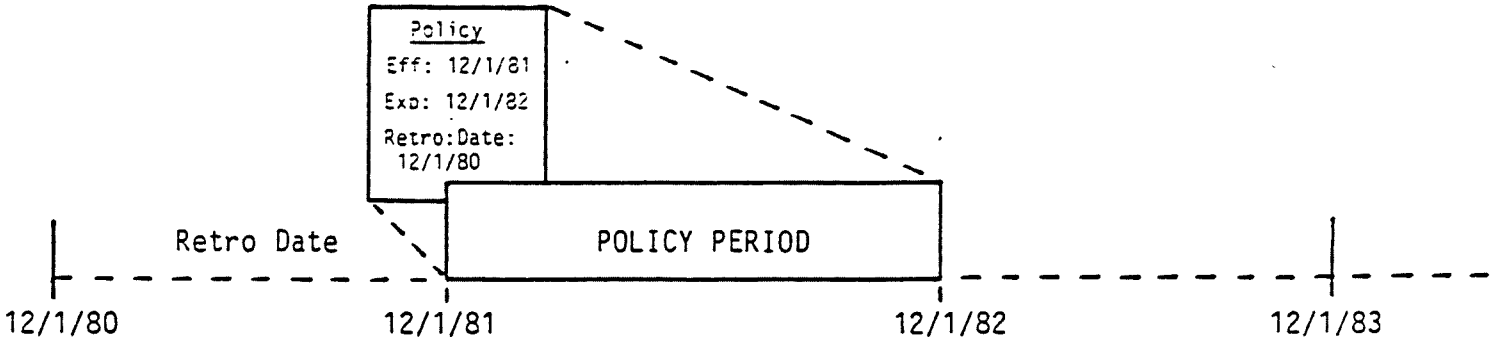
I. The claims made policy does not restrict coverage for prior acts. This is the only insurance coverage the insured purchased.

II. Any claim made against the insured (for which the insured is legally responsible) during the policy period will be covered. The cause of loss need only to take place prior to the expiration date of the claims made policy (12/1/82).

Example: The insured's negligent action caused a third party to be injured on November 1, 1981. The insured did not know of the injury. If the injured party files claim or suit against the insured during the policy period the claim is covered; however, if the claim or suit is filed before December 1, 1981, or after December 1, 1982, there is no coverage.

A variation of this example would be to change the date of injury to fall within the policy period. The coverage answer remains the same--if claim or suit is made against the insured during the policy period it will be covered; but, if it is made after December 1, 1982, it would not be covered.

HOW RETROACTIVE DATES APPLY TO CLAIMS MADE POLICIES

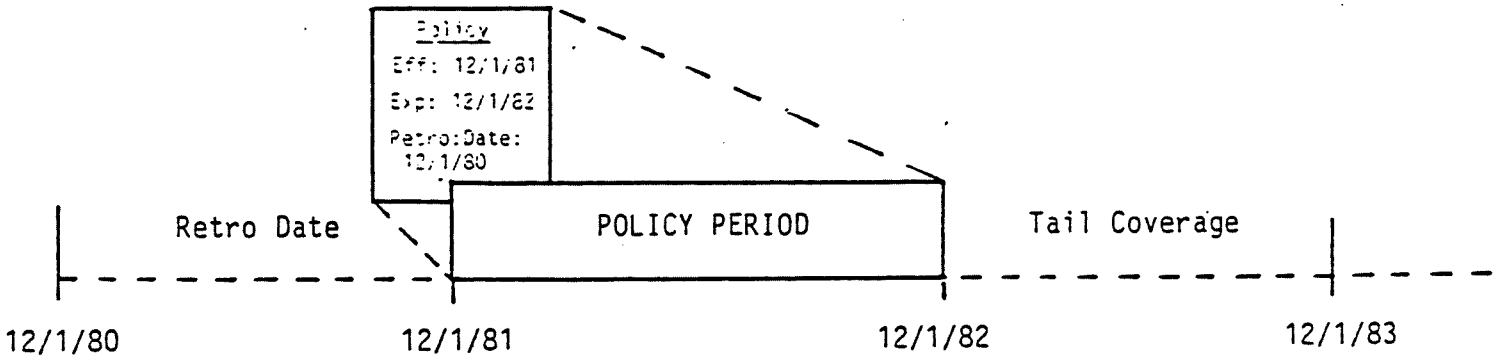


I. The retroactive date of December 1, 1980, establishes a limitation on prior acts covered by the current claims made policy. Any claim or suit made against the insured during the policy period will be covered provided the injury happened between the retroactive date (December 1, 1980) and the expiration date of the policy (December 1, 1982).

The effect is that the insured has obtained coverage for loss exposures created when insurance coverage was not purchased or is no longer applicable to any new claims or suits made against the insured.

II. If the insured renews the policy on December 1, 1982, the new policy's effective date will be December 1, 1982; the expiration date will be December 1, 1983; and the retroactive date will remain to be December 1, 1980.

ENDORSEMENTS (TAIL COVERAGE) APPLY TO CLAIMS MADE POLICIES



I. Policy was purchased for one year, with a retroactive date of December 1, 1980. On August 1, 1982, the insured terminates the business which created the need to purchase insurance. The company offered a 12-month tail coverage for 25% of the annual premium and the insured purchased the additional extended coverage. The duration of the extended discovery may vary with each claims made policy program.

II. The tail coverage will provide coverage for any claim or suit made against the insured during the period of December 1, 1982, to December 1, 1983; provided, the claim is the result of an injury that happended between the retroactive date (December 1, 1980), and the expiration date of the claims made policy (December 1, 1982).

HEALTH CARE STABILIZATION FUND

In Kansas, the Fund has contributed $6,528,963 in 12 judgments since the Fund's inception to July 1, 1985. The Fund has contributed $28 million, approximately, in 123 settlements since its inception for a total amount of approximately $35.3 million. To give you an idea of the increase in those amounts, in 1983, in 25 cases, the Health Care Stabilization Fund contributed $6,515,250. In 1985, in 41 cases, the Fund contributed $13,124,260. It is important to remember those amounts do not include defense costs, attorney fees or administrative expenses, nor do they reflect, amounts paid by others on behalf of defendants who are not covered by the Fund, but nonetheless have a bearing on the overall impact of amounts paid in medical malpractice litigation. Those defendants not covered by the Fund are, for example, nurses, product manufacturers, nursing homes, and other peripheral type institutions and individuals who are not covered by the Fund but who, nonetheless, are involved in medical malpractice litigation and have an impact on the overall environment. Nor do those amounts that I gave you reflect the amounts of the primary coverage applicable in any one case.

To give you an idea of the increase in the number of claims filed in medical malpractice actions against Kansas providers, in Fiscal Year 1984 we had 179 new claims made against the Fund. That was a 15% increase from the preceding year. In 1985 the Fund opened 230 new claim files. Suffice it to say that awards are going up along with the number of claims being filed. Attached to this summary is more detailed Fund data.

As Legislative Research has explained, the Legislature enacted the Health Care Stabilization Fund to encourage insurers to return to Kansas and to remedy the problems of the unavailability of malpractice insurance. The Fund has been successful in fulfilling its objective. The Fund was established to respond to one of the symptoms of the medical malpractice crisis of 1976, that being the unavailability of insurance. Hence, the name of the Act creating the Fund, the Health Care Provider Insurance Availability Act and hence the title of the Fund itself, the Health Care Stabilization Fund.

Today we have a different issue confronting us -- the affordability of medical malpractice liability insurance. Some attempts were made to discuss the affordability of insurance in the 1984 legislative session when Senate bill No. 507 was passed. Senate Bill No. 507 indirectly affected the issue of cost by putting a $3 million single limit $6 million annual aggregate cap on the Fund's indemnity liabilities. Senate Bill No. 507 went into effect on July 1, 1984. The cap, however, is an occurrence based cap, which means that it limits the exposure of the Fund only on those claims pertaining to occurrences which fall on or after July 1, 1984. We, therefore, will not see the benefit of the cap until another year or so when people begin filing claims for events which occurred after July 1, 1984. The benefits of the cap, as is true with most insurance related mechanisms, cannot be ascertained after only one year of experience. However, it must be recognized that the cap was instituted only as a device to insert some "worst case" predictability into the Fund's operation. The cap on the Fund was not intended and will not in fact resolve the medical malpractice problems.

Another provision of Senate Bill No. 507, which went into effect one year ago from today was the creation of the Advisory Board of Governors of the Fund. The Board of Governors serves as a sort of Board of Directors of the Fund. They provide input from the providers' prospective on the management of the Fund and provide expertise for the defense of particular provider's actions. The Insurance Department testified during the legislative hearings on Senate Bill No. 507 that the purpose of the Board was not to cure licensing problems, funding problems, or other medical malpractice problems and issues. We testified that the Board would merely provide input in the administration of the Fund. The advisory role of the Board is exemplified in its membership -- health care providers and one public representative. Another function of the Board of Governors is to cancel Fund coverage for providers who pose significant future risk of liability exposure to the Fund.

The Board as a whole has met twice since July 1, 1984 and is scheduled to meet again next week. The first time it met to discuss its formation and to review the Board's protection under the Tort Claims Act. The second meeting was called specifically to discuss implementation of procedures to curtail Fund coverage in appropriate instances. A subcommittee was formed to analyze the provisions, and difficulties with the Board's powers were noted. A brief synopsis of the problems the Board faces is as follows:

1. The Board has the power to curtail Fund coverage of providers who pose significant risk of future liability to the Fund. Insurers can cancel coverage based upon past claims history but the Board is put in the untenable position of having to show <u>future</u> claims history in order to cancel an insured.

2. The Board may cancel coverage only on an occurrence basis. Consequently, prospective plaintiffs to whose benefit a cause of action has inured but for whom a case has not been filed would still be entitled to sue and collect from the Fund. The Fund, however, would have cut off its own right to receive a surcharge from the provider whose coverage has been cancelled.

3. The Fund has to be forever mindful of its duty to defend. Cutting off coverage to a provider with pending litigation would not only eliminate the Fund's ability to collect the surcharge, but could potentially jeopardize the defense of the provider's case. Each instance where the Board considers cancellation has to be separately and closely analyzed.

You have also asked for a description of how the Fund is funded. The Fund is funded through a surcharge which is calculated on an annual basis using basically two criteria: a prospective loss analysis and retrospective loss analysis. The Fund, not only looks to the future but also adjusts or amortizes its losses which we know it has from the past. The Commissioner hires an independent actuary to review these matters on approximately a quarterly basis. The surcharge is assessed as a percentage

of the primary carrier's premium rate. The primary carrier is responsible for reporting the surcharge to the Fund and remitting the surcharge to the Fund. This process of collecting surcharges is an ongoing continual process and coincides with each provider's policy dates. The insurer is required by law to remit the surcharge to us no later than thirty (30) days from receipt.

Lastly, at least for today's presentation, you have asked about the "defense of the Fund". The Fund is in essence a liability insurance carrier. Consequently, the legislature treated the Fund like any other liability insurance carrier and prohibited suits against the Fund directly. Back in 1976, the Legislature studied the possibility of naming the Fund as a defendant. The Legislature, however, concluded that such a move would be contrary to the Kansas law surrounding liability insurers and would call attention to the "deep pocket" of the Fund against the best interest of the Fund itself and its insureds.

K.S.A. 40-3409, nevertheless, does require the plaintiff in a medical malpractice action to serve the Commissioner of Insurance as administrator of the Fund before the plaintiff may receive any payment from the Fund. The Supreme Court recently held that a plaintiff in a medical malpractice action may dismiss his or her case and refile the case to obtain service on the Commissioner. They found that the Fund was not prejudiced by a delay in notification to us of over one year and a half. We argued that the delay impeded our ability to accurately assess the surcharge, escalated costs and denied access to the discovery process and to appoint our own attorney, if needed. They responded that increased costs were inconsequential, that the attorney appointed by the primary carrier was adequate representation for the Fund and is provided by statute, and that the Legislature would have said that the plaintiff in a medical malpractice action cannot cure defective service by dismissing and refiling if it had intended that to be the case.

Upon receipt of notification of a claim, the primary carrier for the defendant-provider is ascertained from our compliance records. The primary carrier is contacted and asked for an assessment of the case. The primary carrier also notifies us about the attorney appointed to defend the provider. The Fund, then, appoints its own attorney to evaluate the case from the Fund's perspective. Exactly how the defense is handled will depend upon the exigencies of that particular case. We want to emphasize though that no indemnity is, or ever has been, paid from the Fund's resources except upon the advice of an attorney who specifically and legally represents the Fund's interests. We also note that the attorney who makes the recommendation that the Fund settle a case or pay a judgment is in addition to the Fund's own in-house legal counsel. The Fund, thereby, has two attorneys recommending settlement and the amount of settlement when settlement negotiations arise.

The Fund also has the duty to defend providers who had claims made against them for acts while they were covered by the Fund but who no longer have the mandatory insurance for legitimate reasons. For example, doctors who die, retire, or, move to another state will be covered by the Fund for claims made after the time of their departure from practice in Kansas but which pertain to an alleged malpractice episode

which occurred while the provider was in compliance with the mandatory insurance requirements. This is called "tail" coverage. Upon receipt of notification that the provider may be inactive and the defendant in a medical malpractice action where we would have the duty to defend, we immediately appoint an attorney. The attorney will also represent the interests of the Fund. If the attorney perceives a conflict, real or apparent, in defending the Fund, it is incumbent upon him or her to identify the conflict and advise us of it immediately. Conflicts rarely arise between the Fund and the insured, but when they do, they are handled quickly and expeditiously so as not to jeopardize the defense of the provider's suit.

HEALTH CARE STABILIZATION FUND STATISTICS - JULY 1, 1985

1. Balance -July 1, 1985: $ 9,291,425.00

2. Total Awards Against Fund: $35,275,164.00

Total Cases	135
Total Settlements	123
Total Judgments	12
Total Awards In Settlements	$28,746,201.00
Total Awards In Judgments	$ 6,528,963.00

3. Total Balance of Judgments on Appeal: $ 1,429,103.00

4. Total Balance of Future Payments: $ 8,980,139.00

Year	Amount
Fiscal Year 1986	$2,085,544.00
Fiscal Year 1987	$2,395,616.00
Fiscal Year 1988	$1,615,315.00
Fiscal Year 1989	$ 809,024.00
Fiscal Year 1990	$ 414,928.00
Fiscal Year 1991	$ 414,928.00
Fiscal Year 1992	$ 414,928.00
Fiscal Year 1993	$ 414,928.00
Fiscal Year 1994	$ 414,928.00

5. Average Claim Award Against Fund: $ 261,298.00
(135 Cases)

6. Total Cases Filed: 940

7. Total Active Cases: 380

8. Total Claims Closed: 560

9. Percent Of Claims Closed That Required Contributions: 24%

10. Claims Experience Of Fund:

Type Of Case	Number	Percent of Total Cases	Awards	Percent of Total Awards
Incorrect Diagnosis	27	20%	$ 5,153,934	15%
Surgery Related	36	26%	$10,703,931	30%
Improper Care	28	20%	$ 4,399,506	12%
Birth Related	21	16%	$11,348,494	32%
Others	16	12%	$ 1,279,615	4%
Anesthesiology	8	6%	$ 2,389,684	7%

11. Breakdown Of Claim Awards By Fiscal Year:

Year	Fiscal Year	Number	Amount	Percent of Total Awards
1	1977	1	$ 137,500	.4%
2	1978	0	$ -0-	0%
3	1979	3	$ 208,393	.6%
4	1980	0	$ -0-	0%
5	1981	8	$1,773,182	5%
6	1982	24	$3,060,126	9%
7	1983	25	$6,515,250	18%
8	1984	34	$10,456,454	30%
9	1985	41	$13,124,260	37%

12. Claims Filed Against The Fund By Fiscal Year:

Year	Fiscal Year	Number	Percent Per Year Increase
1	1977	5	--
2	1978	38	+660%
3	1979	26	-32%
4	1980	82	+215%
5	1981	100	+22%
6	1982	124	+24%
7	1983	156	+26%
8	1984	179	+15%
9	1985	230	+28%
TOTAL		940	

13. Surcharge Assessment Per Fiscal Year:

Year	Fiscal Year	Percent
1.	1977	45
2.	1978	45
3.	1979	40
4.	1980	15
5.	1981	0
6.	1982	0
7.	1983	0
8.	1984	50
9.	1985	80
10.	1986	110

14.	Largest Settlement:	$ 1,600,000
15.	Smallest Settlement:	$ 650
16.	Largest Judgment:	$ 1,900,000

Date: July 1, 1985

HEALTH CARE STABILIZATION FUND

Other/Claim Awards

		Amount
1.	$	2,500.00
2.	$	205,143.00
3.	$	8,500.00
4.	$	59,500.00
5.	$	156,022.00
6.	$	65,000.00
7.	$	200,000.00
8.	$	85,000.00
9.	$	95,000.00
10.	$	25,000.00
11.	$	20,000.00
12.	$	100,000.00
13.	$	1,200.00
14.	$	1,750.00
15.	$	5,000.00
16.	$	250,000.00
TOTAL	$	1,279,615.00
TOTAL ALL CASES	$	35,275.164.00

Date: July 1, 1985

HEALTH CARE STABILIZATION FUND

Anesthesiology/Claim Awards

	Amount
1.	$ 75,000.00
2.	$ 62,500.00
3.	$ 170,000.00
4.	$ 65,000.00
5.	$ 150,000.00
6.	$ 686,166.00
7.	$ 339,081.00
8.	$ 841,937.00
TOTAL	$ 2,389,684.00

TOTAL ALL CASES: $35,275,164.00

Date: July 1, 1985

HEALTH CARE STABILIZATION FUND

Judgments

	Amount
1.	$ 243,300.00
2.	$ 170,000.00
3.	$ 800,000.00
4.	$ 85,456.00
5.	$ 1,900,000.00
6.	$ 50,000.00
7.	$ 686,166.00
8.	$ 1,150,000.00
9.	$ 96,483.00
10.	$ 1,140,000.00
11.	$ 168,433.00
12.	$ 39,125.00
TOTAL	$ 6,528,963.00
TOTAL ALL CASES	$35,275,164.00

Date: July 1, 1985

HEALTH CARE STABILIZATION FUND

Birth Related/Claim Awards

		Amount
1.		$ 214,485.00
2.		$ 1,000,000.00
3.		$ 600,000.00
4.		$ 40,000.00
5.		$ 42,500.00
6.		$ 982,000.00
7.		$ 443,426.00
8.		$ 150,000.00
9.		$ 200,000.00
10.		$ 1,200,000.00
11.		$ 567,182.00
12.		$ 447,479.00
13.		$ 760,358.00
14.		$ 175,000.00
15.		$ 1,550,000.00
16.		$ 395,000.00
17.		$ 1,140,000.00
18.		$ 521,426.00
19.		$ 15,622.00
20.		$ 835,516.00
21.		$ 68,500.00
	TOTAL	$11,348,494.00
TOTAL ALL CASES		$35,275,164.00

Date: July 1, 1985

HEALTH CARE STABILIZATION FUND

Incorrect Diagnosis/Claim Awards

	Amount
1.	$ 255,047.00
2.	$ 650.00
3.	$ 900,000.00
4.	$ 14,000.00
5.	$ 95,000.00
6.	$ 7,000.00
7.	$ 355,000.00
8.	$ 3,750.00
9.	$ 113,622.00
10.	$ 180,000.00
11.	$ 275,000.00
12.	$ 150,000.00
13.	$ 122,452.00
14.	$ 275,255.00
15.	$ 85,456.00
16.	$ 5,758.00
17.	$ 12,500.00
18.	$ 268,952.00
19.	$ 17,205.00
20.	$ 500,000.00
21.	$ 30,800.00
22.	$ 331,786.00
23.	$ 99,040.00
24.	$ 30,000.00
25.	$ 186,664.00
26.	$ 50,000.00
27.	$ 788,997.00
TOTAL	$ 5,153,934.00

TOTAL ALL CASES $35,275,164.00

Date: July 1, 1985

HEALTH CARE STABILIZATION FUND

Improper Care/Claim Awards

	Amount
1.	$ 200,000.00
2.	$ 1,000.00
3.	$ 30,000.00
4.	$ 4,000.00
5.	$ 17,500.00
6.	$ 122,154.00
7.	$ 65,000.00
8.	$ 175,000.00
9.	$ 150,000.00
10.	$ 28,400.00
11.	$ 126,559.00
12.	$ 25,000.00
13.	$ 40,000.00
14.	$ 320,000.00
15.	$ 390,000.00
16.	$ 1,500.00
17.	$ 22,500.00
18.	$ 143,348.00
19.	$ 239,375.00
20.	$ 32,500.00
21.	$ 20,000.00
22.	$ 27,887.00
23.	$ 1,600,000.00
24.	$ 408,725.00
25.	$ 1,500.00
26.	$ 168,433.00
27.	$ 39,125.00
TOTAL	$ 4,399,506.00

TOTAL ALL CASES $35,275,164.00

Date: July 1, 1985

HEALTH CARE STABILIZATION FUND

Surgery/Claim Awards

File #	Amount
1.	$ 137,500.00
2.	$ 750.00
3.	$ 117,500.00
4.	$ 12,000.00
5.	$ 216,730.00
6.	$ 243,300.00
7.	$ 75,000.00
8.	$ 800,000.00
9.	$ 1,500,000.00
10.	$ 248,500.00
11.	$ 750,000.00
12.	$ 75,000.00
13.	$ 1,900,000.00
14.	$ 115,000.00
15.	$ 550,000.00
16.	$ 101,700.00
17.	$ 7,000.00
18.	$ 100,000.00
19.	$ 1,150,000.00
20.	$ 300,000.00
21.	$ 50,000.00
22.	$ 35,000.00
23.	$ 175,000.00
24.	$ 195,000.00
25.	$ 35,000.00
26.	$ 1,000.00
27.	$ 187,500.00
28.	$ 289,300.00
29.	$ 96,483.00
30.	$ 110,903.00
31.	$ 292,865.00
32.	$ 10,000.00
33.	$ 170,000.00
34.	$ 390,000.00
35.	$ 15,622.00
36.	$ 250,278.00
TOTAL	$10,703,931.00
TOTAL ALL CASES	$35,275,164.00

ATTACHMENT VI.

