MINUTES

SPECIAL COMMITTEE ON MEDICAL MALPRACTICE

October 10-11, 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

Ted Fay, Kansas Insurance Department
Ron Smith, Kansas Bar Association
Jerry Slaughter, Kansas Medical Society
Kathleen Sebelius, Kansas Trial Lawyers Association
Anthony T. Valenti, Dani Associates, Inc., Voorhees, New Jersey
Charles M. Lederman, Insurance Financial Services, Inc., Plymouth Meeting, Pennsylvania
Bob Holmes, Kansas Insurance Department
Mike Mullen, Medical Protective Company
Robin B. Stickney, Attorney, Indianapolis, Indiana
Representative Paul Mannweiler, Attorney, Indianapolis, Indiana
Marsha Harrison, Indiana Department of Insurance, Indianapolis, Indiana
Bob Hayes, Kansas Insurance Department
Marsha Hutchinson, Kansas Medical Society
Richard Harmon, Kansas Association of Property and Casualty Companies
Pat Davis, Budget Division and Governor's Office
Lynne Copple, Shawnee County Medical Auxiliary
Derenda Mitchell, Kansas Department of Insurance
Verna Roberts, Greater Topeka United Way
Tom Bell, Kansas Hospital Association

Gene Ralston, Kansas Trial Lawyers Association
Loretta Class, United Way and League of Women Voters
Patricia Hershall, Office of Judicial Administrator
Bill Henry, Kansas Engineering Society
Jim McBride, United Way
Jack R. Cooper, M.D., Kansas City
Don Strole, Kansas Board of Healing Arts
Vince Leist, MPA student, University of Kansas
Dee Beel, M.D., Overland Park
Karen McQueen, Wichita
Beth Vin Zant, Sedgwick County Medical Auxiliary, Wichita
Sally Perue, Sedgwick County Medical Auxiliary, Wichita

October 10, 1985

Morning Session

The meeting was called to order by the Chairman, Representative Joe Knopp, at 10:00 a.m.

Ted Fay, attorney for the Insurance Department, appeared representing the Commissioner of Insurance to report on the recommendations of the Citizens Committee for Review of the Tort System appointed by the Insurance Commissioner. The Committee studied four areas: legal, screening panels, insurance, and peer review. The reports are in the process of being prepared in final form.

The legal subcommittee moved to adopt the Indiana-type system with a $500,000 total per incident cap. The $500,000 cap would not extend to future medical care or custodial care. The subcommittee recommended that the Legislature adopt a plan for structured payments for future medical care and custodial care expenses. The subcommittee also recommended that attorney fees be on a contractural contingent fee basis up to $100,000 and that a 25 percent cap on fees be imposed on awards above $100,000.

The subcommittee on screening panels moved to adopt the Indiana system with certain modifications, including:

1. to require mandatory participation in the screening panel review process for all cases above $50,000 with the screening panel's finding to be rendered within 90 days from the time the panel was requested and with the evidence supporting the claim to be filed with the letter requesting the panel;

2. to exclude from mandatory screening panel consideration cases where all parties agree