7/1-2/85

	File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled		Amount	Primary or Excess
					Fiscal Year 1977					
(1)		M.D.	Surgery	7	7/76	9/76	2/22/77		137,500	Excess
								TOTAL	137,500	
					Fiscal Year 1978			TOTAL	0	
					Fiscal Year 1979					
(2)		M.D. 80612	Birth Control, Abortion	4	5/77	3/78	10/12/78		2,500	Primary
(3)		80612	Fall	3	7/78	9/78	3/30/79		205,143	Excess
(4)		M.D.	Surgery Related	2	10/76	4/78	6/19/79		750	Primary
								TOTAL	208,393	
					Fiscal Year 1980			TOTAL	0	
					Fiscal Year 1981					
(5)		D.P.M.	Post-Op Infection	5	12/78	11/79	7/21/80		8,500	Primary
(6)		80422 80999	Incorrect Diagnosis	6	4/78	3/79	7/28/80		255,047	Excess
(7)		M.D.	Incorrect Diagnosis	5	7/77	7/79	9/1/80		650	Primary
(8)		80612	Improper Care	9	12/80	2/81	4/3/81		200,000	Excess
(9)		M.D., P.A.	Birth Control, Abortion	5	9/76	6/80	4/24/81		59,500	Primary

	File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled	Amount	Primary or Excess
(10)		80999 80153 80154 80153 80153	Birth Related	7	12/77	3/80	5/27/81	214,485	Excess
(11)		80152 80152	Surgery Related	2	3/77	2/79	6/15/81	35,000	Excess
(12)		M.D. 80153 80612 80999 80151 M.D.	Birth Related	8	8/76	7/78	6/25/81	1,000,000	Excess
							TOTAL	1,773,182	
					Fiscal Year 1982				
(13)		M.D.	Improper Care	2	5/79	3/81	7/24/81	1,000	Excess
(14)		80612 80151 M.D.	Surgery	2	1/78	3/80	7/30/81	1,000	Excess
(15)		M.D.	Improper Care	1	6/78	11/79	8/3/81	30,000	Excesss
(16)		84534	Birth Related	8	10/77	5/79	8/14/81	600,000	Excess
(17)		M.D.	Improper Care	3	5/77	9/79	10/1/81	4,000	Primary
(18)		M.D.	Improper Care	3	6/80	2/81	10/21/81	17,500	Primary
(19)		M.D.	Incorrect Diagnosis	6	8/76	3/78	10/26/81	900,000	Excess
(20)		M.D.	Incorrect Diagnosis	5	8/76	3/78	10/26/81	14,000	Excess
(21)		M.D.	Incorrect Diagnosis	6	7/76	5/79	10/26/81	95,000	Excess
(22)		80612 80273	Birth Related	9	11/79	10/81	10/30/81	40,000	Excess

	File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled	Amount	Primary or Excess
(23)		80612 M.D.	Incorrect Diagnosis	9	9/77	9/79	11/30/81	7,000	Excess
(24)		M.D.	Anesthesiology	9	11/78	9/80	12/4/81	75,000	Excess
(25)		M.D.	Birth Control, Abortion	5	3/77	11/79	1/4/82	1,200	Primary
(26)		80261	Incorrect Diagnosis	7	7/79	7/80	2/11/82	355,000	Excess
(27)		80269 80612 80259	Improper Care	9	10/77	10/81	3/1/82	122,154.65	Excess
(28)		84151 80960	Anesthesiology	9	10/79	5/80	3/9/82	62,500	Excess
(29)		80143 80145 M.D. 80534 80177 80612	Incorrect Diagnosis	9	11/77	11/80	3/26/82	3,750	Excess
(30)		80239	Birth Related	9	8/78	9/81	4/1/82	42,500	Excess
(31)		80266	Improper Care	6	5/81	1/82	4/8/82	65,000	Excess
(32)		80267 80999 80267 80117 80612	Illness from Drugs	8	3/79	4/80	4/15/82	156,022	Excess
(33)		M.D.	Surgery	6	11/78	10/80	5/13/82	117,500	Primary
(34)		80612	Fall	5	8/81	2/82	5/13/82	65,000	Excess

	File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled	Amount	Primary or Excess
(35)		M.D.	Psychiatric	1	11/79	8/80	6/24/82	200,000	Excess
(36)		80117	Illness from Drugs	7	5/78	5/80	6/24/82	85,000	Excess
							TOTAL	3,060,126	
					Fiscal Year 1983				
(37)		80154	Incorrect Diagnosis	5	11/80	11/81	7/22/82	113,622	Excess
(38)		80143 D.O.	Birth Control, Abortion	3	12/79	12/81	7/23/82	1,750	Excess
(39)		80421	Incorrect Diagnosis	6	12/77	6/80	7/28/82	180,000	Excess
(40)		80154 80280 80612	Illness from Drugs	7	5/77	5/78	8/30/82	95,000	Excess
(41)		80153 80612	Birth Related	7	7/78	1/81	9/15/82	982,000	Excess
(42)		M.D.	Surgery Related	5	9/78	9/80	10/8/82	12,000	Excess
(43)		80420 80154 80612	Improper Care	5	11/80	8/81	11/3/82	175,000	Excess
(44)		80421	Incorrect Diagnosis	9	6/79	4/81	11/22/82	275,000	Excess
(45)		80153 80153 80999	Illness from Drugs	6	7/76	12/77	1/6/83	25,000	Excess
(46)		80143 80999	Surgery Related	5	1/81	3/82	1/7/83	216,730	Excess
(47)		M.D. 80117	Vasectomy	4	5/77	7/79	1/18/83	20,000	Primary

	File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled	Amount	Primary or Excess
(48)		M.D.	Surgery	5	5/79	4/81	2/7/83	243,300	Excess
(49)		M.D.	Birth Related	7	2/79	10/81	2/28/82	443,426	Excess
(50)		M.D.	Incorrect Diagnosis	9	11/78	9/80	3/11/83	150,000	Excess
(51)		M.D.	Surgery	5	7/80	7/81	3/17/83	75,000	Excess
(52)		M.D.	Improper Care	9	3/82	10/82	3/30/83	150,000	Excess
(53)		M.D.	Birth Related	9	12/78	3/80	3/30/83	150,000	Excess
(54)		CRNA	Anesthesiology	9	6/81	10/81	5/4/83	170,000	Excess
(55)		M.D.	Incorrect Diagnosis	8	12/80	5/82	5/9/83	122,452	Excess
(56)		M.D.	Surgery	5	6/81	8/81	5/23/83	800,000	Excess
(57)		M.D.	Surgery	7	10/80	9/82	6/7/83	1,500,000	Excess
(58)		M.D.	Incorrect Diagnosis	9	1/79	2/80	6/1/83	275,255.47	Excess
(59)		M.D.	Incorrect Diagnosis	3	1/80	12/81	6/2/83	85,456.54	Primary & Excess
(60)		M.D.	Surgery	5	5/78	3/82	5/27/83	248,500	Excess
(61)		M.D.	Incorrect Diagnosis	9	7/80	7/81	6/15/83	5,758	Primary
							TOTAL	6,515,250	
					Fiscal Year 1984				
(62)		M.D.	Improper Care	6	5/79	7/81	7/5/83	28,400	Excess
(63)		M.D.	Improper Care	6	3/81	12/81	7/11/83	126,559	Excess

	File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled	Amount	Primary or Excess
(64)		M.D.	Incorrect Diagnosis	9	9/80	8/82	7/27/83	12,500	Primary
(65)		M.D.	Improper Care	7	10/79	7/82	8/4/83	25,000	Excess
(66)		M.D.	Birth Related	6	12/79	8/81	8/11/83	200,000	Primary & Excess
(67)		M.D.	Birth Related	8	7/77	10/79	8/12/83	1,200,000	Excess
(68)		M.D.	Surgery	6	11/80	9/82	9/29/83	750,000	Excess
(69)		M.D.	Surgery	4	3/80	10/81	10/19/83	75,000	Excess
(70)		M.D.	Incorrect Diagnosis	7	7/80	8/82	10/19/83	268,952	Primary
(71)		M.D.	Improper Care	5	7/80	7/82	10/25/83	40,000	Excess
(72)		M.D.	Surgery	5	1/80	10/82	10/31/83	1,900,000	Excess
(73)		M.D.	Improper Care	3	2/79	10/81	11/7/83	32,500	Excess
(74)		Hospital	Incorrect Diagnosis	7	8/80	8/82	12/2/83	17,205	Excess
(75)		CRNA	Anethesia	9	5/80	11/81	12/7/83	65,000	Excess
(76)		M.D.	Surgery	5	9/78	8/80	12/13/83	115,000	Excess
(77)		Hospital	Improper Care	9	11/78	11/80	12/19/83	320,000	Excess
(78)		Hospital	Anethesia	7	7/80	8/82	1/19/84	150,000	Excess
(79)		Hospital/ Doctor	Improper Care	9	1/82	10/82	2/23/84	390,000	Excess
(80)		M.D.	Incorrect Diagnosis	9	6/81	10/81	1/9/84	500,000	Excess
(81)		M.D.	Surgery	5	5/80	11/81	1/26/84	550,000	Primary

	File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled	Amount	Primary or Excess
(82)		M.D./ Hospital	Surgery/ Incorrect Diagnosis	5	12/76	4/82	2/16/84	101,700	Primary & Excess
(83)		M.D.	Surgery/ Incorrect Diagnosis	5	12/81	7/82	2/1/84	7,000	Primary
(84)		M.D.	Birth Related	7	3/80	3/82	2/14/84	567,182	Excess
(85)		M.D.	Surgery	5	8/80	8/82	2/28/84	100,000	Excess
(86)		M.D.	Incorrect Diagnosis	9	6/82	4/83	3/16/84	50,000	Excess
(87)		CRNA	Anesthesiology	9	11/79	4/81	4/3/84	686,166	Excess
(88)		M.D.	Surgery	9	8/78		4/13/84	1,150,000	Excess
(89)		M.D.	Surgery	9	3/80	4/82	4/15/84	300,000	Excess
(90)		M.D.	Incorrect Diagnosis		1/78	9/80	4/27/84	30,800	Excess
(91)		M.D.	Incorrect Diagnosis	6	2/81	2/83	5/15/84	331,786	Excess
(92)		M.D.	Surgery	9	6/80	3/82	6/1/84	50,000	Excess
(93)		M.D.	Incorrect Diagnosis	3	6/80	6/82	6/ /84	99,040	Excess
(94)		M.D.	Incorrect Diagnosis	3	4/79	12/81	6/18/84	30,000	Primary
(95)		M.D.	Incorrect Diagnosis	9	2/81	11/82	6/20/84	186,664	Excess
							TOTAL	10,456,454	
					Fiscal Year 1985				
(96)		M.D./ Hospital	Anesthetic	9	10/82	2/83	7/24/84	339,081	Excess
(97)		M.D.	Birth Related	8	5/81	2/84	7/23/84	447,479	Excess
(98)		M.D.	Surgery	5	7/81	7/83	8/ /84	35,000	Primary

File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled	Amount	Primary or Excess
(99)	M.D.	Improper Care	3	1/82	1/84	8/ /84	1,500	Primary
(100)	M.D.	Improper Care	3	3/81	3/83	7/9/84	22,500	Primary
(101)	M.D.	Surgery	5	4/82	2/83	8/4/84	175,000	Excess
(102)	M.D.	Improper Care	9	10/82	12/83	8/ /84	239,375	Excess
(103)	M.D./ Hospital	Birth Related	8	1/83	1/84	8/17/84	760,358	Excess
(104)	Hospital	Miscellaneous	1	12/81	11/82	9/20/84	100,000	Excess
(105)	M.D./ Hospital	Birth Related	6	7/78	5/82	9/25/85	175,000	Excess
(106)	M.D.	Surgery	1	3/81	3/83	9/25/84	195,000	Excess
(107)	Hospital	Improper Care	4	9/82	10/83	10/4/84	143,348	Excess
(108)	M.D./ Hospital	Birth Related	6	4/80	4/82	10/10/84	1,550,000	Excess
(109)	M.D./P.A.	Surgery	9	3/82	12/82	11/13/84	96,483	Excess
(110)	M.D.	Improper Care	3	5/81	5/83	11/21/84	20,000	Primary
~~(111)~~	~~D.C.~~	~~Improper Care~~	~~5~~	~~2/81~~	~~10/82~~	~~11/21/84~~	~~4,900,000~~	~~Excess~~
(112)	M.D./ Hospital/ CRNA	Anesthesiology	5	8/80	10/81	11/27/84	841,937	Excess
(113)	M.D./P.A.	Surgery	5	9/80	10/83	12/3/84	289,300	Excess
(114)	M.D.	Birth Related	7	11/79	11/81	12/6/84	1,140,000	Excess
(115)	M.D./P.A.	Surgery	5	2/81	9/82	12/7/84	187.500	Excess

File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled	Amount	Primary or Excess
(116)	M.D.	Birth Related	8	5/79	5/83	12/13/84	395,000	Excess
(117)	D.C.	Improper Care	5	2/81	10/82	2/4/85	1,600,000	Excess
(118)	M.D., D.O.	Surgery	4	11/81	1/83	2/6/85	110,903	Primary
(119)	M.D., P.A.	Surgery	5	1/81	2/83	2/7/85	292,865	Excess
(120)	M.D.	Birth Related	7	4/79	4/83	2/28/85	521,426	Excess
(121)	M.D.	Surgery (resulting in lost kidney)	6	9/81	9/83	3/5/85	10,000	Excess
(122)	D.O.	Birth Related	9	11/81	10/83	3/11/85	15,622	Primary
(123)	P.A., Hosp. D.O., D.O.	Birth Related	8	12/83	11/84	3/15/85	835,516	Excess
(124)	M.D.	Surgery	6	4/82	4/84	3/15/85	170,000	Primary
(125)	M.D.	Improper Care Emergency Room	9	9/79	8/81	3/19/85	168,433	Excess
(126)	M.D.	Improper Care	3	2/82	2/84	3/27/85	1,500	Primary
(127)	M.D.	Back Surgery	5	7/81	7/83	4/2/85	250,278	Excess
(128)	M.D., Hosp.	Birth Related	7	3/77	1/82	4/4/85	68,500	Excess & Primary
(129)	D.O., Hosp.	Improper Care Emergency Room	9	12/80	1/83	4/5/85	27,887	Excess
(130)	P.A., M.D.	Surgery	5	2/80	3/84	4/8/85	390,000	Excess
(131)	M.D.	Improper Care of Diabetic Patient Following Surgery	5	11/82	3/84	4/10/85	408,725	Primary

File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled	Amount	Primary or Excess
(132)	Hospital	Improper Care-Administration of Test	5	7/82	4/83	5/3/85	39,125	Excess
(133)	Hospital M.D., P.A.	Failure to Notify Patient of Lab Results	8	7/84	2/85	5/15/85	250,000	Excess
(134)	M.D.	Surgery Tubal Ligation	4	2/83	5/84	5/17/85	15,622	Primary
(135)	M.D.	Emergency Room Treatment Following Car Accident	9	2/83	1/85	6/5/85	5,000	Primary
(136)	M.D.	Incorrect Diagnosis	8	2/83	7/84	6/19/85	788,997	Excess
						TOTAL	13,124,261	
						GRAND TOTAL	35,275,164	

Ron Todd
17-2-85

FREQUENCY FIGURES FOR THE HEALTH CARE STABILIZATION FUND

This table contains the frequency figures for the Health Care Stabilization Fund computed on all claims against individual providers on all files/cases open and closed from the Fund's inception in 1976 to January 31, 1985.

The total number of files/cases from which these numbers are derived is 835. The total number of providers covered by the Fund is 16,043 (approx.).

Claims by frequency (includes all claims without regard to actual liability):

Number of Providers	Number of Claims
1,444	1
152	2
56	3 (8 hospitals, 5 P.A.s 2 D.O.s, 41 M.D.s)
16	4 (7 hospitals, 3 P.A.s 1 D.O., 1 D.P.M., 4 M.D.s)
7	5 (1 hospital, 2 P.A.s. 4 M.D.s)
3	6 (1 hospital, 1 P.A., 1 M.D.)
1	7 (1 D.O.)
12	More than 7 (10 hospitals, 1 P.A., 1 M.D.)
1,691	TOTAL Claims

(These figures include claims against defined "inactives" who are no longer rendering professional care in Kansas.)

HEALTH CARE PROVIDER INSURANCE
AVAILABILITY PLAN

1. Authorized by K.S.A. 40-1113
   A. Was intended to be a temporary availability facility
   B. Original expiration date was July 1, 1978
   C. Current expiration date is July 1, 1987

2. Plan provides basic coverage for all classes of health care providers, except HMO (i.e., no insureds)
   A. Number of insureds peaked in fiscal year 1980 with 1,023 policies issued.
   B. Plan's board of governors initiated action to reduce the number of insureds
      1) Required written declinations from voluntary markets
      2) Maintained its rate structure at a level higher than the voluntary markets
      3) Assisted the department in obtaining new or expanded availability of coverage from voluntary markets (for example: Chiropractors and CRNA's)
   C. Number of Plan insureds for fiscal year 1984 was 293 policies

3. Plan's current rate levels (effective July 1, 1985) are 20% greater than St. Paul Fire & Marine Insurance Company's.
   A. The Plan's rating program includes increased premium charges based upon the applicant's prior loss record.
      1) Only prior indemnity losses greater than $10,000 are considered chargable losses. One loss point is assessed for a reserved claim in excess of $10,000. Two points are assessed for a paid loss in excess of $10,000.
      2) The following table is used to determine the additional premium charges for prior losses.

Points and Premium Increase

Points	1	2	3	4	5	6,7,8,9,	10 & Up
Increase	0%	50%	100%	200%	300%	400%	500%

4. Operating profits and losses of the Plan are direct transfers to and from the Health Care Stabilization Fund
   1) Profits transfered to HCSF $1,457,262
   2) Loss transfered from HCSF to Plan $4,620,505

7/1-2/85 ATTACHMENT VII

3) It is anticipated that the Plan's current year operations will result in a loss of approximately $3.5 M to $4.0 M.

5. Miscellaneous Plan Information

1) Coverage can be obtained through any authorized Kansas insurance agent
2) must insure qualified Kansas health care providers
3) serviced by Western Casualty & Surety Company
4) doctors terminated or non-renewed by Medical Protective and then written by the Plan receive a dramatic premium increase because the Plan's rates are 20% above St. Paul rate levels
5) the plan is the only insurance market for podiatrists
6) specific rate provisions have been incorporated for those Osteopathic Doctors insured by the Plan because Professional Mutual is no longer writing in Kansas
7) the Plan does have a greviance procedure

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

Type of Health Care Provider	FY 1977	FY 1978	FY 1980	FY 1981
Physicians, Surgeons (includes Osteopaths)	389	431	373	326
Chiropractors	269	271	330	247
Podiatrists	36	40	51	57
Physical Therapists	14	12	2	0
Pharmacists	56	64	55	44
Optometrists	16	15	18	15
Certified Reg. Nurse Anesthetists	69	81	83	89
Medical Care Facilities	10	11	5	7
Mental Health Centers	0	6	6	8
Partnerships & Prof. Corp. of HPC's	0	76	100	105
	868	1007	1023	898

Type of Health Care Provider	FY 1982	FY 1983	FY 1984
Physicians, Surgeons (includes Ostepaths)	257	194	124
Chiropractors	68	24	13
Podiatrists	62	58	76
Physical Therapists	0	0	4
Pharmacists	28	17	13
Optometrists	6	10	4
Certified Reg. Nurse Anesthetists	80	40	7
Medical Care Facilities	6	5	2
Mental Health Centers	6	4	1
Partnerships & Prof. Corp. of HCP's	83	57	49
	596	409	293

NOTE: FY 1979 data was not readily available.

Summarization of the HCPIA Plan's Operations

	FY1977	FY1978	FY1979	FY1980
Earned Premium	$ 736,377	$1,311,442	$1,414,784	$1,183,156
Incurred Losses & Loss Reserves	$ 166,534	$ 277,568	$ 715,288	$ 501,308
Excess of Earned Premiums	$ 139,869	$. 565,240	$ 103,184	$ 285,349

	FY1981	FY1982	FY1983	FY1984
Earned Premium	$1,168,717	$ 985,220	$ 902,141	$ 711,301
Incurred Losses & Loss Reserves	$ 500,974	$ 1,309,095	$ 1,522,359	$ 2,049,309
Excess of Earned Premiums	$ 363,620	$-1,063,015	$-1,379,305	$-2,181,185

FCSM5889

SUMMARY OF
KANSAS CITIZENS COMMITTEE
ACTIVITIES TO JULY, 1985

On January 23, 1985, Fletcher Bell, Commissioner of Insurance, State of Kansas, appointed a Kansas Citizens Committee for the Review of the Tort System in Kansas. The Committee's purpose was to study the medical malpractice liability situation and related issues in this State. Commissioner Bell's original charge to the Citizens Committee, along with the initial press release for the Committee, is attached as Exhibit A.

The Citizens Committee is chaired by John Anderson, Jr., former Governor of Kansas. The Honorable James Buchele, a former U.S. Attorney, and present Judge for the Third Judicial District of Kansas, Shawnee County, Kansas, was named Vice-Chairman. The present members of the Citizens Committee are attached as Exhibit B.

As Commissioner Bell's charge to the Committee indicates, the work of the Citizens Committee was not intended to interfere with the work of the Legislature, but was instead intended to assist Commissioner Bell form his own recommendations and to complement the work of the Legislature. Historically, Commissioner Bell has successfully employed Committees to study serious problems confronting Kansas citizens and involving insurance related issues. In fact, similar Committees appointed by Commissioner Bell made recommendations in 1975 that were instrumental in the final recommendations made by a Legislative Interim Committee in 1975, which recommended the medical malpractice bills that were enacted by the 1976 Legislature.

Following the enactment of the 1976 medical malpractice laws, Commissioner Bell was closely associated with the medical malpractice situation in Kansas, both as the Commissioner of Insurance responsible for monitoring malpractice insurance companies admitted to do business in Kansas, and also as the supervisor of the Health Care Stabilization Fund, the Fund being established by the Legislature to provide excess insurance coverage for Kansas health care providers.

In 1984, through numerous meetings and discussions, it became apparent that there were increasing concerns of the health care community regarding dramatically increasing medical malpractice insurance premiums. The health care community and a number of insurance companies considered the problem a crisis. To address these concerns, Commissioner Bell took a number of steps in late 1984 which culminated in his decision to form the Citizens Committee in early 1985. It was his hope that the Citizens Committee might find a solution acceptable to the majority of interested parties or, at least, develop the evidence necessary for Commissioner Bell to arrive at his own recommendations to the Legislature.

The Kansas Citizens Committee brought together members of the medical community as well as members of the trial bar to review the present malpractice problem. Additionally, the Citizens Committee includes members of the insurance industry and a number of public members representing non-health care related groups, including labor, retired persons, teachers, and government employees.

7/1-2/85 ATTACHMENT VIII

The Citizens Committee has meet on the second Tuesday of each month from February through June. The following witnesses have appeared and testified:

Griffin Bell, King & Spalding, Atlanta, Georgia.
Former U.S. Attorney General, Chairman of American Bar Association.
Testified: February 12, 1985.

Betty J. Anderson, Assistant General Counsel, American Medical Association, Committee on Tort System.
Testified: February 12, 1985.

Tom Theis, Attorney.
Speaking on behalf of Kansas Defense Lawyers Association.
Testified: March 12, 1985.

Richard Hite, Attorney.
Speaking on behalf of Kansas Bar Association.
Testified: March 12, 1985.

Bob Trunzo, Senior Government Affairs Manager, St. Paul Insurance Company.
Testified: April 9, 1985.

Tim Graham, Chief Actuarial Officer, St. Paul Insurance Company.
Testified: April 9, 1985.

Michael S. Mullen, Executive Vice-President, Medical Protective Company.
Testified: April 9, 1985.

Ron Todd, Assistant Commissioner of Insurance, Kansas Insurance Department.
Testified: May 14, 1985.

Derenda J. Mitchell, Attorney, Kansas Health Care Stabilization Fund.
Testified: May 14, 1985.

Robert Hayes, Supervisor, Professional Liability Section, Kansas Insurance Department.
Testified: May 14, 1985.

Jerry Slaughter, Executive Director, Kansas Medical Society.
Testified: June 11, 1985.

Kathleen Sebelius, Executive Director, Kansas Trial Lawyers Association.
Testified: June 11, 1985.

The bound testimony of all witnesses who appeared before the Citizens Committee will be provided to Legislative Research for use of Committee members.

The June meeting of the Citizens Committee was the final meeting devoted to public testimony before the full Committee. Beginning July 9, 1985, the Committee will begin work in four Subcommittees. The first Subcommittee will study all matters related to insurance, including rating practices and the Health Care Stabilization Fund. The second Subcommittee will direct its attention to the need for change in the legal, common-law or tort systems. The third Subcommittee will address peer review,

including procedures to more efficiently remove incompetent health care providers from either their insurance coverage or licenses to practice in Kansas. The fourth Subcommittee will review screening panels and study how they might become more useful in settling conflicts in Kansas.

The members of the separate Subcommittees are attached as Exhibit C.

John Anderson, Jr., the Chairman of the Citizen Committee has announced that the Citizens Committee's final report to Commissioner Bell should be available immediately following the Citizens Committee meeting on October 9, 1985. It is anticipated that the report will also be available for the Legislature at that time.

JANUARY 23, 1985

PRESS RELEASE

FOR IMMEDIATE RELEASE

KANSAS INSURANCE DEPARTMENT

BELL ANNOUNCES FORMATION OF CITIZENS COMMITTEE TO STUDY LEGAL LIABILITY

Fletcher Bell, State Commissioner of Insurance, today announced the formation of a Kansas Citizens Committee to study the medical malpractice liability situation and related issues in Kansas. Officially called the "Kansas Citizens' Committee for the Review of the Tort System as it Affects Insurance and Related Costs", the group includes representatives from business, agriculture, academia, senior citizens, the legal and medical professions and the insurance industry. Former Governor John Anderson, Jr., and Shawnee County District Court Judge James Buchele are among the members of the Committee.

In explaining his reasons for forming the Committee, Bell said, "For the past several years I have become increasingly concerned about the medical malpractice liability environment in Kansas. The number of liability claims and the amount of damages involved with such claims seem to have been rising dramatically. As a result, medical malpractice liability insurance premiums have increased to a similar degree and the end result of these increases will be reflected in even higher health care costs at some point in the near future. These increased costs are quite visible and the fact that the public will sooner or later pay the bill is known. What we don't know is whether the public is satisfied that preservation of the current system of assessing fault, measuring damages, and presenting the facts is worth whatever it costs or if the public would prefer to see costs reduced even if it requires the imposition of restrictions on what they must do to be compensated for an injury and/or how much compensation they can receive. What the public wants from the tort system and how much they are willing to pay is really what this Committee is about," Bell declared, "And that is why the membership of the Committee includes persons from the streets, storefronts, campuses and farms of Kansas. The tort system is their system and while I have included professional and industrial expertise, I sincerely hope the conclusions emanating from the study will reflect a reasoned, well-ordered, objective public policy that will compensate injured victims in a way and at a cost that every citizen can embrace."

Bell said that his formation of the Kansas Citizens' Committee was not intended to defer legislative consideration on initiatives other parties may present to the 1985 legislature. "The Kansas Legislature is also a citizens' forum," Bell stated, "and the activities of that body with regard to civil liability will provide valuable information and insight. Thus, I see the work of the Kansas Citizens' Committee as being complementary to rather than competitive with any discussions or changes that might emanate from the 1985 legislative process. Our system of civil justice is so vital to the checks and balances of our free society that its efficacy and integrity demands all the attention we can give it." Bell continued. "It will be the legislative and judicial branches of government that ultimately mold the way we determine negligence, assign responsibility, settle civil wrongs but I am convinced that we can never devote too much effort to studying it, changing it, refining it, or doing whatever else is required to make it serve all of us effectively and fairly in a practical, affordable manner."

Note: A copy of the document used to describe the perceived problem and the Committee's duties is attached as is a copy of the Committee roster.

EXHIBIT A

KANSAS CITIZENS' COMMITTEE
FOR THE REVIEW OF THE TORT SYSTEM
AS IT AFFECTS INSURANCE AND ITS RELATED COSTS

HISTORY OF PROBLEM

1. In 1976, in response to what was then called a medical malpractice crisis, the Kansas Legislature enacted thirteen bills into law addressing numerous facets of the malpractice problem. The most ambitious law was the "Health Care Provider Insurance Availability Act," which created a mechanism to provide malpractice insurance coverage to every "health care provider" in Kansas. The bill created a "Health Care Stabilization Fund" under the supervision of the Kansas Commissioner of Insurance, which basically provides excess coverage for health care providers.

2. The legislative hearings held to consider the malpractice issue received evidence that insurance companies were discontinuing the writing of medical malpractice insurance in Kansas. Various reasons were given the Legislature as to the reasons for the medical malpractice problem. Some witnesses testified that more malpractice claims were being filed by a more litigious society. Some of these suits were resulting in jury awards of as much as $500,000. Some physicians in the highest risk areas of medical practice had seen their medical malpractice insurance premiums approach annual amounts in excess of $10,000.

3. During their deliberations, the Kansas Legislature considered various solutions to the medical malpractice problem. One group of considerations addressed the need for the medical profession to oversee its own house to better train health care providers and discipline those providers who were causing malpractice claims to be filed. The second group of considerations concerned alternatives to the court system, including screening panels and arbitration. Still other proposals dealt with the existing court system and procedural and substantive changes, including a limitation upon contingent fees, possible modification of punitive damages, limitation of the amount of recovery in medical malpractice cases, alteration of the collateral source rule, and extension of the Good Samaritan Act. While modifications were made in some of these areas, the Legislature left, for the most part, the tort system much as it had been. The Legislature also considered and enacted the Health Care Insurance Availability Act to insure that all health care providers were covered by insurance.

PROBLEM TODAY

1. Many believe the problems addressed in 1974 and 1975, as serious as they were, pale in comparison with the problems Kansas faces today. Medical malpractice claims have increased both in number of cases filed and in amounts awarded. It is clear that juries today are returning awards in much larger sums compared with those returned just a few years ago.

2. These awards and other issues appear to have created new health care problems. Large jury awards influence out-of-court settlements. As juries assess higher monetary damages lawyers and the public alike expect and demand higher pre-trial settlements. It is true that some settlements reported in the media as multi-million dollar awards are actually "structured settlements" where money is paid to the injured party over many years. It is also true that these "structured settlements" cost only a fraction of the publicized settlement figures. Equally important, the frequency of medical malpractice claims seems to be increasing significantly. In 1984, the Legislature limited the amount of exposure of the Health Care Stabilization Fund to $3 million dollars and also took steps to provide an assessment against health care providers to eventually make the Fund actuarially sound. Even with the passage of this legislation, some contend that problems still exist.

3. It is time to take another look at these issues. Because civil justice and legal liability insurance are inter-related and because the economic impact is a direct concern of the Commissioner, he must view the concerns regarding tort actions and liability insurance from a unique perspective. As the State official primarily responsible for the Health Care Stabilization Fund, he must act, in effect, as an insurance company. The Fund must defend actions brought against health care providers with the same vigor as an independent insurance company. As the State Insurance Commissioner, he must also view the problem from a separate perspective. It is the contention of some medical providers and insurance companies that high judgments, settlements, and medical malpractice premiums result in higher health care costs, which translate into higher insurance premiums for all persons in the State. Insurance spreads the cost of high awards among all insureds. This is the purpose of insurance. This becomes a problem only when costs increase to such an extent that the health care system itself is undermined. Some are suggesting that this critical juncture may have been or soon will be reached. It is suggested that insurance costs have increased to the level where the steps taken to lower health care costs by encouraging competition and efficiency in the health care system, have been offset somewhat by higher costs resulting from larger malpractice judgments and the cost of defensive medicine now being practiced by hospitals and doctors.

4. Many members of the legal profession believe that physicians and other health care providers cause malpractice claims by their own negligent actions. They generally believe that not enough has been done by the medical profession itself to remove incompetent providers, or at least to provide disciplinary sanctions. These individuals generally accept a responsibility for that group of people who may someday be injured by malpractice and argue that the present large awards given by juries are honestly arrived at by fair minded, impartial jurors. They believe in the jury system and recommend few, if any, major changes to the present tort system. They argue that if limitations on recoveries are provided to members of the medical profession, shouldn't limitations also be placed on other professions and members of our society? Contingent fees permit an injured person who could not otherwise afford a lawyer a chance to pursue their claims in court. Since the jury is presently prohibited from receiving any information regarding contingent fee arrangements, many lawyers suggest that such fee arrangements are totally irrelevant and have no bearing on jury awards. They argue against a cap on monetary awards in medical malpractice actions because they contend they are an arbitrary infringement upon public rights, and

because limitations previously existing by statute for wrongful death failed to keep pace with inflation and were eventually modified by Kansas. They also see limitations on medical malpractice suits as discriminatory as long as they do not apply to other types of tort actions.. If high judgments increase overall health care costs, some members of the legal profession believe that these are costs that are absolutely necessary to protect injured persons.

5. Physicians feel they are not being treated fairly. Health care providers recognize that physicians and hospitals are sometimes negligent, and in these instances, the injured party is entitled to just compensation. Most, however, believe that malpractice actions have moved beyond negligence to hold health care providers retrospectively responsible for errors in judgment made under sometimes difficult circumstances in a dangerous, risky profession, as well as injuries that result despite the best, most competent medical treatment available. Physicians are fearful that they may be sued by a system that will second guess their honest judgments rendered under the most stressful of circumstances. Health care providers also seem convinced that monetary awards are excessive and, in some instances, substantially greater than called for by the facts. Believing that they are being treated unfairly, physicians argue that some health care providers are talking about early retirement; transferring from high risk areas to lower risk areas of their profession; or trying to "play it safe" even though, by doing so, a patient's overall welfare may not be enhanced.

THE REASON FOR THIS COMMITTEE

1. The Kansas Citizens' Committee has been formed to review the present medical malpractice situation in Kansas. In the past, members of the bar and the medical community have been brought together to seek solutions to the health care problem. Unfortunately, these groups have such a vested interest in the system that they have been virtually unable to compromise many of their disagreements. Perhaps, because of what they view as their professional responsibilities, these groups have found compromise difficult. In view of this fact, the "Kansas Citizens' Committee" has been formed in an effort to provide a balanced, objective view of the tort system from the general public's perspective.

2. The health care system is too important to be left solely to those who have a direct interest in the system. It is the public that has the most to lose, and it is hoped this Committee will represent the interests of the general public in investigating the problem and providing recommendations.

DIRECTIONS FOR COMMITTEE

As indicated by the foregoing history and description of the problem, the medical malpractice situation is to be the primary focal point of the Committee's consideration. Not only are the concerns more immediate and more visible with respect to medical malpractice, but data and information to assist the Committee is also more readily available with respect to the tort system's operation in this segment of legal liability.

The charge to the Committee is simple. The Committee is to review the medical malpractice liability environment in Kansas and render an opinion as to whether such environment is, in fact, a situation which should be cause for public and legislative concern.

If so, the Committee is to identify, to the extent possible, the causative factors that seem to be responsible and develop, at least in conceptual terms, such recommendations as may be necessary to alleviate the direct and indirect adverse influences. Finally, the Committee is to determine whether or to what extent the Committee's recommendations should, in whole or in part, be applied to other tort liability areas.

On the other hand, if the Committee concludes that few, if any, medical malpractice awards and settlements are excessive; that injured persons are treated fairly; and that the process used in determining whether negligent acts were committed and the manner in which the damages are calculated is effective, efficient, and meets society's needs, the Committee should so state and its recommendations should reflect such a finding.

The Committee shall have complete freedom to pursue its charge as the Committee, itself, shall determine.

SUMMARY

The problems cited previously are not just unique to Kansas, they are also national in scope. This Committee has an opportunity to introduce a new and fresh perspective -- the perspective of the general public. Careful and thoughtful consideration of the problem and well reasoned solutions -- if the Committee considers them necessary -- will not only assist the Kansas Insurance Department to formulate policy, but may provide the foundation for new laws for this State as well as an example for other States to follow.

Mr. Larry Heeb
1706 Indiana
Lawrence, KS 66044
(913)843-6505

Mr. Stephen M. Blaes
225 N. Market, Suite 350
Wichita, KS 67202
(316)264-0301

Ms. Virginia Bozich
Lincoln Elementary School
Box 316 Route 3
Pittsburg, KS 66762
(316)231-6668 (work)
(316)231-7248

Mr. L.M. Cornish
900 Merchants National Bank
Topeka, Kansas 666122
(913)232-0545

Dr. Kermit Krantz
K.U. Medical Center
3900 Rainbow
Kansas City, KS. 66103
8-560-6201

Mr. Homer Cowan
Western Fire and Casualty Co.
Ft. Scott, KS 66701
(316)223-1100

Dr. John H. Hill, II
944 Kentucky
Lawrence, KS 66044
(913)841-9555

Mr. Ted Heim
Chairman, Criminal Justice Dept.
Washburn University
1700 College
Topeka, KS 66621
(9130295-6411

Mrs. Barbara Frick
High School Librarian
601 Vine
Atwood, KS 67730
(913)626-3289 (work)
(913)626-3660

EXHIBIT B

Mr. W.L. (Dean) Parker
Plan Manager and House Counsel
Ks. Construction Trades Fringe
Benefit Fund
4101 Southgate Drive
Box 5186
Topeka,KS 66605
(913)267-0140

Dr. Jimmie Gleason
Lincoln Center Obstetrics
& Gynecology, P.A.
Eighth at Lincoln
Topeka, KS 66606
(913)233-5101

Mr. Harold Ryan, Vice President
Human Resources
Dillon Companies
Box 1266
Hutchinson, KS 67504
(316)663-6801

Mr. Richard Hite
Kahrs, Nelson, Fanning, Hite and
Kellogg
200 West Douglas, Suite 630
Wichita, KS 67202
(316)265-7761

Mr. Jerry R. Palmer
112 West 6th, Suite 102
Topeka, KS 66603
(913)233-1836

Mr. John J. Jurcyk
Security National Bank
707 Minnesota Ave. 4th Floor
Box 1398
Kansas City, KS 66117
(913)371-3838

Mr. Dee Mann
Sargent Wanamaker
Box 4266
Topeka, KS. 66604
(913)233-2790

Mr. Paul Fleener
Kansas Farm Bureau
2321 Anderson
Manhattan, KS 66502
(913)537-2261

UPDATED LIST 5/3/85

Judge James Buchele
Shawnee County Court House
3rd Judicial District Div. 12
Topeka, KS 66603
(913)295-4405

Mr. Reid Holbrook
Holbrook and Ellis, P.A.
Title BLDG.-727 Ann Avenue
Kansas City, KS 66101
(913)342-2500

Mr. Eugene B. Ralston
Ralston and Frieden
Capital Tower
4th Floor, Suite409
Box 539
Topeka, KS 66603
(913)232-7266

Mr. Lynn Johnson
Merriam Oaks Bldg.
8500 W. 63rd, Suite 210
Shawnee Mission, KS 66202
(913)384-0100

Mr. Gerald D. Marlatt
Emmett, Ks. 66422
(913)535-2095

Mr. John Anderson, Jr.
95th and Nall
306 Capital Federal Bldg.
Overland Park,KS 66207
(913)648-6332

Dr. Keith Gallehugh
9027 Birch
Shawnee Mission, KS 66207
(913)541-5386

G.R. Watson, D.O.
Family Medical and Industrial Clinic
110 North St. Francis, Suite 120
Wichita, Kansas 67214
(316)265-1631

M E M O R A N D U M

TO: Members Of The Citizens Committee
For The Review Of The Tort System

FROM: Ted F. Fay
Citizens Committee Attorney

SUBJECT: Subcommittee Assignments

DATE: June 18, 1985

The Subcommittee assignments, made by the Agenda Subcommittee on June 11, 1985, are shown on the enclosed lists. All Subcommittees will meet at our next regularly scheduled meeting on July 9, 1985, at 1:30 p.m. Please meet in the third floor conference room of our offices. Rooms will be designated for each Subcommittee at that time. In August, the Subcommittee will meet on August 13th for the entire day, beginning at 9:30 a.m. In September, there will be two days of meetings -- on September 10th and September 11th -- beginning at 9:30 a.m.

Chairman Anderson hopes a final report will be available for the Interim Subcommittee of the Legislature immediately following the October meeting.

Unfortunately, the Agenda Subcommittee did not have the ability to assign everyone to their requested Subcommittee. Too many members requested the Legal and Insurance Subcommittees. The Agenda Subcommittee does hope that the final selections are balanced and fair. All Subcommittees are extremely important and will require a great deal of effort by their members.

Respectfully submitted,

Ted

Ted F. Fay, Attorney
Citizens Committee

TFF:jlb
Enclosure
LE/2092

INSURANCE SUBCOMMITTEE

STEPHEN M. BLAES
Blaes & Heath
225 North Market, Suite 350
Wichita, Kansas 67202

VIRGINIA BOZICH
Lincoln Elementary School
Route #3, Box 316
Pittsburg, Kansas 66762
(913) 231-6668
(913) 231-7248 (Home)

* HOMER COWAN (Chairman)
Western Insurance Companies
14 East First Street
Fort Scott, Kansas 66701
(316) 223-1100

LYNN JOHNSON
Merriam Oaks Building
8500 W. 63rd, Suite 210
Shawnee Mission, Kansas 66202
(913) 384-0100

JOHN J. JURCYK
Security Nat'l Bank, 4th Floor
707 Minnesota Avenue
Kansas City, Kansas 66117

DEE MANN
Sargent-Wanamaker Insurance
Post Office Box 4266
Topeka, Kansas 66604
(913) 233-2790

LEGAL -- COMMON LAW -- TORT SUBCOMMITTEE

L.M. CORNISH
Glenn, Hanson, Cornish & Karns
900 Merchants National Tower
Topeka, Kansas 66612
(913) 232-0545

PAUL FLEENER
Kansas Farm Bureau
2321 Anderson Avenue
Manhattan, Kansas 66502
(913) 537-2261

RICHARD HITE
Kahrs, Nelson, Farming, Hite & Kellogg
200 West Douglas, Suite 630
Wichita, Kansas 67202
(316) 265-7761

REID HOLBROOK
Holbrook and Ellis, P.A.
Title Building
727 Ann Avenue
Kansas City, Kansas 66101
(913) 342-2500

*JIMMIE GLEASON (Chairman)
Lincoln Center Obstetrics
and Gynecology, P.A.
Eighth at Lincoln Street
Topeka, Kansas 66606
(913) 233-5101

JERRY R. PALMER
Columbian Building, Suite 102
112 West Sixth Street
Topeka, Kansas 66603
(913) 233-1836

PEER REVIEW SUBCOMMITTEE

*JUDGE JAMES BUCHELE (Chairman)
Shawnee County Courthouse
Third Judicial District
Division No. 12
Topeka, Kansas 66603
(913) 295-4405

KEITH GALLEHUGH
9027 Birch Street
Shawnee Mission, Kansas 66207
(913) 541-5386

LARRY HEEB
1706 Indiana Street
Lawrence, Kansas 66044
(913) 843-6505

JOHN H. HILL
944 Kentucy Street
Lawrence, Kansas 66044
(913) 841-9555

EUGENE B. RALSTON
Ralston & Frieden
Capital Tower, Suite 409
Topeka, Kansas 66603
(913) 232-7266

HAROLD RYAN
Vice-President, Human Resources
Dillon Companies
Post Office Box 1266
Hutchinson, Kansas 67504
(316) 663-6801

G.R. WATSON
Family Medical and Industrial Clinic
110 North St. Francis, Suite 120
Wichita, Kansas 67214
(316) 265-1631

SCREENING PANEL SUBCOMMITTEE

JUDGE JAMES BUCHELE
Shawnee County Courthouse
Third Judicial District
Division No. 12
Topeka, Kansas 66603
(913) 295-4405

BARBARA FRICK
High School Librarian
601 Vine Street
Atwood, Kansas 67730
(913) 626-3289
(913) 626-3660 (Home)

TED HEIM
Chairman, Criminal Justice Dep't.
Washburn University
1700 College Avenue
Topeka, Kansas 66621
(913) 295-6411

KERMIT KRANTZ
K.U. Medical Center
3900 Rainbow Avenue
Kansas City, Kansas 66103
(913) 588-6201

GERALD D. MARLATT
Emmett, Kansas 66422
(913) 535-2095

* W.L. PARKER (Chairman)
Plan Manager and House Counsel
Kansas Construction Trades
Fringe Benefit Fund
4101 Southgate Drive
Topeka, Kansas 66605
(913) 267-0140

STATE OF KANSAS

BOARD OF HEALING ARTS

OFFICE OF
RICHARD A. UHLIG, SECRETARY
ELIZABETH W. CARLSON, EXECUTIVE SECRETARY
DONALD G. STROLE, GENERAL COUNSEL
503 KANSAS AVENUE, SUITE 500
TOPEKA, KANSAS 66603-3449
PHONE (913) 296-7413

Testimony before the Legislative Interim Committee on Malpractice:

Chairman Knopp and members of the Committee. I am Don Strole, General Counsel for the Kansas State Board of Healing Arts. In the letter requesting us to appear before this committee the chairman outlined 5 questions that we should address. I will address each question in turn.

1. A REVIEW OF THE BOARD'S MEMBERSHIP: HOW IT OPERATES: WHO IS SUBJECT TO ITS JURISDICTION: AND HOW IT RECEIVES, INVESTIGATES, AND DISPOSES OF COMPLAINTS.

The Board is composed of 13 members; 5 medical doctors, 3 osteopathic doctors, 3 chiropractic doctors, one podiatrist, and one lay member. In my opinion this composition works quite well in that the mixture of professions and the lay person have given the Board the kind of diversity it needs to review and decide the issues that come before us. Each profession is represented sufficiently to ensure that the technical expertise is present on the Board; however, no profession has a majority so that it can control the Board. Thus, each profession is looking at the qualifications of the other professions and thus, claims made by licensees of each profession are viewed with healthy skepticism. In addition, any licensee who comes before the Board will be reviewed ultimately by a majority of persons who are not in the same profession as that licensee, thus, any questions about the Board protecting its own has no real merit.

7/1-2/85

ATTACHMENT IX

Each year the Board elects one of its members to serve as Secretary and one of its members to serve as President of the Board. The President is in charge of running the meetings, appointing committees, etc. The Secretary is essentially the Chief Executive Officer of the Board and makes the day-to-day policy decisions for the Board. The Board meets every two months with the Secretary handling matters in between Board Meetings. The Board also has two full time attorneys and an Executive Secretary. The Board has two main functions, the licensing of physicians and the disciplining of physicians. It also has the responsibility for licensing or registering of podiatrists, physical therapists, physical therapys assistants and physician assistants.

With respect to the disciplining of physicians which I take to be the subject of the Committee's inquiry, the Board receives and acts upon complaints submitted to it about certain licensees. "Complaint" is construed in the broadest possible sense to include any information received by the Board regarding a possible violation of the Healing Arts Act. These complaints essentially fall into four categories: 1) impaired physician, 2) physicians who excessively prescribe or misprescribe drugs, 3) physicians who commit ethical violations and 4) physicians who are incompetent. I will discuss how the Board deals with each of these areas in turn.

With respect to impaired physicians, the Board may treat these complaints differently than the other three areas. The Board's philosophy on impaired physicians is that the licensee who is impaired has a disease that needs to be treated. Accordingly, from the very beginning our goal is to get the licensee into a treatment and rehabilitation program so that he or she can again become a productive member of the medical community. In that regard we almost always

try to work out some kind of stipulation with provisions which ensure that licensee is getting adequate treatment, does not practice during such period of treatment and that an aftercare program is established in which the doctor is monitored by both the Board and more directly by an "aftercare" physician in his or her area. Only if the doctor is reluctant or refuses to cooperate with us would the Board proceed to a full-blown adversarial proceeding on an impaired physician. We have established an advisory committee on impaired physicians whose members are a mixture of psychiatrists and other professionals who work daily with impaired persons. This committee will enable us to establish concrete protocol on how we should deal with the impaired physicians.

On persons who overprescribe and misprescribe drugs or other medications, the Board's initial response is to prohibit that person from prescribing the drugs. Accordingly, we immediately try to restrict the practitioner from prescribing the drugs either by limiting the doctor's ability to prescribe certain scheduled substances under the uniformed controlled substances act or by taking away the doctor's ability to prescribe certain specific drugs such as amphetamines. If we are able to enter into such a stipulation or limitation, the Board feels that it has satisfactorily dealt with the problem without the necessity of going through a long, involved process whereby the doctor is still able to prescribe the drugs until such time as we are able to finally take his license. For example, we have had a case in the last few years where we did get into a full blown adversarial proceeding. The doctor fought us at each step of the way which involved five years of litigation during which time the doctor has been allowed by the Courts to continue writing prescriptions. Accordingly

if we are able to get a stipulation immediately, we solve the problem while protecting the public much more adequately than we would if we go to a full licensure revocation proceeding. Of course, there are cases in which there is no choice but to proceed to a full revocation because the doctor will not agree to any limitations or because the Board believes the prescribing practices of the doctor indicate more serious problems involving the doctor's competency.

The third category is a broad category which I have called ethical violations. This can range from something simple as over-charging a patient to something as serious as a felony conviction. These cases are investigated on an individual basis to determine the extent of the violation and whether it falls under any specific statute in the Healing Arts Act or whether it falls under the catch all of dishonorable or immoral conduct. One aspect of such cases is whether the action committed directly relates to the practice of medicine. If it does, we would probably take whatever action is appropriate which could either mean that we would limit the practice or we might proceed to a full revocation depending upon the seriousness of the allegations. However, if it does not relate to the practice of medicine, we would view it in the sense of whether the doctor's judgement and ability to practice has been affected by the action. If we feel the doctor is able to continue to practice, we would not necessarily take action. In support of this position, K.S.A. 65-2836(c) states that even on a conviction of a felony, the Board must determine whether the person has been sufficiently rehabilitated to warrant the public trust. That is clear indication by the legislature that a person can practice, if in the Board's judgement, the person will not detrimentally affect his or her patients.

The final category, in which this committee is most interested, is the issue of competency. Ovbiously, this presents the most difficult problem for the Board because competency usually is not determined by objective criteria but rather subjective criteria based upon expert medical opinion. We receive complaints essentially of two kinds on the issue of competency: 1) the malpractice petitions received from the insurance department, or other alleged instances of malpractice received from attorneys, newspapers and other such sources, and 2) complaints either from private persons, hospitals, medical associations, etc. indicating a question about a certain doctor's ability to practice. Our normal procedure on such complaints is to determine the seriousness of the allegations and whether it involves repeated instances of ordinary negligence or one or more instances of gross negligence which is the statutory standard found in K.S.A. 65-2837(a). Obviously, not every malpractice petition filed against a licensee or a complaint filed for alleged incompetency can be investigated thoroughly if for no other reason that the time and staff available to the Board is not sufficient to do such investigations. More importantly, only probably about 10% of either the malpractice petitions or the complaints alleging incompetency are serious enough to constitute violations of the Healing Arts Act. Doctors are human and on occasions they will make mistakes and may be sued for such mistakes. But the making of such mistakes does mean that the doctor is incompetent. The Board simply cannot take the license away of every person who makes such mistakes.

2. STATISTICS ON THE PAST FIVE YEARS RELATING TO COMPLAINTS HANDLED BY THE BOARD WITH PARTICULAR EMPHASIS ON PERSONS LICENSED UNDER THE KANSAS HEALING ARTS ACT.

The following are statistics for the last five years regarding complaints received, hearings held and actions taken with respect to M.D.s, D.O.s and D.C.s licensed by the Board.

	Complaints	Hearings (informal & formal)	Denials For Cause	Informal Admon.	Stipulations including limitations	Suspensions, Surrenders or Revocations
FY85:	379 (190 Malpractice petition)	39	3	3	13	4
FY84:	290 (159 malpractice petition)	32	6		21	5
FY83:	82	38	6		7	1
FY82:	81	48	1		12	3
FY81:	57	14	4		8	3

3. THE FUNCTION OF THE THREE-MEMBER REVIEW COMMITTEES AND HOW THEY OPERATE.

In Senate Bill 507, which was passed during the 84 legislature and became effective July 1, 1984, three members review committees were established. The purpose of these committees was to review complaints received by the Board on each specific profession. There are three, three-member review committees, i.e., one review committee for M.D.s, one for D.O.s and one for the D.C.s. On each committee there are two permanent members and there are various ad-hoc members who serve depending upon the complaint received and speciality of the persons against whom the complaint is made. Each review committee meets approximately once a month to review those cases which have been determined to have sufficient merit to warrant submission to the committee for further investigation or action. One problem that the committees and the Board have

had in the past year is the extent to which due process applies to the review committee proceedings. For example, does the licensee have a right to appear, present evidence, cross examine witnesses, etc. at this stage of the process? Certain language in the statute would imply that this is the case. Accordingly, if the licensee does appear at the review committee, which we have always allowed them to do, he or she has the right to confront whatever evidence is presented by the board's attorneys to the review committee. In addition, the review committee cannot receive information prior to the actual meeting of the review committee if the licensee has indicated that he will appear and contest the allegations made against him or her. This obviously has slowed down the process.

After July 1, when the Administrative Procedures Act goes into effect the review committees will serve in the capacity as their name implies, i.e. to review patient records and determine whether the licensee has fallen below the minimum standard of care. We will send information out to these committees on a case-by-case basis and get input from them without the necessity of having them all appear at a formal setting and the licensee being able in essence to have a two-tiered hearing process. Only if probably cause is seriously in question will we use the committees in a formal sense. After July 1, the main person who will be in charge of deciding when to file charges will be the Secretary of the Board, who will function as the presiding officer under the newly adopted Administrative Procedures Act. Hopefully, by this process we will be able to get cases worked up and decided in a lot quicker fashion than we have in the preceding year.

4. HOW MEDICAL MALPRACTICE LAWSUITS TIE IN WITH THE BOARD'S DISCIPLINARY ROLE AND WHAT RECORDS ARE RECEIVED FROM THE HEALTH CARE STABILIZATION FUND AND OTHER SOURCES.

I will discuss this question in two parts, first I will talk about how malpractice suits tie in with the disciplinary role and secondly, what records we have received from the Health Care Stabilization Fund and other sources.

It is at best uncertain as to how malpractice suits correlate with the Board's malpractice functions. The argument has always been made that if the Board were more active in disciplining physicians, that somehow the "malpractice crisis" would go away. This is quite unclear, however, because most of the time when we find out about malpractice cases, it is usually four or five years after the offense has occurred, and thus, anything that we do is not going to prevent that particular malpractice suit or any malpractice suit filed in the intervening 4-5 years. In addition, our experience seems to indicate that even when we find about cases early if a suit has been filed our taking action may have a detrimental effect upon that malpractice suits and may promote further malpractice suits being filed. One must remember that there is at least a 4 year statute of limitations during which time a person could possibly file a malpractice suit. Accordingly, whenever we take action any patient of that doctor who becomes aware of that action may decide that they have been harmed by that doctor as well and seek out an attorney to have a suit filed. As evidence of this point, we have cases where the attorneys hired by the doctor's malpractice carrier are defending the doctor before the Board as well and threatening to seek protective order or

injunctions to prevent the Board from taking action. However, the Board's duty is to protect the public from unprofessional and incompetent doctors. Thus, we cannot be concerned about whether our actions will spur more malpractice. Rather, we must prevent incompetent doctors from practicing their incompetency regardless of the effect such actions have on malpractice suits or malpractice premiums.

One thing is certain that whatever role malpractice plays in our disciplinary functions it is essential that we receive information regarding a doctor's incompetency as soon as possible, hopefully before any malpractice petitions are filed; or, even more importantly, before any malpractice is committed. One way of doing that is to have vigorous peer review done at hospitals and other such institutions to ensure that we know when a doctor's competency is in question, so that the hospital or we are able to limit the doctor's practice in some manner so that he or she never gets into a problem in the first place. In addition, we have explored the idea and in fact have contacted the medical center to see whether we can institute a program by which when we question a doctor's competency we can require that doctor to attend a course or courses to make him or her competent.

With respect to the second part of this question, i.e. records and reports received from the Health Care Stabilization Fund and other sources, we believe that there are reports and records that we could receive much earlier. As indicated above, if we are at all going to be successful in preventing malpractice we need to receive information about the licenee's qualifications as soon as possible. With respect to the Health Care Stabilization Fund, I note specifically that K.S.A. 40-3403 states that the

Board of Governors created by SB 507 shall provide "advice, and information and testimony to the appropriate licensing or disciplinary authority regarding the qualifications of the health care provider." I would assume that the intent of that statute is for the Board of Governors of the Fund to inform us whenever they have questions about the competency or qualifications of the licensee of this Board. Unfortunately, we have received no such reports from the Board of Governors. In addition, we have had some difficulty simply in receiving information such as the number of petitions filed against the licensee and in fact, we have had great difficulty in receiving petitions and closed claim reports on licensees against whom the petitions were filed prior to July 1, 1983, when the law was changed to require petitions to be forwarded to us. As noted before, our greatest problems with respect to petitions is identifying which petitions deserve serious investigation. If the Board of Governors would simply tell us that we should be looking more closely at a given doctor, a great part of our problem would be solved.

The 1983 legislature also set up two other reporting statutes: K.S.A. 65-28,121, which requires hospitals to report to us whenever they take action terminating, suspending or restricting a licensee's privileges in a hospital and K.S.A. 65-28, 122, which requires all licensees to report to the Board whenever they have knowledge of a violation of the Healing Arts Act (so long as such knowledge does not fall under physician/patient privilege) We have received some reports in both of these categories. However, the reporting has been at best low and in some instances nonexistent. We have discovered long after the fact that knowledge was in the hands of various licensees about the qualifications or the competency of a doctor and such was not reported

to us. I understand to some extent why this occurs because the licensees or the hospitals are fearful of having counter suits or similar action filed against them if such reports are made to us. Hopefully, something can be done to require the reporting to be done on a more timely basis and in fact we would support legislation which would require that such information about hospital privileges is reported to us even before any action is taken so that we can investigate the case early and determine whether the doctor is or is not competent. In this manner we may be able to actually prevent some malpractice by dealing with a doctor's competency prior to the time he commits any malpractice.

5. A REVIEW OF THE DUE PROCESS RIGHTS OF MEDICAL PROFESSIONALS TO PRACTICE THEIR PROFESSION.

The license to practice the healing arts is a property right which cannot be taken away or limited without giving the licensee proper notice and an opportunity to be heard to rebut any allegations that are being made against him or her. Accordingly the licensee has all the due process rights accorded to him or her under the Kansas and U.S. Constitutions. Essentially, this means that whenever the Board institutes action, it must give the person a chance to rebut evidence introduced by the Board and has all the rights accorded to any individual in a hearing, i.e., right to cross examination, right to present any relevant evidence that he or she wishes, a right to have the decision based solely upon the evidence adduced, and the right to appeal whatever decision the Board makes based upon that evidence. In its attempt to revoke, suspend, or limit a license the Board has the burden of proof to show that a violation of the Healing Arts Act occurred. Such decision

must be based upon substantial evidence and cannot be arbitrary or capricious. Licensees must all be treated equally and, as the term due process notes, must be treated with fundamental fairness.

One thing is necessary to mention. Given that a licensee has a right to confront the evidence presented against him or her, the Board is unable to take a license based simply upon the fact that malpractice petitions have been filed against the licensee no matter how many have been filed. In other words, even if a licensee has 15, 20, 30 malpractice petitions filed against him or her, the Board must, before it can take that license away or restrict it in any manner, prove that the alleged actions contained in each of those petitions did occur and that such actions constitute acts of negligence. Accordingly, the Board whenever it is faced with a case like this must put all the records together, prove that the negligence has occurred, present the case in adversarial forum at which time the licensee has the right to present any evidence he or she wishes, cross examine witnesses examine all witnesses presented by the Board. Obviously this means that these cases will be extremely complex and detailed and quite long. In addition, after the Board makes a decision the licensee will have a right to appeal the decision to district court and appellate courts all of which takes an even longer time. However, anything less would violate the due process rights of the licensee and probably result in the Board being sued in Federal Court as well.

I have attached to my testimony a letter I previously wrote to the Chairman and some other members which compares the number of disciplinary actions taken by

by us to those taken by the Disciplinary Administrator of the Bar. I also have attached statistics comparing the actions taken by all States.

Thank you for your time and attention. I will be happy to answer any questions.

DGS/pd
Attachments 2

STATE OF KANSAS

BOARD OF HEALING ARTS

OFFICE OF
RICHARD A. UNDIS, SECRETARY
ELIZABETH A. ANDERSON, EXECUTIVE SECRETARY
DONALD C. STROLE, GENERAL COUNSEL
235 SOUTH KANSAS AVENUE, SUITE 200
TOPEKA, KANSAS 66603-3449
PHONE (913) 296-7413

May 31, 1985

Representative Joe Knopp
410 Humboldt
Manhattan, KS 66502

Dear Joe:

As you are aware, the Board of Healing Arts repeatedly receives criticism that it is not as effective in disciplining doctors as the Disciplinary Administrator's Office of the Bar is in disciplining attorneys. In an attempt to ascertain whether such criticism has merit, I contacted Arno Windschiffel's Office to compare the number of attorneys disciplined in a given year to the number of doctors disciplined in the same year. The attachment sets out that comparison.

As you can see, Arno's Office or the Supreme Court had a total of 29 disciplinary actions in FY 1984. Of those, 22 were admonishments which means nothing really happened to the attorney's practice, especially if it was a private or informal admonishment of which 18 were. In that same period the Board of Healing Arts had a total of 23 disciplinary actions and denied 6 licensures for cause. Of these, 18 were stipulations or limitations placed upon the license itself, which means that the doctor's practice was restricted in some manner (e.g., required to undergo rehabilitation treatment; stop practicing obstetrics; prohibited from prescribing certain drugs; undergo additional training, etc.) I would argue that such limitations are much stronger forms of action than simply a private or public admonishment.

Given that there are approximately the same number of doctors as lawyers practicing in the State, I believe that this comparison shows that the Board of Healing Arts has disciplined doctors just as well, if not better, than the Bar has disciplined lawyers.

Of course, this may only mean that neither entity is doing enough to weed out the "bad apples", and thus, we certainly intend to be as vigorous as possible on discipline in the future. The key to our success, however, is receiving the information on bad doctors as early as possible, so that we can prevent those individuals from doing any more harm.

In that regard, it is essential that hospitals and their medical staff, including the nursing and other support staff do vigorous peer review. I am convinced, for example, that the 15 million dollar verdict in Kansas City (Olsen v. Younglove) involving Humana Hospital could have been prevented if that hospital would have had an adequate Quality Control Program. The evidence at the trial, however, showed

that no peer review was even conducted on this case and, in fact, it was not even talked about among any of the staff at the hospital. Accordingly, we did not become aware of the case until 4 years after the incident occurred after the judgement was rendered. The sad part is that a very similar incident occurred one month later involving the same doctors, same nursing staff and obviously the same hospital, which the hospital may have prevented if adequate peer review had been done or which we may have prevented if we had become aware of the incident immediately.

I would appreciate any response or questions that you may have.

Sincerely yours,

Donald G. Strole
General Counsel

DGS/pd
c: Senator Robert Frey
Senator Frank Gaines
Senator Wint Winter
Senator Dave Kerr
Representative Sandy Duncan
Representative John Solbach
Representative Lee Hamm

Disciplinary Action by Bar:

August 3, 1984 Report:

243	Complaints
21	Panel Hearings
16	Private Admonishment
4	Public Censure
2	Informal Admonishments
4	Undefined Suspensions
1	Disbarment
2	Surrender

No licensed: Active 5,766
Inactive 1,290

Disciplinary Action by the
Kansas State Board of Healing Arts:

1983-1984 (FY 84) Report:

289	Complaints (158 malpractice petitions)
32	Hearings (formal and informal)
86	Investigations
6	Denial for Cause
18	Stipulations/Limitation
1	Suspensions
4	Revocations

No. Licensed:	Total:	Active Practice in KS
M.D.	6,300	3,212
D.O.	451	196
D.C.	750	458

tory. The overwhelming majority of physicians are competent and honest professionals. By identifying and disciplining the few who are not, we meet our public and professional responsibilities.

State medical boards must share responsibility for medical licensing and discipline with agencies of their state governments. All states and territories currently have medical regulatory boards that are state financed and mandated by state law. Medical disciplinary meetings should be held in public view to dispel myths about cover-up. Public members should continue to serve on boards to offer a nonphysician's perspective on the disciplinary process and to allay public anxiety.

These boards, however, must continue to include a majority of physicians, who can better understand the doctor's position. They can empathize with sick colleagues, and they can mete out strict discipline to incompetent and dishonest physicians when it is appropriate. The single overriding goal of state medical boards must continue to be the protection of the public from incompetent and unethical doctors. A second goal, and one of increasing importance in the past decade, is the rehabilitation of the impaired physician.

State medical boards can serve as the arbiters of medical practice in their states by defining minimally acceptable levels of conduct and practice. In so doing, they must adhere strictly to the statutes that govern the practice of medicine in their state.

Florida, California, and many other states periodically publish newsletters that are distributed to all physician licensees, hospitals, county medical societies, and other interested parties. In Florida, the newsletter is used to educate physicians about the medical laws of the state so that ignorance of the law will not lead to statutory violations. The newsletter, published four times a year, also lists the names and addresses of doctors who have been found guilty of breaking the law and have been disciplined by the medical board. The newsletter has been well received and has served as an invaluable asset in identifying physicians who may have to be more closely watched by hospitals, colleagues, and patients.

We realize that some physicians who have lost their medical licenses in Florida, because of revocation, suspension, or voluntary relinquishment in the face of impending discipline, will travel to other states in which they still possess a valid medical license. They may practice there until the new state is notified of their administrative difficulties in Florida and chooses to initiate an investigation. The board in Florida attempts to find out in which other states a physician is licensed to practice medicine and notifies those states of its action by mailing a copy of the board's final order. Reports of all disciplinary actions are also sent to the Federation of State Medical Boards, which has the responsibility of notifying all other states and territories. Each state will usually look into the reason that a physician was disciplined in another state and act appropriately.

Most states use similar applications for a medical license to be granted on the basis of an examination given in another jurisdiction. These applications contain questions about prior disciplinary actions in other states, and an affirmative response is always investigated before a license is granted.

Table 1. Disciplinary Actions Taken against Medical Doctors in 1982.*

State	No. Licensed M.D.'s (U.S. State)	No. Disciplined per 1000 M.D.'s
Florida	20,100	7.4
Arizona	5,000	7.0
Nebraska	2,500	6.8
Mississippi	3,000	6.0
South Dakota	862	5.9
Iowa	4,000	5.5
Wyoming	663	4.5
South Carolina	4,500	4.4
Georgia	7,500	3.3
New Mexico	2,400	3.3
Idaho	1,200	3.3
New Jersey	22,000	3.1
Kansas	2,987	3.1
Louisiana	6,500	3.1
Missouri	9,000	3.0
Oklahoma	4,000	3.0
Utah	2,600	3.0
Wisconsin	8,500	2.9
West Virginia	3,500	2.9
California	51,000	2.8
Minnesota	7,000	2.6
Maine	1,900	2.6
Alaska	411	2.4
Indiana	8,000	2.3
Nevada	1,300	2.3
Maryland	11,000	2.0
Michigan	14,500	1.9
Virginia	10,000	1.9
Oregon	5,270	1.9
Colorado	6,500	1.8
Alabama	4,880	1.8
Hawaii	1,900	1.6
Tennessee	7,000	1.4
Illinois	20,000	1.2
Washington	7,850	1.2
New York	45,000	1.1
Kentucky	5,250	1.1
Montana	1,000	1.0
Texas	24,500	0.9
Ohio	19,000	0.9
Vermont	1,160	0.9
North Carolina	8,500	0.8
Massachusetts	17,500	0.7
New Hampshire	1,546	0.6
Rhode Island	1,732	0.6
Pennsylvania	30,000	0.5
Connecticut	6,500	0.3
Arkansas	3,100	0.0
Delaware	752	0.0
District of Columbia	3,500	0.0
North Dakota	939	0.0
Puerto Rico	4,657	0.0

*Source: Federation of State Medical Boards. Data represent the number of reported actions and are only approximations because reporting may be incomplete in some states.

3361 S. Miami Ave.
Miami, FL 33133

RICHARD JAY FEINSTEIN, M.D.

SCOPE STATEMENT

Board of Healing Arts and the Health Care Stabilization Fund

The Board of Healing Arts is a regulatory agency with 13 members. Twelve are health care professionals and one member represents the public. The Board is responsible for licensing and regulating medical, osteopathic, and chiropratic doctors. In addition, the Board registers physicians' assistants and registers and examines physical therapists and podiatrists. As part of its responsibilities, the Board is empowered to revoke, suspend, or limit a license after an investigation and hearing.

In fiscal years 1984 and 1985, the Legislature increased the budget of the Board and added a total of four full-time positions in order to strengthen the Board's disciplinary procedures. Other recent changes include strengthening reporting requirements. The changes were also prompted in part by concerns over the solvency of the Health Care Stabilization Fund, which pays for successful claims against doctors in malpractice suits when the amount awarded exceeds the minimum amount of liability insurance the State requires each doctor to carry.

Legislative concerns have been raised recently about the effectiveness of the Board of Healing Arts. An audit in this area would address the following questions:

1. **Do current procedures for reporting cases of incompetent health care practitioners to the Board appear to be adequate?** The auditors would review statutes, rules, and regulations to determine the mission of the Board. Information would be compiled from budget documents and other relevant sources to determine the kinds of activities in which the Board is involved. The auditors would examine the reporting requirements currently in place and note any changes that have been made to them in the past two fiscal years. They would also examine the number of disciplinary reports filed with the Board by health care employers both before and after any recent changes made to the system, and would review the number of malpractice cases reported to the Board by the Insurance Commissioner. Appropriate staff would be interviewed to determine how the new procedures for reporting problems work. The auditors would also examine any other procedures in place to investigate complaints from other sources.

2. **How effective is the Board in protecting the public against unprofessional, improper, unauthorized, and unqualified practice of the healing arts?** The auditors would examine the number of disciplinary reports from all sources filed against health care practitioners over a period of time. They would collect data relating to the investigation of such reports and any actions taken as a result of the reports or complaints. The auditors would examine the requirements for peer reviews of health care practitioners. They would also examine any suggestions that have been made or could be made to improve the Board's effectiveness in ensuring the public safety. Finally, they would examine the Health Care Stabilization Fund and analyze trends in its balances over time.

Estimated completion time: 6-8 weeks

7/1-2/85

ATTACHMENT X

KANSAS BAR ASSOCIATION

Suggestions To

SPECIAL COMMITTEE ON MEDICAL MALPRACTICE

For Investigation Of Subject Matter

I. Identify the nature, extent and cause of the problem.

- The problem is high medical malpractice insurance premiums for certain specialists.
- The primary reason for the high premiums is deviation by doctors from the standards of care set by doctors resulting in
    - Settlements.
    - Judgments.
- A secondary reason is that the Health Care Stabilzation Fund established in 1976 was not actuarially sound.
    - Original premiums inadequate for unlimited coverage.
    - No surcharge made in 1980, 1981 and 1982.
- Is there clear evidence that abuses of the tort system and adversary system contribute to the problem?

II. Consider the remedial effect of actions already taken.

- 1984 legislative action.
    - Confidentiality of peer review records.
    - Modification of HCSF.
        - Higher basic limits.
        - Cap on maximum liability.
- 1985 legislative action.
    - Modification of Collateral Source Rule.
- When will full effect of these actions be known?
- What will effect be?

7/1-2/85

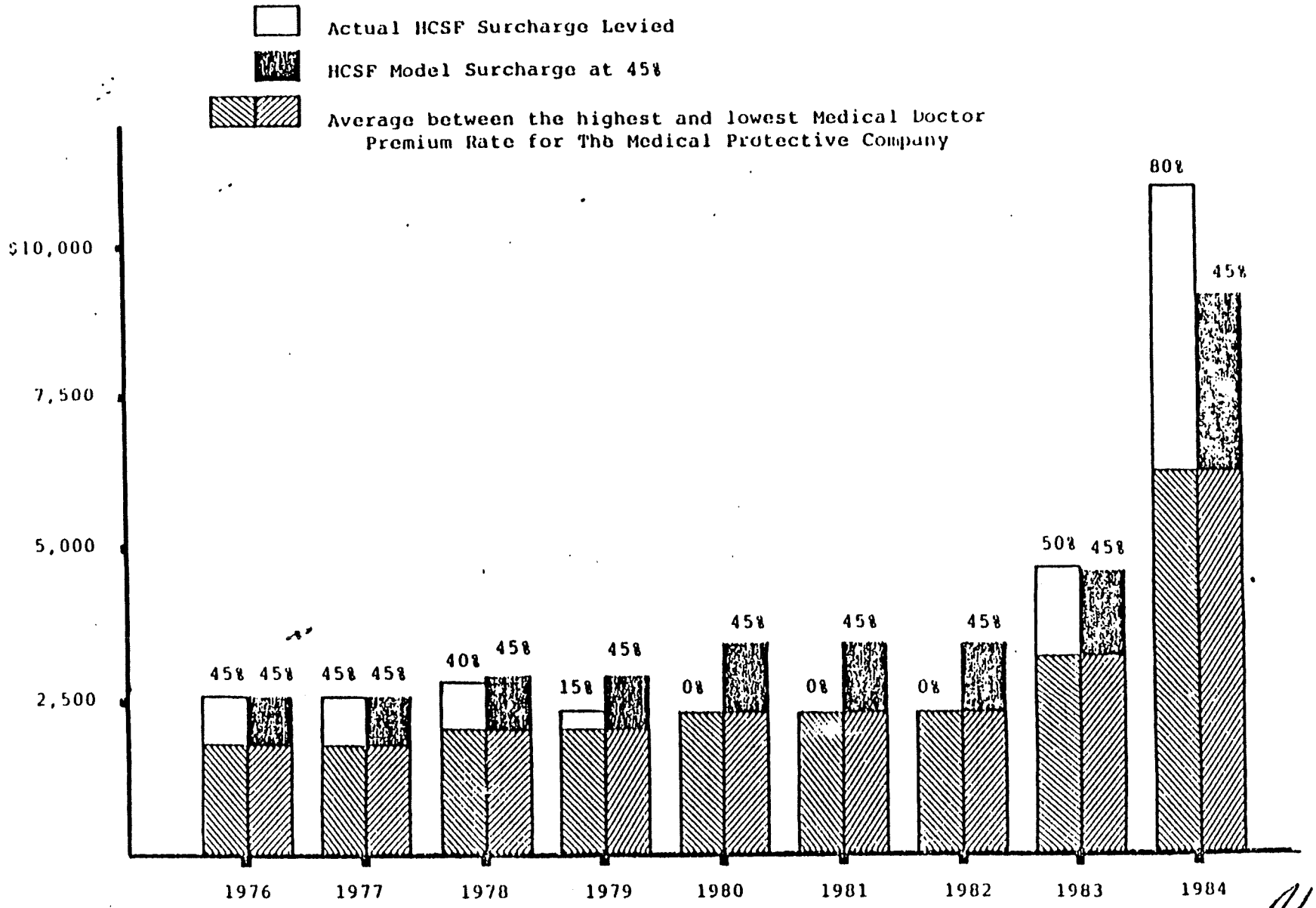
ATTACHMENT XI

III. Give most careful consideration to proposals for basic changes in tort and adversary systems.

- Require specific proposals.
- Require clear evidence that proposal would address the problem.
- Consider carefully the rights which would be diminished or eliminated.
- Provide full opportunity for comment.

Richard C. Hite
Chairman, Legislative Committee
Kansas Bar Association

COMPARISON OF THE 45% HCSF MODEL SURCHARGE TO THE ACTUAL HCSF SURCHARGES



ATTACHMENT XII

Atch. XII
11-2/85

Alternative Health Care Stabilization Fund
Surcharge Strategies
As Requested By The
Citizens Advisory Committee

The attached exhibits provide HCSF balance information which has been derived from the HCSF past experience data that has been modified by utilizing different HCSF surcharge percentages.

Exhibits I and II develop what the HCSF balance would have been if a constant 45% surcharge had been levied by the insurance depratment. The constant 45% surcharge model is not consistant with the statutory surcharge provisions of K.S.A. 40-3401 et seq.

Exhibit III provides another HCSF surcharge model by attempting to determine what the HCSF surcharge percentage would have been if the accrual funding requirement had been implemented immediately after the $10 million balance was achieved. This model, like the 45% constant surcharge scenario is not consistant with the statutory provisions of K.S.A. 40-3401 et seq.

Finally, the following table presents a comparision of the total HCSF surcharge levied by the insurance department.

Surcharge Procedure	FY-77 to FY-84 Total HCSF Surcharge Revenue
In accordance with K.S.A. 40-3401	$17,262,011
At 45% - Exhibits I and II	41,737,529
Accrual Funding after $10 million balance - Exhibit III	45,736,478

Exhibit I

Fiscal Year Ending June 30	Basic Coverage Premium*	HCSF Revenue at 45% Surcharge*	Actual Losses and Expenses	Cumulative Balance with Est. Invest. Income**	Actuarial Estimation of HCSF Accrual Losses Payment Responsibility
1977	$ 7,427,684	$ 3,342,458	$ 176,574	$ 3,482,472	$10,000,000 By Statute
1978	7,638,346	3,512,160	74,811	7,611,803	$10,000,000 By Statute
1979	7,842,064	4,094,168	216,561	12,638,351	$10,000,000 By Statute
1980	8,157,421	3,774,023	161,111	17,876,389	$10,400,000
1981	9,392,632	4,512,033	1,265,671	23,235,026	($18,687,000 Discounted) $24,851,000 Undiscounted
1982	10,782,790	5,215,876	3,208,737	27,766,381	($19,877,000 Discounted) $27,464,000 Undiscounted
1983	11,733,289	5,279,980	6,005,222	29,745,253	($22,632,000 Discounted) $32,277,000 Undiscounted
1984	15,091,012	6,790,955	7,881,026	31,520,700	($37,746,000 Discounted) $47,183,000 Undiscounted
6-30-1984	$78,063,238	$41,737,529	$18,989,713	$31,520,700	$47,183,000

*Based on policies made effective July 1 through June 30 of each fiscal year. HCSF revenue includes excess income from the HCPIA Act in FY 78, FY 79, FY 80, FY 81, and FY 82.

**Investment Income estimated at 10%.

Exhibit II

HCSF MODEL BALANCE AT 45% SURCHARGE

HCSF ACTUAL BALANCE

HCSF ACTUARIAL ACCRUED LOSSES

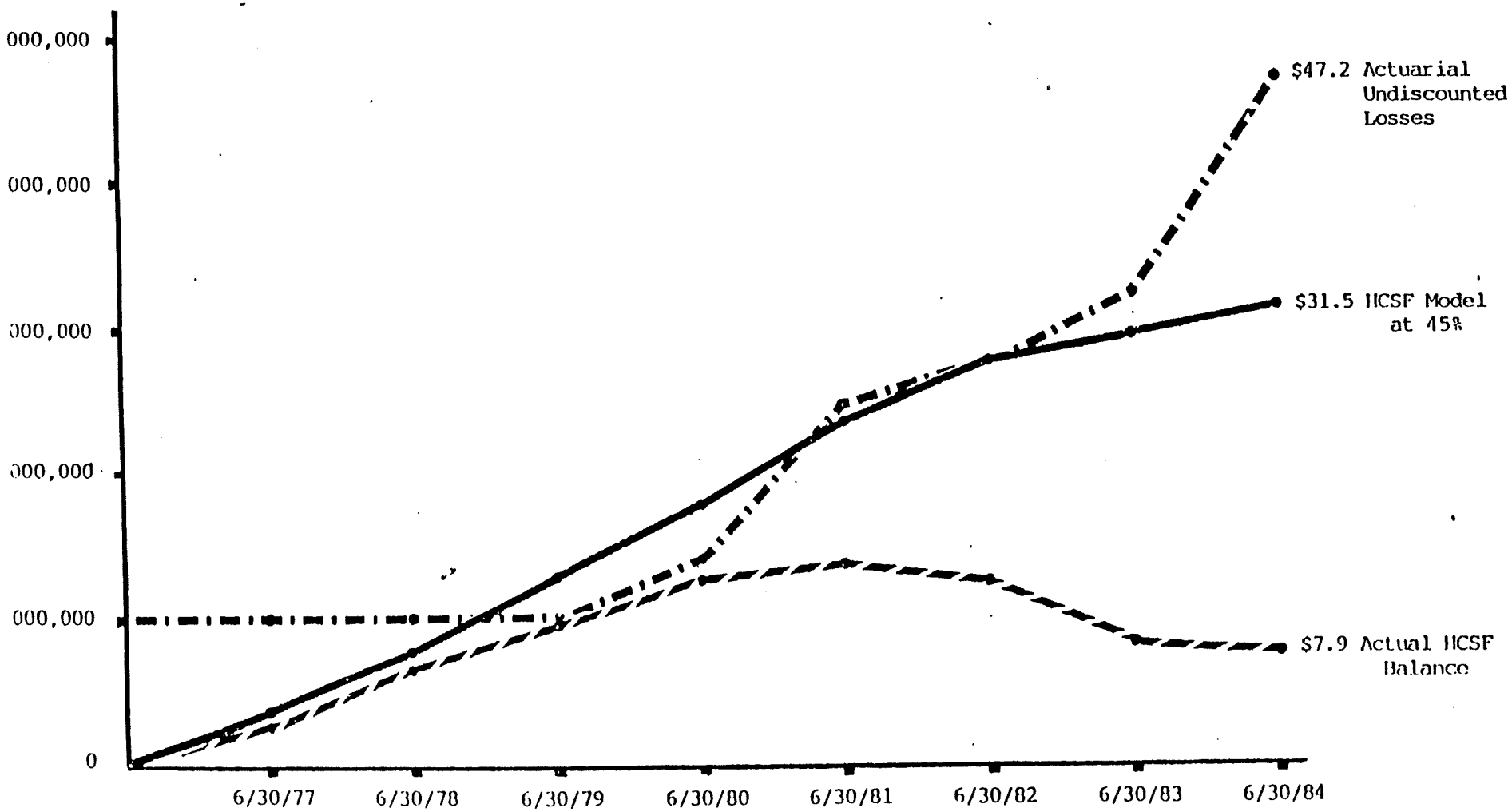


Exhibit III

ASSUMED HCSF MODEL

ACCRUAL FUNDING OF DISCOUNTED* LOSSES

Fiscal Year Ending 6/30	HCSF Surcharge Percentage	HCSF Surcharge Receipts	Cummulative HCSF Balance
1977	45%	$ 3,342,458	$ 3,482,472
1978	45%	3,512,160	7,611,803
1979	40%	3,702,064	11,313,867
1980	0		12,217,073
1981	65%	6,460,000	18,762,274
1982	30%	3,234,837	20,667,211
1983	50%	5,866,644	22,581,497
1984	130%	19,618,315	37,750,665

*Discounted means that future interest income projections have been estimated in determining the needed HSCF accrual balance. For example, if the HCSF ceased operation on June 30, 1984, and the HCSF balance was $37,750,665 future investment income would pay out a total of approximately $47,183,000.

TESTIMONY OF THE KANSAS HOSPITAL ASSOCIATION
BEFORE THE SPECIAL COMMITTEE ON MEDICAL MALPRACTICE
July 2, 1985

Thank you Mr. Chairman and members of the committee. My name is Tom Bell and I am an attorney with the Topeka law firm of Goodell, Stratton, Edmonds & Palmer. I am appearing today as a representative of the Kansas Hospital Association.

There are 158 member hospitals in the Kansas Hospital Association. The size of the member institutions varies greatly. For example, the Holton City Hospital in Holton, Kansas has 27 acute care beds; Asbury Hospital in Salina has 200 acute care beds; and St. Francis Regional Medical Center in Wichita has over 800 acute care beds. The larger hospitals in the state are, of course, located in the urban areas while the smaller ones are located in the rural areas. At the present time there are hospitals in every part of the state. The range of services offered by those hospitals, however, may be limited in certain areas. Approximately 70 of the hospitals in Kansas are owned by a governmental unit, 8 are proprietary or for profit hospitals, and the rest are nongovernmental, not-for-profit hospitals.

As every member of this committee knows, the medical malpractice problem is a painfully complex one, involving hospitals, physicians, attorneys, patients and insurance companies. The

ATTACHMENT XIII

solution likewise will involve all those parties. The task of this committee and indeed of the legislature as a whole, is to insure that our system works to identify victims of medical malpractice and compensate them adequately without placing too great of burden on the providers of health care.

The Kansas Hospital Association appreciates the opportunity to appear before the Special Committee on Medical Malpractice and hopes that it can assist the legislature in working toward a solution. The Association has sent out a special survey requesting its members to respond to various questions regarding the current medical malpractice situation. The results of that survey are not yet complete, but should be finished and tallied in the next month. At that time, the Kansas Hospital Association will be glad to share the results of this survey with the members of this committee.

Although as I stated the results of the Kansas Hospital Association survey are not yet complete, those responses which I have examined to date confirm the fact that the current medical malpractice crisis is affecting Kansas hospitals in basically two ways. First, Kansas hospitals, like other health care providers in the state, are experiencing large increases in the rates of medical malpractice insurance. For example, Providers Insurance Company, which insures approximately 30 hospitals in the state, last year increased its rates by 110%. Correspondingly, the surcharge of the health care stabilization fund continues to rise, this year to 110% of the primary coverage premium. Second, Kansas hospitals are observing that patient access to care is

threatened. Physicians are cutting back on the number of high risk services. Some are leaving the field entirely or taking early retirement. In other areas of the state physicians have expressed concern to hospitals that economically, they would be better off transferring their practice out of state where malpractice premiums are lower. When a community loses a physician or a physician's services, no matter what the reason, access to care is reduced. In rural Kansas, where many of our small hospitals are struggling to survive, access is already limited. If these hospitals are to remain a viable source of health care, they must be able to attract and keep physicians and services without fear of losing them to the medical malpractice crisis.

This committee has recognized the complex nature of the problem and therefore has divided its study into basically four areas: (1) primary coverage insurance; (2) the health care stabilization fund; (3) peer review and risk management; and (4) the tort system in general. Because the committee has chosen this structure, I would like to briefly discuss each of these areas.

Insurance and the health care stabilization fund. The basic concern of hospitals here is, of course, cost. Again, the health care stabilization fund has announced that the surcharge for 1985 will be 110% of primary coverage premiums. This is up from 80% last year. Further, costs of primary coverage insurance have generally equaled or exceeded the increase in the health care stabilization fund surcharge.

A growing concern for hospitals in this area, however, is availability. Out of approximately 300 companies in Kansas that could legally write professional liability insurance for hospitals, only 3 are now doing so. Beginning January 1, 1986 one of those companies will insure hospitals only if all the physicians on staff are insured to one million dollars. The excess insurance market is also showing signs of drying up.

Peer review and risk management. The Kansas Hospital Association recognizes that health care providers must share responsibility for minimizing the occurrence of medical malpractice. Presently, all Kansas hospitals with over 60 beds are accredited by the Joint Commission on the Accreditation of Hospitals, a national organization. The JCAH requires these hospitals to maintain "an ongoing quality assurance program designed to objectively and systematically monitor and evalute the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems". Each hospital's quality assurance program must be evaluated at least annually. Hospitals that are not accredited by JCAH must meet similar standards set out in Medicare "conditions of participation" promulgated by the Health Care Financing Administration, and enforced through surveys by the Kansas Department of Health and Environment. In addition, the Kansas Hospital Association sponsors risk management seminars around the state, the most recent being in Wichita at the end of May. The Association is also in the process of developing a risk management program in conjunction with the Kansas Medical Society.

The "Tort System". The "Tort System" spans the entire range of human activity. The Kansas Hospital Association recognizes that this system, as it is in place today, has evolved over hundreds of years and constitutes a major part of American jurisprudence. This fact, however, is no reason to ignore the need for further change and evolution. Indeed, one of the virtues of our system of laws is its willingness to re-examine old rules and procedures in light of past experience and present needs.

The Kansas Hospital Association supported Senate Bill No. 110 last session. We feel it accomplished some necessary changes in the system. There are, however, other alternatives to consider, including structured settlements and awards, mandatory screening panels and reasonable limitations on awards and attorney fees.

Again, the Kansas Hospital Association commends this committee for its diligence and thoroughness in attempting to get a handle on this problem. The Association stands ready to help in any way possible.

Kansas Association of Osteopathic Medicine

TESTIMONY OF THE KANSAS ASSOCIATION OF OSTEOPATHIC MEDICINE BEFORE THE LEGISLATIVE SPECIAL COMMITTEE ON MALPRACTICE, KANSAS LEGISLATURE, JULY 2, 1985

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

My name is Harold Riehm and I represent approximately 175 practicing osteopathic physicians in Kansas. I appear today to affirm what we testified to last Session--that there is a crisis in malpractice insurance and that it has begun to alter the way physicians practice medicine in the State. Were these trends to continue, some offer unfortunate consequences for parts of the State, particularly our rural areas and small towns.

In a survey presented during the Session, we reported that between one-fourth and one-third of osteopathic physicians were seriouslyconsidering altering their practice, with the most frequent changes involving ceasing obstetrics and ceasing minor surgery. At the same time, we estimated that only about five percent of our physicians had done so. It is fair to state, I think, that were malpractice premiums to remain at the level they were, few changes would actually occur. But what concerns physicians even more than current rates, is the spiral upward in these rates, that gives little indication of abating in the immediate future--short of some form of remedial change in the overall milieu of medical malpractice insurance.

In the 1985 Session we supported the passage of provisions in the original S.B. 110. We continue to think these are needed changes. We also urge consideration of restructured screening panels to serve as a source of arbitration and/or mediation of malpractice claims. At the same time we emphasize strongly that we have been and plan to continue to review our role in peer review, both within our own profession, and in conjunction with The Board of Healing Arts.

We also urge serious consideration of some form of lid on overall settlements and judgments--a lid lower than the $3,200,000 lid now on basic and Fund coverage. Lids inserted in the tort system are always controversial and we also emphasize that we strongly support reasonable compensaion for all those injured due to miskates or negligence by practicng physicians. Emphasis, though, should be on "reasonable"

To put in bluntly--physicians who urged creation of the Fund, now may well be sutck with it. Unfortunately, the base of provider population that supports the Fund is so relatively small, then even an occasional very large settlement or judgment most likely will further perpetuate the Fund's existence as well as exacerbate the problem of upward spiraling rates. Given this small base, we think there is merit in considering a maximum settlement-limit lower than the $3,200,000 now in place.

Mike Heim in his letter of invitation to appear, suggested that the Committee is interested in some specific rates. This is a difficult time to be taking a rate survey due to so many changing variables eithin a short period of time. This is particularly true of the osteopathic profession, since approximately one-fourth of D.O.s were forced to switch companies within the past few weeks, due to a company ceasing to wirte malpractice in the State.

7/1-2/85 ATTACHMENT XIV

Generally speaking, the osteopathic profession is one of physicians in general or family practice. Approximately 90% of the D.O.s practicing in Kansas practice general medicine. For physicians in general practice five or more years, most of them are in a class that provides some obstetrics, some minor surgery and some emergency medicine. It is difficult to categorically state where they fall in that different companies classes are differently defined. Most general practice physicians, though, fall in calsses that have base premium costs ($200,000/$600,000) ranging from $3,500 to $8,000. The Fund surcharge of 110% would then raise total premiums to approximately $7,350 to $16,800. It should be emphasized that this does not include either the 20% surcharge over St. Paul rates, or the revised surcharge for claims history (assigned risk), or both, for those physicians insured by the Plan through Western Insurance Co.

Again, it is not only these high rates that are of genuine concern, but the fear of what lies ahead, a fear based on realities of the substantial increases of recent years.

Permit me, Mr. Chairman, to address one additional concern of the osteopathic profession. Yesterday you heard testimony about how companies writing malpractice insurance may determine the parameters of what physicians they choose to cover. This often takes the form of choosing to exclude one type of provider--such as deciding not to insure doctors of chiropractic or podiatrists. One other is to exclude, either by policy or selection, physicians by the nature of the speciality. The Insurance Department holds that there is no law that permits it to preclude some selection policies.

We wish to address an additional form of exclusion that we view as arbitrary and capricious .It is the policy of The Medical Protective Company not to insure any osteopathic physicians (unless then are in practice with allopathic physicians). We have protested this exclusion to The Kansas Insurance Department and their response is that they have no statutory means of prohibiting such selection policies.

Theoretically, it is possible that two physicians with identical practices in every way, located side by side in the same community only one an M.D. and one a D.O; one could be accepted by a Company writing insurance in Kansas, the other refused because of being an osteopathic physician. The consequences of this are substantial. In testimony heard earlier by this Committee, along with handouts (partial attached), it was shown that Medical Protective was one of the two large carriers writing malpractice insurance in Kansas, writing almost onr-third of all physicians in Classes I-IV). It was also shown that the rates of this company were substantially lower than most other cases--with a mean rate level in recent years less than one-half of the other large carrier, St. Paul Fire and Marine. The net result, then, is that this policy of Medical Protective to not write D.O.s precludes D.O. access to what is the single most reasonably priced large carrier writing in the State. This, in turn, is magnified by the fact that the very low base prices of Medical Protective are the rates to which the State Fund surcharge (now 110%) is applied. We remain curious as to why Medical Protective sustains this policy and why the Insurance Department has taken to steps to insure this form of arbitrary exclusion is not discouraged or ended. Should a representative of Medical Protective Company appear before this Committee, we invite you to pose this question to them.

In conclusion, Mr. Chairman, may I state as I did during the Session. Physicians just want to practice medicine. The overehleming majority do so with great care and concern. No physician wants to unreasonably limit compensation to persons injured by accident or negligence of a physician--but the key is "reasonable" It is our contention that we need to examine both the procedures and substance of our tort practices to determine if they can be altered in a way that maintains fair compensation but insures the presence of reason for all those caught up in the medical malpractice milieu. Thank you. Your attention to this matter is appreciated.

ADDENDUM: Below are the recent developments of an osteopathic physician specializing in general surgery. He has been insured by Professional Mutual Insurance Co, but with that Company ceasing to write in Kansas, was forced to seek other coverage. He and the 64 others in this category, were informed by St. Paul they would not write any of them because of a question of past liability. Medical Protective writes no osteopathic physicians. Two other sources were available: Medical Defense which is a very selective company that rejected some applications in developing their "practice profiles" and, the source used by most--Plan coverage through the Western Company. Below are some figures pointing out the dilemma along with notes.

INSURANCE YEAR July 1 - JUNE 30

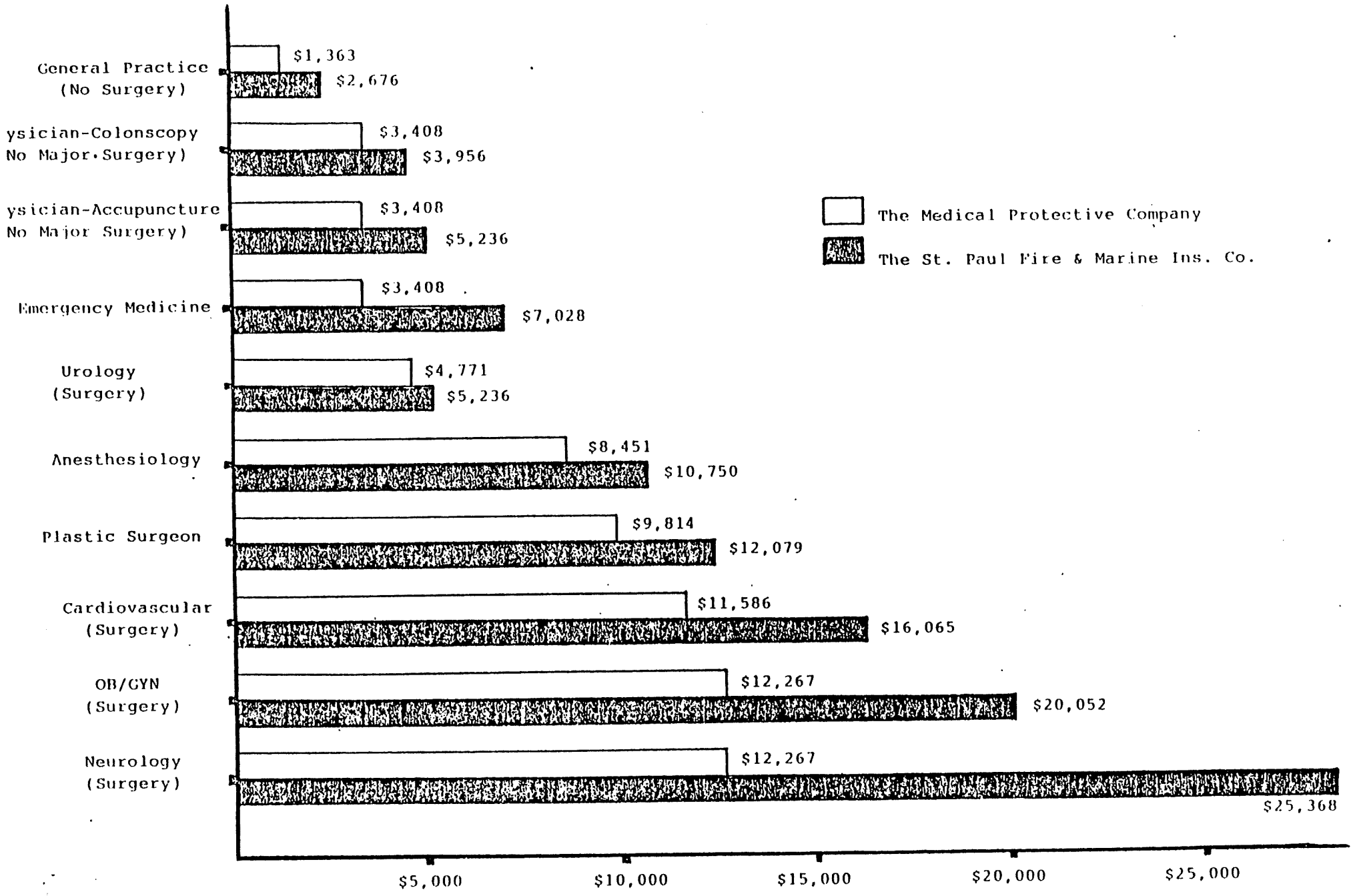
YEAR	BASE COVERAGE $100,000/$300,000	ADD STATE FUND SURCHARGE	ADD CLAIMS HISTORY S/CH.	TOTAL PREMIUM
1984 - 4th YEAR IN PRACTICE (PROFESSIONAL MUTUAL CO.)	$ 6,725	$ 5,380	--	$12,105
QUOTED APRIL 23 BY AGENT FOR WESTERN CO.	2,584	$ 3,101 (120%) (2)	$ 2,843 (50%)	$ 8,528
REVISED QUOTE FROM WESTERN ON JUNE 27, 1985	6,418 (1)	$ 7,060 (110%)	$ 26,956 (200%) (3)	$ 40,434

(1) Base higher than previously quoted because determined not eligible for first year immature rate despite moving from occurrance policy to claims made policy.

(2) Surcharge figured at 120% before revised downward

(3) New, higher, claims history surcharge determined by Plan Administrators (According to formula - doctor in question has had 2 claims - one settled for a few thousand dollars (along with hospital) and second one settled - indicated large settlement.

PROFESSIONAL LIABILITY INSURANCE RATES
AS OF 7-1-85



THE KANSAS CHIROPRACTIC ASSOCIATION
1911

Kansas Chiropractic
ASSOCIATION

TESTIMONY BEFORE THE 1985 LEGISLATIVE
INTERIM COMMITTEE ON MALPRACTICE

JULY 2, 1985

Mr. Chairman, members of the committee, my name is Sherman A. Parks, Jr. I serve as the executive director of the Kansas Chiropractic Association, representing approximately 86% of the doctors of chiropractic in Kansas. Chiropractic is the second largest branch of the healing arts in Kansas. I appreciate the opportunity to share some of our thoughts with you this morning.

Malpractice insurance in Kansas has been skyrocketing in recent years and is effecting all branches of the healing arts. The Kansas Chiropractic Association (K.C.A.) feels it is time to reexamine our present Kansas malpractice laws. If no action is taken on malpractice insurance increases, then regular health care as we know it today will become something most people can't afford in a few years from now. It is not the intent of the KCA to make it harder to bring or win a legitimate suit or not to get doctors "off the hook" when they are negligent, but to reduce costs while preserving the rights of injured patients to have their day in court.

Public policy, as expressed by many of the Kansas statutes, fully recognizes the doctor of chiropractic as an integral part of the health care delivery system in Kansas. In the Kansas Healing Arts Act, K.S.A.65-2801, the doctor of chiropractic is specifically listed as a member of the healing arts. Since the Kansas Legislature has granted us this status, the Kansas doctor of chiropractic and the KCA have done a lot to reduce the incidence of malpractice in our state.

1334 S. TOPEKA • TOPEKA, KANSAS 66612 • (913) 233-0697

7/1-2/85

ATTACHMENT XV

In 1976, we supported successful legislation requiring doctors of chiropractic to carry malpractice insurance and to participate in the Kansas Health Stablization Fund so that Kansas patients can't be left in the cold. This legislation made the State of Kansas the only state in the United States to have statutory mandated malpractice insurance for doctors of chiropractic. Many doctors of chiropractic in other states do carry malpractice insurance, however, not all doctors do. Kansas citizens have the "peace of mind" that before a Kansas doctor of chiropractic is granted a license to practice in Kansas, they have met the statutory malpractice insurance requirement. Since 1976, there have been less than twenty successful malpractice suits in Kansas, against Kansas D.C.s. There has only been one judgment large enough to have the Kansas Health Stablization Fund assist in the payment of a judgment. Considering the hundreds of thousands of patients the Kansas doctor of chiropractic has seen, this is an excellent "track record" and a tribute to the high standards the Kansas doctor of chiropractic has.

When Kansas became one of the first states to require all doctors of the healing arts to participate in continuing education every year, Kansas became the first state in the United States to mandate continuing education for doctors of chiropractic. Since that legislation was introduced in Kansas, a few other states have required D.C.s to have continuing education. However, Kansas has the highest standards of continuing education for D.C.s in the United States. The Kansas doctor of chiropractic is required, like the other branches of the healing arts in Kansas, to have fifty (50) hours each year. The few other states that require continuing education for D.C.s require only twelve hours or less. I feel this is a factor in the very small number of successful malpractic suits in Kansas against doctors of chiropractic.

We have supported legislation which has established a process in which a doctor's claims history is reviewed by fellow physicians working for our patient's compensation fund.

We have supported legislation which beefed up the disciplinary system of the State Board of Healing Arts, and increased its legal staff - whose only job is investigating doctors.

The reason why Kansas doctors of chiropractic and the KCA have supported these pieces of legislation is because we feel the Kansas doctors of chiropractic are the best in the United States and the few negligent ones make it tougher - and more expensive - for the rest of us. KCA and the Kansas Legislature have done alot in the past to reduce the chance of malpractice, now is the time to do something more.

Skyrocketing malpractice insurance has had a great impact on rural Kansas. We have few enough rural doctors of chiropractic as it is. Unless something is done soon, the number of rural Kansas doctors of chiropractic can only become worse. When a rural doctor considers early retirement or thinks about other states as an alternative because he or she can't afford the premiums, surcharges, or the risk of a suit, something has to be done quickly.

Premiums have increased. When I say premiums, I am speaking both of the insurance premium and the surcharge. The Kansas doctor of chiropractic's medical malpractice premium and surcharge together has risen over 300% in the last year. That presents a problem. These premiums are increasing because more suits are being filed and because the average cost of the claim, what it costs to resolve a claim, continues to increase also.

The KCA suggests four areas to be modified and one additional recommendation:

1.) We ask this committee to consider limiting awards both pecuniary and non-pecuniary as suggested by the Kansas Medical Society. That is, a $500,000 limitation on pecuniary awards and $100,000 limit on non-pecuniary damages. The reason why KCA supports these numbers is that they are realistic dollars as it pertains to the few awards rendered against doctors of chiropractic. All of the successful judgments rendered in Kansas, except one, have well been below these figures.

2.) KCA believes that a restructing of the screening panel system in this state would be a positive move. In cases of true negligence it will get the insurance company in the position to settle quicker. In addition, we hope it would identify some of the unnecessary or not-meritorious cases and thereby put less of a burden on the system entirely. We suggest that the state of Indiana approach be used as a model.

3.) KCA suggests that the use of structured awards in medical malpractice cases be required. It makes sense to us at a time when the system is under a strain, that instead of giving lump sum awards of $2 or $3 million dollars or whatever is required, give the fund the power to purchase an annuity to pay its obligation. The purpose of the fund is to compensate someone fairly for their loss, not to overly enrich them, or not to put an unnecessary burden on the syatem. In addition, KCA feels that if the plaintiff has recovered to such a positive level where future medical expenses cease to be needed, let's either stop the benefit or reduce it to meet their present needs.

4.) KCAs final suggestion is that the legislature should by statute establish a contingent fee system in medical malpractice cases. We do not have a dollar recommendation or a percent to suggest at this time. However, we do feel that what method is developed, the plaintiff should be given first consideration. By doing this, it will return more of the award dollars to the plaintiff and that's where it ought to be.

K.C.A. feels SB 110 was the first step of many steps to be taken. We worked with the other branches of the healing arts in the development of that bill. We feel any action taken by the legislature is the vehicle to slow down the rising malpractice insurance problem. We appreciate the status the Kansas legislature has granted us, - the highest standards for doctors of chiropractic in the United States - however, unless the legislature takes some action now on the rising cost of malpracticeinsurance, thousands of Kansas citizens may be deprived continued chiropractic availability.

Testimony before Special Committee

on Medical Malpractice

July 2, 1985

Presented by Homer Cowan
The Westerin Insurance Companies

7/1-2/85 ATTACHMENT XVI

As an Insurance industry representative, many of you have heard before what I will say. I can only say I'm sorry, but there is not any way to state the truth with any variety or variation. You can not embellish it, nor distract from it.

The truth is - medical malpractice insurance is at the present time a loser.

Pollution liability insurance at the present time is a loser.

Municipal liability insurance at the present time is a loser.

Dram shop insurance, at the present time is a loser.

In fact, nearly all insurance covering legal liability of others is a loser.

The primary cause is society.

It's not the insurance mechanism.
It is not the legal system.
It is the people who use both systems.

Those of you who have served in the legislature for a number of years know that every legislative proposal involving the "right to sue" involves

(1) the Insurance Industry;

(2) the Legal Profession, and in particular, the Trial Bar (Plaintiff Bar).

What you see in Kansas is happening in every legislature in every state of this country. It happens every year. Same issues -- same proponents and same opponents. We each say we speak to the benefit of the public.

We --- "trying to keep rates down."

They --- "trying to protect the rights of the injured public."

I can tell you, the industry for the most part is telling you the truth. I, personally, have never knowingly told you anything but the truth as I see it.

"They" (the Bar) likewise is, for the most part, telling you the truth as they see it.

The motives. --Why should we want to keep rates down? We have more gross income if rates go up! It is not serving the profit motive to keep rates down.

They (the Bar) has the motive to make it easier to sue, easier to collect, and to increase the ways for awards to be higher. -- It is true, the easier it is, the higher the awards, the more money they can make --- but by the same token, there are more benefits for the injured person.

So you now are studying medical malpractice again.

> The Bar will say -- "Where is the data" --- .
> The Bar will say -- "It's an insurance manufactured crisis" --- .
> The Bar will say -- "Look at all the investment income" ---.

Well -- as to data -- we will furnish it again -- few have read the reams we've furnished over the past 10 years.

> When you read it, few will understant it --- so it will be easy for you to believe the Bar when they say "it's mysterious" --- "it's meaningless".

However, it should be extremely easy to recognize the state's "Non-Profit" Medical Malpractice Insurance Companies is broke and over $25 million in the hole.

It should be extremely easy to recognize that if all of this "profit" the Trial Bar will talk about is there. Why aren't we all fighting for it? There are over 600 companies. Why are there only two companies in Kansas writing it and they are getting nervous?

And it's not just Kansas. -- Every medical malpractice "non-profit" hospital created over the past 10 years is also broke. -- Arizona paid $18 million just to have a company take over their "non-profit" hospital insurance company.

As to investment income. --- We are using every drop of it -- we make an average of 12% -- and we are subsidizing our rates approximately 20%. --- Look at the surplus of nearly every company in the business -- it's down --- dramatically --- so far down over 113 companies are on the "watch list" for insolvency.

Figures may lie - but what is really happening is there for all to see and it's real.

So real --- reinsurance markets in Europe are telling the industry --- "we are approaching the time when we may withdraw from the American market. -- " Lloyds of London already has in respect to medical malpractice.

CRISIS!!! You bet is it -- and if something isn't done --- you ain't seen nothing yet.

What is it -- The TORT SYSTEM! Period - paragraph. There is merit to peer review -- strict policing of bad doctors, or bad lawyers or bad insurance companies -- but a fix of these things is nothing but a band-aid. --- The broken part -- is the TORT System!

Do away with it?? No -- the insurance industry does not want that! As an individual, I defend the tort system -- and always will -- it's the best system ever devised ... .

But it's broke. --- Legislators across the land have passed laws about human behavior -- drunk driving, helmets, seat belts, smoking --- . All intended to protect the public -- . I think you need to establish statutory rules in the field of civil justice. You've created Statutes of Limitations - You've set limits on wrongful death. You've added the collateral source rule --- I think you must now do a lot more. You've set rules about insurance rates -- you must now address the fee system in TORTS.

And I think time is running out. ---

What would I do? --- I don't know. I'm as perplexed as you, because I do not want the badly injured person to be ignored.

We have to establish ground rules for recovery in civil law suits. Is the system to be one of guaranteed recovery or should you defind the "word negligence" to clearly mean that if there was an injury, there was not necessarily a wrong. He who asserts must prove beyond any reasonable doubt that the defendant violated the standard of his profession as defined by his peers in and around the State of Kansas.

We have to figure out how much -- what is reasonable ... .

We have to study punitive damages again. --- Why are punitive damages assessed at all except as a criminal wrong with the penalty going to the State, not an item carrying a 50% contingent fee.

Society does not understand the system. It's up to you to guide society to save the system.

If I had a magic want -- here is what I would do today:

(1) Abolish punitive damages in respect to civil damages. -- If there is a fuse, it should go to the General Fund. If the Act is bad enough -- put the wrongdoer in jail.

(2) Cap non-pecuniary damages at $500.000. --- Who knows the value of pain?? --- No-one. -- A half million dollars won't take away the pain -- but you can drive to the doctor's office in air-conditioned comfort.

(3) No cap on actual damages -- whatever the jury says --- but it must be in two parts:

    (A) All damages to date.

    (b) Future damages as needed, with the court retaining jurisdiction.

Lifetime medical -- That ain't bad -- but you do have to show you need it.

(C) Attorney fees at the contract price (between attorney and client) on all damages awarded to date of trial -- but none on future medical, or wages -- it's too speculative.

(D) Tighten instructions to the jury, i.e., injury does not mean there was negligence.

(E) Restrict expert witnesses to state and surrounding areas who are in like practice - not just writing books because they can't practice medicine.

(F) Witness fees disclosed to jury.

That's what I'd do if I were you. --- I'm just glad I'm not you.

Respectfully submitted,

Homer Cowan, Vice President
The Western Insurance Companies
Fort Scott, Kansas

A BRIEF OVERVIEW OF

THE PLAN

As Set Forth in K.S.A. 40-3401 et seq.,
Known As THE KANSAS HEALTH CARE
PROVIDERS INSURANCE ACT

Presented to the Kansas Legislature
Interim Study Committee

July 1985

— THE PLAN —

When you think of **The Plan**, think of primary coverage: e.g. 100/300 from July 1, 1976 and 200/600 from July 1, 1984. Think of it as the assigned risk pool for medical malpractice insurance risks that were not acceptable to the private market.

When you think of **The Fund**, think of it as being the Excess Carrier, the mechanism that pays all losses above the primary coverages of 100/300 or 200/600 (1984). — This mechanism afforded unlimited coverage from 1976 to 1984, and three million dollars coverage from July 1, 1984.

The Servicing Carrier for **The Plan** is The Western Casualty and Surety Company of Fort Scott, Kansas. The Western handles policies for **The Plan** just exactly as it would for risks written directly by The Western. All underwriting, policy writing, claims service, safety and engineering services are exactly the same for **The Plan** as it is for its own insureds. The only difference in the policy contract is that a **Plan** policy has an endorsement which states;

> "This policy is issued on behalf of the Kansas Health Care Provider Insurance Availability Plan."

The Western collects the premium and immediately forwards it to Topeka where it is invested by the Health Care Plan Board of Governors. All investment income is therefore credited to The Plan, not The Western.

The Board of Governors are appointed in compliance with statutory requirements. All members serve without compensation, except for reimbursement of out of pocket expense. The Chairman is Mr. James Ketcherside, President of Farmers Alliance of McPherson. Jim has been Chairman since the inception of **The Plan**.

Claims are paid with Western claim drafts, and **The Plan** reimburses The Western. If **The Plan** makes a profit, the profit is transferred upstream to **The Fund**. If **The Plan** operates at a loss, **The Fund** downstreams the loss to **The Plan**.

For **The Plan** ever to make a profit, it must have the base. It was never intended that **The Plan** make a profit. — Idealistically, our goal is to de-populate **The Plan**, so that only the private carriers are handling medical malpractice insurance.

The Plan did make a profit the first two years of its existence. That was because of the "claims-made" policy cut off the pre-existing tail (IBNR - Incurred But Not Reported) claims. As we have testified for years, it takes time for claims to catch up with premium. Therefore, the premiums started out in 1977 in excess of $1,000,000.00, and as **The Plan** de-populated, the premium gradually decreased. The present premium in **The Plan** is too low to ever make a profit.

One claim can equal **The Plan's** present annual premium.

Year	Number of Risks	Total Premium
1976/77	850	$ 736,376.00
1977/78	1,056	1,311,441.00
1978/79	978	1,414,784.00
1979/80	1,030	1,183,156.00
1980/81	898	1,168,717.00
1981/82	596	985,220.00
1982/83	409	902,141.00
1983/84	293	711,301.00

Claims, on the other hand, increased each and every year.

Year	Amount Paid
1976/77	$ 165,700.00
1977/78	426,250.00
1978/79	1,047,550.00
1979/80	1,422,310.00
1980/81	1,717.713.00
1981/82	2,329,379.00
1982/83	3,134,500.00
1983/84	3,774,075.00

Servicing Carrier Fee: The servicing carrier fee for all services is 25% of earned premium. This is a standard percentage used on a countrywide basis. The profit percentage is 5%. The Western did not solicit the role of servicing carrier. In fact, we did not want it. However, we were chosen because we were restricting our writing and therefore would not be making unfair selection of risks. However, our tax structure gave the medical profession a 10% tax break.

In 1976, no-one had operated as a servicing carrier for claims-made policies. Therefore, we were aware that claim activitiy would be less in the early days of the contract than it would have been for the standard "occurrence" type policies. Therefore, as a voluntary move, The Western agreed to "track" actual claim expense and would make voluntary refunds of what would be called excess reimbursement. On a voluntary basis then, The Western made refunds to **The Plan** as follows:

Year	Amount
1976/77	$ 63,735.00
1977/78	69,367.00
1978/79	65,822.00
1979/80	46,012.00
1980/81	35,998.00
1981/82	30,387.00
1982/83	13,842.00
1983/84	None
	$325,163.00

As you see, refunds declined as premium went down and claims activities increased. Today, it is very doubtful that The Western can continue on the present fee structure. — We are not only failing to make the 5% profit allowed in the fee structure, we are probably now subsidizing **The Plan**! We are paying a fee to lose money. At the moment we are working without contract.

The mechanism now in place works extremely well. There is no lost motion whatsoever ... whereas, most similar plans across the country have paid administrators and employees, and still contracts with a carrier to service the business. This legislature is to be complimented upon the structure of **The Plan** and **The Fund**. The only thing wrong is losses now exceed income and will continue to do so.

Respectfully Submitted,

Homer Cowan, Jr. - Vice President
The Western Insurance Companies
on behalf of The Kansas Health Care
Provider Insurance Availability Plan

13.5 PHYSICIAN'S RIGHT TO ELECT TREATMENT TO BE USED

A physician is not bound to use any particular method of treatment or surgery with his patient. If among physicians of ordinary skill and learning more than one method of treatment or surgical operaton is recognized as proper, it is not negligence for a physician in good faith to adopt and use either of such methods of treatment or surgical operation.

Comments: Eckels v. Traverse, 362 P.2d 680 (Okla. 1961); McBride v. Roy, 58 P.2d 886 (Okla. 1936).

INSTRUCTION NO. _____

A physician owes to this patient a duty to exercise that degree of skill and care which is ordinarily exercised under the same or similar circumstances by other physicians of similar training. The mere fact of an undesirable condition or injury does not give rise to any presumption of negligence or breach of duty on the part of the defendant. In order to constitute negligence, the act or failure to act complained of must be shown to be medically unreasonable, that is, the defendant physician must have departed from standards of reasonable medical practice. It is insufficient that other measures were available or that another physician would have acted differently; the actions of the defendant must be such as would not have been committed by any reasonable physician.

In this regard, you are instructed that medicine is not an exact science, and if you find from all the evidence that the defendant made no error, or that an error was made which was reasonable on the part of the defendant in light of that which he knew or should have known, then the defendant was not negligent, and your verdict must be in favor of the defendant physician.

If, on the other hand, you find that the defendant made an error in the diagnosis or treatment of the plaintiff which was medically unreasonable, and if your further find that such error was the proximate cause of injury to the plaintiff, then your verdict should be for the plaintiff.

In judging the defendant's conduct, you may not consider facts which were discovered only at a later time, but only those facts which the defendant knew or reasonably should have known at the time of the diagnosis or treatment complained of.

*

_____
Judge of the District Court

GIVEN _____

REFUSED _____

EXCEPTIONS ALLOWED _____

ktla
suite 300 columbian building
112 west sixth
topeka, kansas 66603
(913) 232-7756

July 2, 1985

TO: Malpractice Legislative Interim Committee.
FROM: Kathleen Sebelius.
RE: Malpractice Climate in Kansas.

1976 Legislation.

- report malpractice claims to Board of Healing Arts.
- limit statute of limitations.
- admit collateral source evidence.
- immunity for reports to Board of Healing Arts.
- provide for periodic payments of judgments.
- mandate continuing education for doctors.
- court approval of all attorney fees.
- establish screening panels.
- establish Health Care Stabilization Fund.
- expand powers of Board of Healing Arts.
- continue malpractice study for 2 years.

Since 1976.

Various definition changes in Fund.
Passage of frivolous lawsuits legislation.

'83 Removal of $10 million cap on Fund.
Restore surcharge.

'84 Raise mandatory primary coverage limits to $200,000.
Allow increased surcharge.
Limit Fund liability to $3 million.
Seal peer review records.

'85 Limit punitive damages to $3 million or 25% of gross income whichever is less.
Admit collateral source evidence in trial.
Sunset in four years.

FACTS.

* Malpractice suits are tiny fraction of litigation:
1983 - 156 filings of 84,756 civil cases (.18%).

* 64% of Kansas doctors have never been sued; 24% have 1 claim (88% of Kansas doctors). 16 doctors responsible for 16% of claims filed and approximately 30-40% of money paid.

7/1-2/85 ATTACHMENT XVII

* Malpractice premiums are less than 1% of total health care, nationally and in Kansas.

* On average, Kansas doctors pay approximately 4% of "after expenses, before taxes" income for malpractice premiums.

* Nationally, top 75 insurance companies collected $7.3 billion in premiums from doctors between 1978-1983 and have paid $1.5 billion in claims.

* In Kansas, Medical Protective has collected $10.6 million in malpractice premiums and paid $4.6 million in losses, between 1979-1983.

* St. Paul insurance collected $15.6 million in premiums and have paid $7.3 million in claims (1979-1983).

* 65% of Kansas doctors with St. Paul coverage pay $7,000 or less for malpractice insurance.

* 75% of Medical Protective Kansas doctors pay less than $3,400 in premiums.

* 2,000 Kansas doctors in Classes I-IV, with premiums below $7,000.

KGS:jlc

KANSAS TRIAL LAWYERS PROPOSALS

I. We propose that doctors who repeatedly commit acts of malpractice pay higher rated premiums.

II. We oppose frivolous lawsuits and support the use of the provisions of K.S.A. 60-2007 and the discovery rules mandated by the Kansas Supreme Court in Nelson v. Miller.

III. We oppose unreasonable and excessive attorney fees and remind the Legislature of the judicial regulation mandated in malpractice cases by K.S.A. 7-121b.

IV. We propose that immediate data be gathered and analyzed to determine the justification for the malpractice rates charged to Kansas doctors and other health care providers. If the rates cannot be justified, the Legislature should award rebates.

V. We propose offering qualified immunity to doctors who are willing to offer testimony at hospital hearings or before the Board of Healing Arts on acts of malpractice.

VI. We propose that the Kansas Board of Healing Arts be given access to pertinent data on acts of malpractice and consider instituting an automatic review of cases resulting in settlements or verdicts over $100,000 and any doctor with more than 2 malpractice claims in a two-year period.

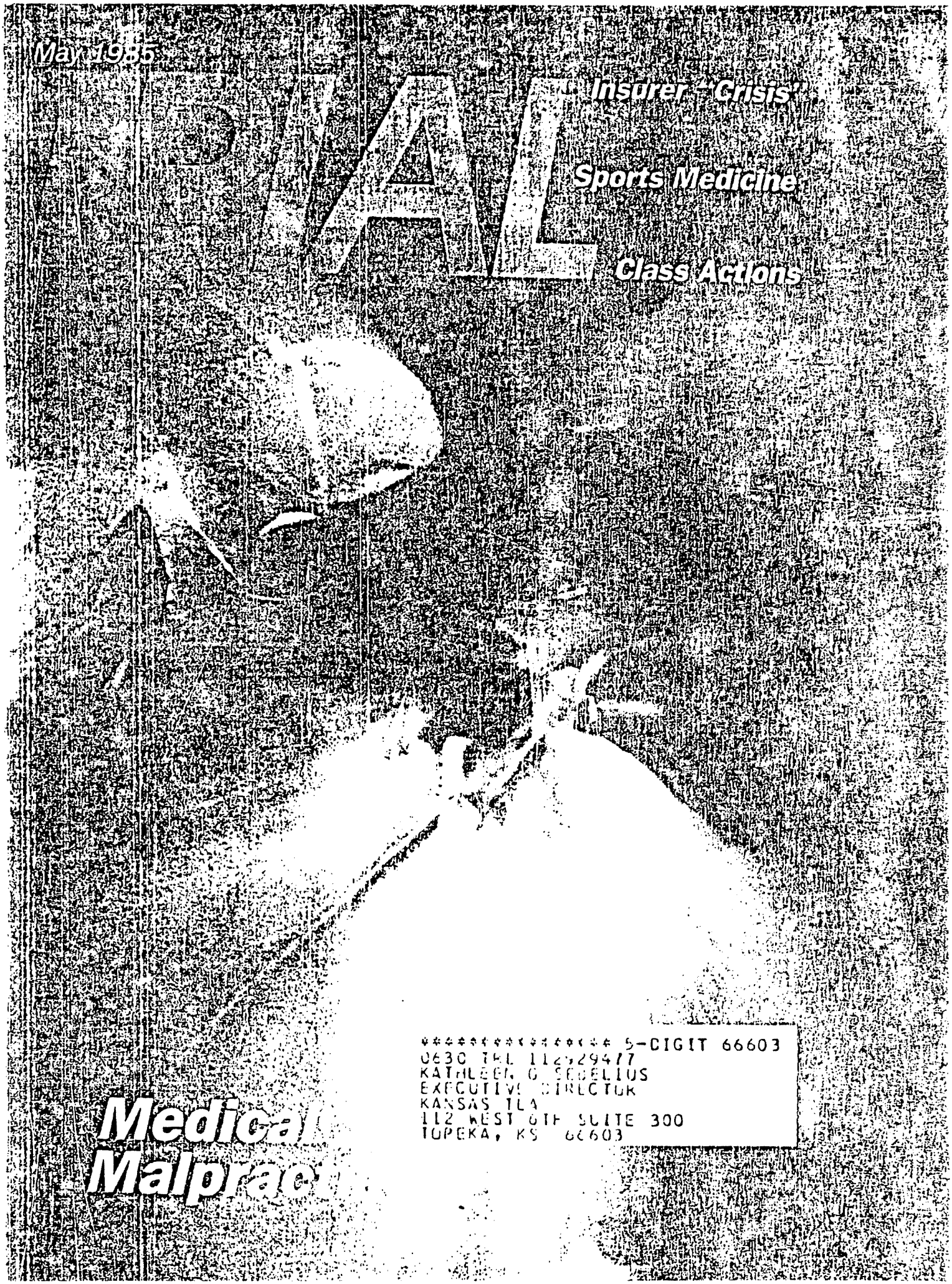
May 1985

TRIAL

Insurer "Crisis"

Sports Medicine

Class Actions



Medical Malprac

The Medical Malpractice "Crisis"

Underwriting Losses and Windfall Profits

Thomas F. Londrigan

This article examines how the insurance industry has profited through exemption from federal antitrust laws and the lack of effective state regulation of rates.

The article explores the present malpractice "crisis" and suggests alternatives to "emergency" legislation designed to take away the rights of individuals. The solution suggested is not in the legislative assemblies but in the courts, which are uniquely equipped to search for the truth and to require an accounting from an industry that has created crisis after crisis.

The article highlights [illegible] cases, one in Illinois and one in California, that [illegible] achieved [illegible] as a result. The article compares [illegible] and suggests that these cases are only the beginning of a new battle.

MEDICAL
PRACTICE
CRISIS

Since 1945 the insurance industry has enjoyed a unique immunity from federal antitrust laws.[1] The exemption was recently given a broad interpretation by the United States Court of Appeals for the District of Columbia in *Proctor v. State Farm Mutual Automobile Insurance Co.*[2] In a dissent, Judge J. Skelly Wright pointed out the dangerous implication in such a broad exemption.

> The majority's conception of the business of insurance has pernicious implications. As long as a factor is "*directly* related to the calculation of premiums" [emphasis in original], insurers can conspire to affect it. . . . In short, under the guise of the 'business of insurance,' the majority would allow insurance companies to reach price-fixing agreements on an endless array of factors that affect the magnitude of the payments that insurers must make. Such an approach amounts to a stark departure from the narrow limits of the business of insurance exemption.[3]

The exemption was premised on the existence of effective state regulation of ratemaking. State statutes originally required prior approval of new liability insurance rates by departments of insurance. Because of changes in state laws and budgetary constraints, most states no longer require prior approval.

In the malpractice "crisis" of 1975, major liability carriers like St. Paul and Aetna stopped writing medical malpractice insurance in many states, but continued to write policies in others. This selective withdrawal allocated the medical malpractice market and eliminated competition among insurers. In the absence of both national antitrust regulation and effective state rate regulation, medical malpractice rates rose dramatically. The same thing occurred in other insurance markets, such as workers' compensation and product liability.

Thomas F. Londrigan, a partner in the firm of Londrigan, Potter & Randle, P.C., in Springfield, Illinois, specializes in civil trial and appellate practice. He has served as chairman of the Civil Practice and Procedure Council of the Illinois State Bar Association and as chairman of the Uniform Circuit Court Rules Committee. He is immediate past president of the Illinois Trial Lawyers Association.

California

In California, Dr. Edward Zalta, president of the Los Angeles Medical Society, took on the Travelers Insurance Companies with the aid of attorney William Shernoff, then president of the California Trial Lawyers Association. *Medical Economics* featured Dr. Zalta and his courageous efforts on July 20, 1981.

> In 1976, Travelers demanded a 486 percent rate increase to cover the market losses it expected in future years.
>
> "We felt helpless," Zalta recalls. "Travelers was the only carrier in the field, and there was no place anywhere else to turn. The crisis atmosphere continued through 1976 and into '77 and '78. Headlines across the nation frequently depicted Southern California as a [illegible] of malpractice.
>
> "Actually," [illegible] Zalta, "that wasn't true at all. [illegible] '76, '77, and '78, Travelers made enormous profits on its contract with SOCAP."[4]

Southern California Physicians Council (SOCAP) demanded return of the excess premiums due under their contract, which had established a rate stabilization fund. Travelers first resisted the claim and later suggested a delayed payout of $36 million over 10 years. The doctors refused.

> "That may sound like a good deal," Zalta comments, "[illegible]. There was to be no interest paid on premiums held, and [illegible] on the excess profits made by Travelers. They had collected over $31 [illegible] less than 2[illegible] [illegible] had cost [illegible] [illegible]"
>
> When suit was [illegible] Travelers' response was [illegible] included a demand for $1 [illegible] in punitive damages [illegible] Travelers reacted, as Zalta expresses it, 'as though they'd been goosed. They virtually leaped across the country to Los Angeles and diligently resumed negotiations with us.'"[4]
>
> The suit resulted in a $50-million return of premiums to SOCAP. Shernoff and Travelers differed on the implications of the suit.
>
> Can more refunds be expected around the country? No, Travelers maintains: the rate-stabilization fund was unique to the two groups of California doctors. Attorney Shernoff, however, sees broader implications. "The SOCAP case marks the first time a medical-malpractice insurance company has acknowledged overcharges and been forced to refund them. I think it's very possible that other actions will follow."[5]

Illinois

In 1981, Illinois employers brought an action challenging a 23.8 percent rate increase that created a workers' compensation "crisis." The result was dramatic: More than $1 billion in excessive premiums were determined to be due to Illinois employers because of excessive rates. In deciding the case, Judge James C. Murray quoted the Massachusetts Supreme Court: "The Commissioner [of Insurance] said that the traditional actuarial procedures can be defined as a mixture of fact, estimate and fiction. And, as will be seen, it is the element of fiction that is the cause for my greatest concern."[6]

This case was settled while on appeal. Therefore, there is no reported reviewing court decision, although briefs of the parties on file with the Illinois Supreme Court show that the state Department of Insurance had acknowledged that an insurer might be motivated to inflate losses in the absence of effective auditing and regulation.[6]

Insurer or Court-Created Crises?

In the absence of effective rate regulation, the industry has selectively socked it to employers, manufacturers, and professionals in the form of unprecedented increases in premiums. The mid seventies saw a workers' compensation "crisis," a product liability "crisis," and a medical malprac-

tice "crisis." The explanation the industry gave was that its giant premium increases were caused by the court system. The industry told insureds to demand immediate "crisis" legislation to reform the tort system.

In medical malpractice, the impact was immediate.

> In 1975 medical malpractice problems reached crisis proportions in many states. . . . As a result, 52 states and territories passed remedial legislation in a two-year period beginning in 1975 and ending in 1976. It is difficult to recall a problem in the history of the United States which generated more state legislation in such a short period of time.[10]

This rash of hastily drafted legislation resulted in a favorable climate to defend medical malpractice actions. According to a study conducted by the National Association of Insurance Commissioners, medical malpractice claims litigated during the three-and-a-half years after 1975 resulted in defense verdicts in 81 percent of the cases.[11] Obviously doctors are *not* being taken advantage of by the justice system.

Responsible medical publications admit that the news media have exaggerated the problem. "Whopping Settlements Are a Rarity," *Medical Economics for Surgeons* states:

> Judging by newspaper headlines, you'd think that most malpractice plaintiffs walk away with huge payments. But our survey doesn't bear that out. The median settlement before trial is $9,050. The median settlement during trial is $13,350. In fact, of 819 survey respondents who've had at least one lawsuit, only 28 have ever had to pay out $100,000 or more as the result of a settlement or court award.[12]

Doctor-Insurers

In recent years, doctors have entered the area of insurance in a big way. In many states, doctor-owned mutuals and reciprocals now collect the premiums and lay off a portion of the risk to the rest of the industry through reinsurance treaties. Although doctor-insurers are a minority of the profession, they nevertheless dictate policy and distort the perception of other doctors about the cause of the medical malpractice "crisis."

Doctor-insurers are presently orchestrating another "crisis" in each state. The message is the same: *elimination of the present tort system.* In fact, this was the avowed intention of the Medical Liability Mutual Insurance Company of New York when it was organized in 1975-1976.

> It was unanimously felt that creation of such a company would in no way solve the Professional Liability problem and that the lack of coverage at reasonable rates was not the fault of the insurance industry but rather was the fault of the entire system. It was felt, however, that creation of a company operated by physicians for physicians and closely answerable to the policy holders would remove any lingering doubt about where the illness for the very high premiums lay.
>
> . . . .
>
> *"The eventual solution of this problem will require a total change of the current system of liability."*[13]

In the absence of effective rate regulation, the industry has selectively socked it to employers, manufacturers, and professionals in the form of unprecedented increases in premiums.

In Illinois the doctor insurers recently announced another crisis because of an "unexplained explosion" of suits: "The crisis of the early 70's and its modest decline has now risen to an unexplained explosion of suits in the early 80's so that *we are now ascending to a momentous crisis.*"[14] The "unexplained explosion" is actually a planned explosion in insurance rates used as a rallying point to "reform" the tort system through emergency legislation. Similar "crisis" legislative agendas have been announced by doctor-insurers in other states throughout the country.[15]

Underwriting "Losses" and Investment Income

Underwriting losses have nothing to do with whether an insurance business is profitable. "Projected" underwriting losses for future years are an even more distorted means of determining the profitability of an insurance line like medical malpractice.

Underwriting profit or loss compares the number of dollars received in premiums in a single year to the number of dollars *predicted* to be paid out in future years. This "loss" is not real, although it is continually presented as real to state legislatures and the media.

What the public does not realize is that insurance companies are in the business to invest and profit from the use of other people's money, much as are banks and other investment institutions.[16] However, liability carriers never account for the use of the insureds' money except in terms of *underwriting* profit or loss. A line of insurance can be portrayed as unprofitable simply by inflating the projection for future claims to show an "underwriting loss." This has two desirable effects: First, it avoids payment of income tax; second, it demonstrates a need to increase premiums.

In those few states where prior approval of rates is still required, state departments of insurance have ignored investment income in determining whether liability rates are excessive. However, the Investment Interest Task Force of the National Association of Insurance Commissioners (NAIC) is finally looking into investment income. An NAIC Task Force report concludes that investment income insures reasonable profits in all lines of insurance despite "underwriting losses."[17]

With the high inflation and high interest rates of the early 1980s, the importance of investment income became obvious. A claim reserved in 1977 but not paid for until 1985 generates investment income equal to the value of the claim.[18] Because of inflation, older claims are also paid with tomorrow's cheaper dollars. These economic realities began to dictate claims policy in all lines of insurance in recent years, but nowhere was it

[illegible] evident than in the [illegible] practice where insurance [illegible] the largest and [illegible] [illegible] [illegible] interest.

The NAIC Closed Claim Study for 1975 through 1978 [illegible] the industry [illegible] [illegible] was terminated.[20] The same study, however, was the basis for a more recent analysis of the problem by an Advisory Task Force for the American Academy of Orthopaedic Surgeons.[21] From the findings of these two studies, a definitive claims policy emerges: more time from claim to disposition, therefore reserves retained longer, particularly on the larger and more severe claims.[22]

This same policy also justifies more being spent for defense to protect the investment income earned on unpaid claims. In fact, the Orthopaedic Surgeons Study concludes that the increase in the cost of defense far exceeds the increase in indemnity payments. "The average defense cost and other allocated expense increased even more than the average indemnity [illegible], and expense costs increased disproportionately with the larger cases."[23] During this same period, investment income compounded year after year throughout the United States, totally disproportionate to claims paid.

When doctor insurers met in Chicago in 1983 to plan another "momentous crisis," they instructed their members and selected defense attorneys to use any tactic necessary to delay payment of claims. "Dissuade plaintiff's attorneys to target their cases by delaying as long as possible by whatever tactics since the longer the case persists the more [illegible] the plaintiff's attorney needs to absorb the cost himself."[24]

The same group of doctor insurers take credit for defeating prejudgment interest legislation in Illinois. Prejudgment interest is designed to encourage early settlement by eliminating the incentive of investment income to delay payment of [illegible]

"Accepted Insurance Accounting"

The economic incentive to inflate estimates of future claims is enormous. This fact has been recognized in congressional studies [illegible] [illegible] industry's method of [illegible] [illegible] future claims in product liability as subjective and a principal cause of the product liability "crisis."[25] In Illinois, legislative studies have also concluded that there was no evidence that there was a "crisis" in product liability other than unexplained increases in premiums.[26]

In no state is the practice of over-reserving for future claims more apparent than in New York. For example, in the 1982 rate analysis of the Medical Liability Mutual Insurance Company of New York, the MLMI complained it would collect only $170 million in premiums under 1981 rates; this was in addition to $216.6 million of investment income. However, the MLMI claimed future "losses" of $520.6 million. This is ludicrous.

Between July 1975 and December 1978, the total indemnity paid by *all* medical malpractice insurers to *all* claimants in the entire United States was only $521.4 million.[27] The same 1982 MLMI rate analysis shows that the total of all claims paid during the seven years from its inception in 1975 is only $99 million. Based on this grotesque actuarial projection of future "losses," the MLMI concluded it needed more than $223 million in additional premium income.[28]

In 1983, the MLMI proposed an astounding 170 percent increase in premiums, thereby creating another "crisis" calling for immediate legislative reform of the legal system. However, in response to entry into the market of a competing group of doctor-insurers, the MLMI reduced premiums 25 percent. In January of 1984 the New York press reported:

> Only last year, the Medical Liability asked the state Department of Insurance for a 170 percent rate increase. The company, which writes 85 percent of the malpractice policies in the state, was granted a 52 percent increase.
>
> "They said they needed that (52 percent) to cover rising costs and less than a year later, they turn around with a 25 percent decrease. That's a 77 percent swing in one year," noted Mark Thomas, spokesman for Sen. Tarky Lombardi, R-Syracuse, chairman of the Senate Health Committee.[29]

This arbitrary increase in rates is also the practice in other states. Between 1978 and 1983, the Illinois State Medical Inter-Insurance Exchange

(ISMIE) collected from Illinois doctors premiums of $250,110,552—more than a quarter of a billion dollars! During the same years, total claims paid amounted to just over $42 million. The 1983 investment income of the ISMIE was $36,856,436. This was an increase of almost $10 million in investment income from the previous year. In both years, investment income far exceeded the total amount of claims paid.[30] In other words, Illinois doctors could have paid all claims from only their investment income without collecting a penny in premiums. Yet in June of 1983, both Medical Protective Company and the ISMIE announced another giant increase in rates. Another "crisis" was created by doctor-insurers that they claim was caused by lawyers, judges, and the legal system.

From 1981 to 1983, hard assets of the ISMIE increased more than $104 million, from $266 million to $370 million. Medical Protective Company of Indiana, a national insurer writing only medical malpractice insurance for doctors, saw its assets increase more than $55 million in 1982 alone, from $439,303,382 to $494,940,915.[31] Yet at the same time, both insurers claimed "underwriting losses" to justify 1983 rate increases.

These "losses" are based on future projected claims, most of which have not yet been reported, much less paid. In addition to reported claims, the liability carriers list Incurred But Not Reported (IBNR) claims. These have not only not been paid—they have never been reported. For instance, the ISMIE 1982 Annual Report predicted future "losses" at $385,270,962; of that figure $193,829,088 was IBNR (incurred but not reported) losses. In its eight years of existence, the largest amount of dollar claims was paid in 1983: only $28,140,508, more than $8 million less than its investment income for the same year.

This "accepted insurance accounting" for reporting "losses" resulted in more than $5 million being claimed as Federal Income Tax Recoverable by the ISMIE in its 1982 Annual Statement filed with the Illinois Department of Insurance. This "accepted insurance accounting" has been repeatedly used to shield investment income under the nebulous umbrella of future IBNR claims. This "accepted insurance accounting" paints an artificially bleak financial picture to justify "crisis" legislation designed to eliminate the tort system.

Remedies

There is no question why insurance companies inflate their reserves in selected lines such as medical malpractice and product liability; the issue is how to combat the practice. The bench and bar must be alerted that the courts are being unjustly charged with creating repeated public crises. These crises are used to panic the public to support immediate reform of the tort system through emergency legislation. To prevent a stampede toward crisis legislation, both the legislative and judicial branches of the state governments must conduct in-depth analyses of insurance accounting and reporting.

Legislative Remedies. It is doubtful

that Congress will amend antitrust laws to eliminate the insurance exemption; therefore, the specter of either criminal prosecution or civil treble damages will remain only a phantom deterrent. Perhaps the greatest chance of intervention by the federal government will come from the staggering national deficit and the desire of the Internal Revenue Service to tap another source of revenue.

On the state level, some states have recently enacted common-sense insurance reporting statutes. The Louisiana statute[32] allows policyholders and legislators to compare investment income and premiums collected with claims paid. Other states have led the way in adopting prejudgment interest as a way to remove the incentive for delaying claim settlement in order to maximize investment income.[33]

Once the practice is exposed, legislative reform will follow. If the public is not educated, however, the forthcoming insurance "crisis" will again result in regressive emergency legislation aimed at the wrong target.

Judicial Remedies. The most conclusive inquiry into insurance profiteering should come from innovative litigation like the cases in Illinois and California. Skilled advocates of the common law, aided by actuaries, can first discover and then prove the misuse of premium dollars and the significant impact of investment income on claim policy and court backlog. There must be a judicial determination that premiums and the investment income they return are not being used to pay claims and that the huge reserves for payment of future claims are eventually written off at great profit to the insurer. Informed commentators predicted this in 1976 during the first malpractice "crisis."[34]

When the prediction became reality, former ATLA President Ted Koskoff commented—

> The IRS has testified before Congress and if there is one fact that is eminently clear it is that the IRS has been unable to prevent insurance companies from maintaining excessive loss reserves. Aetna and St. Paul alone have reduced their estimates of incurred losses for the years 1975 and 1976 by almost 500 million in Medical Malpractice alone.[35]

In September 1983, a more intricate …at common practice used by insurers

to pocket the profit from excessive medical malpractice premiums was disclosed to the public. Certainly the best evidence of value has always been a recent transaction between a willing buyer and willing seller. Just such a transaction was reported by the *Wall Street Journal*.

> How does an insurer sell losses? Generally, it involves paying another insurer now for its promise to pay certain claims in the future. Aetna, for example, passed the liability for an estimated $80 million of unpaid medical-malpractice insurance claims to Fireman's Fund Insurance Cos., a unit of American Express Co. In return for agreeing to eventually pay those claims, Fireman's Fund got $22 million from Aetna.
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> Aetna "saves" $58 million—the difference between the estimated $80 million in claims and the $22 million Aetna paid to rid itself of the claims—which its accountants say becomes part of Aetna's earnings and can be considered taxable income this year.[36]

Any time an insurer "takes down" or reduces its reserves on inflated future claims or disposes of them for their true present value, it must account for and pay taxes on the profit it has hidden over the years. Good business? You bet it is. The same *Wall Street Journal* article also recognizes this segment of the insurance market to be in great demand.[37]

Hundreds of millions of dollars in excessive premiums have been extracted by the insurance industry in the last 10 years from the medical profession alone. These unregulated and unjustified profits were assessed at the public's expense and should be disgorged. Only then can the judicial system put an end to this "crisis," instead of silently bearing the blame for its creation. ■

Notes

1. 15 U.S.C.A. § 1012(b) (West 1976).
2. 675 F.2d 308 (D.C. Cir. 1982).
3. *Id.* at 343.
4. Carlova, *How Doctors Forced a Malpractice Carrier to Refund $50 Million*, MEDICAL ECONOMICS, July 20, 1981, at 171, 172.
5. *Id.* at 172-73.
6. *Id.* at 175.
7. *Id.* at 175-76.
8. Liberty Mut. Ins. Co. v. Commissioner of Ins., 313 N.E.2d 897, 900 (Mass. 1974).
9. "The reasons for auditing the data used in a rate filing go beyond the mere need to correct inadvertent errors. With hundreds of millions of dollars annually at stake, there is an inducement for companies to inflate losses and expenses artificially or to decrease premium income reported." Coordinating Comm. of Mechanical Specialty Contractors Ass'n, v. Philip R. O'Connor, Acting Director of Ins., No. 55456 (Ill.) (brief of plaintiff-appellees)
10. NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC), MALPRACTICE CLAIMS, MEDICAL MALPRACTICE CLOSED CLAIMS 1975-1978 3 (Sept. 1980). *See generally*, Fegan, *The Medical Malpractice Statute of Limitations: The Severance of the Long Tail of Liability*, 70 ILL. BAR J. 114 (1981); Rathman, *The Illinois Medical Malpractice Acts: Response to Crisis*, 65 ILL. BAR J. 216 (1977).
11. NAIC, *supra* note 10, at 70.
12. Goldberg, *Which Surgeons Are the Biggest Malpractice Targets?* MEDICAL ECONOMICS FOR SURGEONS, August 1982, at 40.
13. ADVISORY TASK FORCE, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS, PROFESSIONAL LIABILITY UPDATE 40, 43 (1982) (emphasis added).
14. Ad Hoc Committee on Issues, Chicago Surgical Society, Report of April 15, 1983, at 1 (emphasis added).
15. In 1985 to date, medical malpractice "reform" legislation has been introduced or proposed in the following states: Arizona, Colorado, Florida, Georgia, Hawaii, Illinois, Kansas, Maine, Massachusetts, Mississippi, Missouri, Nevada, New York, Oklahoma, Oregon, Tennessee, Utah, Virginia, Washington, and West Virginia. Interview with Thomas G. Goddard, Public Affairs Department, AMA, Feb. 27, 1985.
16. A. TOBIAS, THE INVISIBLE BANKERS 67 (1982).
17. Losses from underwriting may well be anticipated at the time the insurance is priced. "Cash flow" underwriting, as it is known, is based on the availability of investment income to offset underwriting losses anticipated and still provide a reasonable operating profit. BEST'S INSURANCE MANAGEMENT REPORTS, NAIC TASK FORCE REPORT ON THE ROLE OF INVESTMENT INCOME IN PROPERTY CASUALTY RATE MAKING 2 (Jan. 26, 1984).
18. Standard interest tables calculate that a sum of money compounded at 10 percent interest will double in 7 years; and will do so at 15 percent in 4.65 years. The converse is a reason doctor-insurers oppose prejudgment interest. "ISMS calculated that a 10 percent interest rate compounded annually would double the award during the several years it often takes to litigate a claim." Illinois State Medical Society (ISMS), ISMS Action Report, June 3, 1983, at 1.
19. "When the study resumed in July 1977, it was planned to continue through June 1980 claim closures, however, lack of adequate funding forced a premature discontinuation. This book represents the final statistical collection." NAIC, *supra* note 10, Foreword.
20. ADVISORY TASK FORCE, *supra* note 13.
21. *Id.* at 1-3.
22. *Id.* at 2.
23. Ad Hoc Committee on Issues, *supra* note 14, at 2.
24. ISMS, *supra* note 18.
25. H.R. REP. No. 97-190, 97th Cong. 1st Sess. 4-5 (1981).
26. *See* Houlihan, *Limitations of Action: Strict Liability in Tort—The Legislature Has Intervened*, 97 ILL. B.J. 214, 215 (1978).
27. NAIC, *supra* note 10, at 5-6.
28. ADVISORY TASK FORCE, *supra* note 13, at 46.
29. Flateau, *Medical Insurer Discount Decried*, Oneonta (N.Y.) Daily Star, Jan. 28, 1984.
30. ILLINOIS STATE MEDICAL INSURANCE EXCHANGE, 1982 & 1983 ANNUAL STATEMENTS.
31. MEDICAL PROTECTIVE INSURANCE CO., 1983 ANNUAL STATEMENT.
32. LA. REV. STAT. ANN. § 22:1451.2.
33. The states are Alabama, Alaska, California, Hawaii, Iowa, Louisiana, Maine, Michigan, New Hampshire, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, Utah, and Wisconsin.
34. *The Malpractice Insurance Story: Doctor, Lawyer, Insurance Thief*, DOLLARS AND SENSE: A MONTHLY BULLETIN OF ECONOMIC AFFAIRS, September 1976, at 5.
35. Koskoff, *Forum*, TRIAL, June 1980 at 16, 18.
36. Herzberg, *Insurers' Move to Lift Profits Is Questioned*, Wall St. J., Sept. 7, 1983.
37. The article went on to say:

> Only a few insurance companies acknowledge selling loss reserves, including Aetna and Reinsurance Corp. of New York, a unit of Piedmont Management Co. But many insurance executives say that loss-reserve selling is on the rise, prompted by pressure to improve earnings. "There seems to be an enormous demand" for these transactions, says Jay A. Novik, a vice president of North American Reinsurance Corp., a unit of Swiss Re Group . . . .
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> So far, few insurers are telling stockholders they are selling loss reserves. But several reinsurance companies, including General Re Corp., North American Reinsurance, ITT Corp.'s New England Reinsurance and American International Group, say they are buying loss reserves. They won't name the sellers. Myron Picoult, an Oppenheimer & Co. analyst, says that loss-reserve selling by insurers appears to be "much more extensive than most of us realized." Evidence of the sales is often buried in financial statements that insurers file once a year with state regulators. *Id.*

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PUBLIC AFFAIRS DEPARTMENT

State Legislative Bulletin

REQUEST FOR INFORMATION: IS THERE A LEGAL MALPRACTICE CRISIS?

ATLA is receiving some indication that trial lawyers in various parts of the country are facing a lack of availability and/or sharply rising premiums of legal malpractice insurance. We would very much appreciate any information about this situation that our readers could provide us.

WASHINGTON STATE PASSES INSURANCE REPORTING ACT

The Washington State Legislature approved a comprehensive medical malpractice insurance reporting act, signed by Governor Gardner on May 10. The bill, modeled after a bill drafted by former ATLA Executive Director C. Thomas Bendorf, is designed to provide policy-makers with information on frequency and severity of claims, and investment income on a state-by-state basis. The bill requires insurers to provide such information from 1975 forward. The Washington State Trial Lawyers Association has advocated passage of the bill for the last four years as a means of acquiring the necessary information to demonstrate that the so-called insurance "crisis" of recent years in medical malpractice is, in fact, a creation of the insurance industry.

MEDICAL MALPRACTICE

Although April and early May were quite busy with respect to medical malpractice legislation, only four state legislatures approved such legislation to bring the total number of states approving restrictive medical malpractice legislation in 1985 to six. By signing SB 110, Kansas Governor Carlin made Kansas the third state to approve medical malpractice legislation this year (Georgia and Utah were reported in the last State Legislative Bulletin).

1050 31st Street, N.W., Washington, D.C. 20007 (202) 965-3500

Although the bill started out as a very long wish list for the Kansas Medical Society, it passed in a very different form: (1) punitive damages in all tort cases are limited to $3,000,000 or 25% of the defendant's gross income, and (2) the collateral source rule is abolished in medical malpractice cases. One interesting highlight is that the bill includes a four-year sunset provision.

On May 30, the Florida Legislature approved a 100-page bill which is virtually certain to be signed by Governor Graham. The only portions of the bill to which the Academy of Florida Trial Lawyers seriously object are: (1) structuring of awards for future damages in excess of $500,000 and (2) a "sliding scale" contingent fee limitation. The rest of the bill imposes strict requirements upon health care providers and their insurers to promptly report possible cases of malpractice and to provide more complete information with regard to closed claims. There are also a variety of provisions intended to strengthen malpractice risk management. The injustice of the structured awards provision is ameliorated by the fact that it leaves a great deal of discretion with the trial judge as to the rate of payment. Likewise, the contingent fee restriction contains a provision which provides for the elimination of legislative controls upon any action on the subject by the Florida Supreme Court. The Court is currently considering the issue.

The New Hampshire General Court has approved two measures establishing interim study committees which are to study two possible areas of medical malpractice legislation: statute of limitations and abolition of the ad damnum clause.

On May 31, the Connecticut General Assembly approved HB 5364 (File # 753) which abolishes the collateral source rule in all tort and contract cases for those benefits for which no right of subrogation exists. The bill, drafted by the Connecticut State Medical Society, mandates reduction of any award by the amount of such collateral sources, less any premiums paid in connection with such sources. The Assembly also approved a bill to set up a study committee to review medical malpractice and health care costs.

Nine states legislatures are still considering restrictive malpractice legislation: Illinois, Maine, Massachusetts, Michigan, New Jersey, New York, North Carolina, Pennsylvania, and Rhode Island. Of these, the most likely state to next approve medical malpractice legislation is Illinois, where a compromise package has passed the House Judiciary Committee and is expected ultimately to be approved by both houses and the Governor, probably before July 1. The measure would, among other things:

1) provide for a structured pay-out of all future medical damages over $250,000;
2) modify the collateral source rule to allow a 100% deduction of collateral benefits not subject to subrogation, not to exceed 50% of the verdict;
3) establish a mandatory screening panel, the conclusions of which would not be admissible at trial, with a provision to assure that the panel acts promptly and a provision that a party that loses on the issue of liability before both the panel and the jury must pay costs and fees to the prevailing party);
4) require a certificate of meritorious claim as a prerequisite to filing a medical malpractice lawsuit;
5) allow a physician to file an affidavit of non-involvement;
6) modify the rules regarding expert witnesses;
7) abolish punitive damages;
8) establish a right to countersue;
9) limit attorneys fees to 33-1/3% of the first $150,000, 25% of the next $850,000, and 20% of damages over $1,000,000;
10) provide for improved reporting of medical malpractice insurance data;
11) establish immunity for persons appearing before a peer review committee; and
12) give increased power and funding to medical disciplinary boards to investigate and discipline incompetent doctors.

In New York, Governor Cuomo released his long-awaited medical malpractice proposal, a multi-faceted bill which, as expected, drew criticism from both doctors and lawyers. Key provisions of the proposal, introduced on April 16 as A.7367 and S.5191, include:

1) the abolition of the collateral source rule with respect to future damages;
2) mandatory periodic payments of future damages;
3) the imposition of costs and fees for the bringing of "frivolous lawsuits";
4) a "sliding scale" contingent fee system;
5) several provisions broadening and strengthening malpractice reporting requirements;
6) hospital malpractice arbitration panels;
7) mandatory pre-trial conferences and disclosure of expert witnesses; and
8) a requirement that, should a physician surrender his/her license in another state during the pendency of disciplinary proceedings, such surrender would constitute grounds for a New York disciplinary action.

The bill is given a much better chance of passage than the more restrictive bill which passed the Senate in March.

The **North Carolina** General Assembly is currently considering a proposal to establish a hearing panel for the administration of certain vaccine-related personal injury cases. That body is also considering a measure to establish a medical malpractice study commission.

The **Massachusetts** General Court (that state's legislature) is currently considering a large number of bills including virtually every type of restrictive malpractice proposal yet encountered, including a no-fault proposal, a shortened statute of limitations, panels, caps on damages and fees, and structured awards. Similar legislation is pending in **Michigan**, Maine, **New** Jersey, and **Pennsylvania.**

The **Oregon** Legislative Assembly, in its last week of the 1985 session, is still considering the "Omnibus Tort Reform" bill, as well as the two remaining bills of a group of malpractice bills introduced in the Senate this year. The across-the-board tort reform bill would: limit non-economic damages to $100,000, limit loss of consortium to actual monetary value, limit punitive damages to situations in which actual intent to do grave bodily harm is proven, abolish the collateral source rule, limit attorneys fees under a "sliding-scale" provision, and limit a survivor's damages for the decedent's pain and suffering and for the loss of society to $100,000. The bill seems unlikely to pass in light of a recent hearing at which opponents of the bill testified extensively. SB 550, requiring that a prima facie case of conduct justifying an award of punitive damages be made before evidence of the defendant's income be

admitted as evidence, has passed the Senate but is languishing in the House Judiciary Committee. SB 547, providing that the filing of a medical malpractice action constitute a waiver of the physician-patient privilege, also seems likely to die in that committee. The remainder of the Oregon Medical Society's proposals have been killed in the Senate, proposals which would have limited general damages to $100,000, capped contingent fees, and abolished the collateral source rule.

The Ohio Medical Society recently revealed that it will propose a package of malpractice bills this year, probably in September.

The news for health care consumers has not, however, been all bleak this year. 26 state legislatures have adjourned without approving restrictive medical malpractice legislation (although some of the following states have established interim study committees): **Alabama** (May 20), **Alaska** (May 12), **Arizona** (May 8), **Arkansas** (March 22), **Colorado** (May 26), **Hawaii** (April 22), **Idaho** (March 13), **Indiana** (April 5), **Iowa** (May 4), **Maryland** (April 8), **Minnesota** (May 20), **Mississippi** (April 11), **Missouri** (June 15), **Montana** (April 25), **Nebraska** (June 5), **Nevada** (June 4), **New Mexico** (March 16), **North Dakota** (April 16), **South Carolina** (June 6), **South Dakota** (March 14), **Tennessee** (May 23), **Texas** (May 27), **Vermont** (May 11), **Virginia** (February 23), **West Virginia** (April 6), and **Wyoming** (February 23).

Many of those states considered and rejected some very seriously restrictive proposals. The **Colorado** General Assembly defeated two major medical society proposals this year: (1) a measure immunizing doctors from liability for a decision not to perform further tests or procedures when they get a second opinion regarding that decision, and (2) a bill limiting punitive damages in all tort cases to the amount of compensatory damages, and dividing such damages between the plaintiff and the Crime Victims Compensation Fund. The **Missouri** Senate had a two-hour debate on a bill which would have capped non-economic damages at $350,000 and would have mandated periodic payments of future medical damages over $50,000, but in the end removed the bill from the active calendar.

A variety of proposals, from limitations on contingent fees to the abolition of the collateral source rule were rejected by the **Nevada** Legislature. The **Tennessee** General Assembly refused to approve a package of bills which would have, among other things, capped pain and suffering awards at $50,000, mandated structured payment of damages for future medical payments, and modified the rules under which expert witnesses may testify.

The **Washington** Legislature killed an across-the-board

tort proposal which would have abolished the collateral source rule and mandated periodic payments, among other things.

COMPARATIVE NEGLIGENCE AND JOINT AND SEVERAL LIABILITY

The closely related issues of comparative negligence and joint and several liability continue to be common subjects of state legislation this year. However, with the continuing spread of the abolition of contributory negligence, the issues has shifted away from "to compare, or not to compare" toward "now that we compare, how do we do it?"

The majority of the 45 states which have adopted comparative negligence has also retained joint and several liability (only **Alabama, Maryland, North Carolina, Tennessee and Virginia** have kept the doctrine of contributory negligence). However, some state legislatures have chosen to limit joint and several liability's traditional applications. In **Oklahoma**, joint and several liability applies only in those cases in which the plaintiff is not at fault. **Iowa, Nevada, Oregon,** and **Texas**, apply the doctrine to defendants only if their negligence is greater than the plaintiff's. Joint and several liability is not recognized in **Kansas, New Hampshire, New Mexico** and **Vermont.**

The bulk of the proposed legislation in this area in 1985 would either modify comparative negligence (generally from the "pure" form to the "51%-bar" form) or repeal joint and several liability. In recent years, such proposals have generally been made the session immediately following the year in which a state has adopted comparative negligence, such as **Iowa** and **Missouri.** However, the so-called medical malpractice "crisis" of 1985 has served as a springboard for such proposals in some states. In the final days of the 1985 session, a **Florida** bill abolishing joint and several liability in all tort cases, which had passed the full House as well as a Senate Committee, was removed from the Senate Calendar. The President of the Florida Senate removed the bill when the Chairman of the Committee on Finance and Tax requested referral to his Committee to study the public finance implications of the bill.

A **Nebraska** bill would adopt a modified comparative fault standard by removing the "slight/gross" standard and by providing instead that a plaintiff may recover if his or her negligence is not more than the negligence of the defendant. While the bill was not approved this year, it remains on the General File for consideration in 1986. A Colorado bill which was signed by the Governor would require a fact-

Editorials

DOCTORS AREN'T ABOVE THE LAW

Any fight between doctors and lawyers is a good one to stay out of. But some 30 state legislatures are rushing in to try to settle one of the most heated conflicts today: the medical malpractice situation (page 93). Doctors say too many lawyers make too much money from encouraging patients to bring malpractice suits against doctors. Lawyers say too many doctors bungle their work and then try to avoid paying for injuring patients. You could take either position and be right, but essentially this is a quarrel that should be settled by the parties involved.

Malpractice suits belong to that large class of problems for which no entirely satisfactory solution is likely to be found. Doctors, lawyers, and patients with medical-injury claims all have legitimate rights to press. Legislated remedies generally lack the flexibility required to be fair to everybody—and often reflect the interests of the strongest lobbying group. California and several other states, for example, restrict awards that plaintiffs in malpractice suits can receive. This is unwise, since circumstances could easily arise where severely injured plaintiffs would be entitled to more than the law allows.

Many states have also imposed limits on the contingency fees that lawyers who represent these plaintiffs may receive. A lot of people who look on as lawyers eagerly start to circle a developing world-class lawsuit—as they did around the poisoning at Bhopal, India—would applaud these constraints. Yet holding down fees by fiat is not the way to curb abuses. Lawyers and their clients should remain free to set fees by agreement. Some lawyers have gone to court to test whether such restrictions on fees are constitutional.

Some of the furor over malpractice suits has been whipped up by the medical profession, including threats by doctors to withhold their services. Let them. When they make grievous mistakes or demonstrate incompetence that injures a patient, doctors, like everybody else, must be held accountable.

RETREAT [illegible]

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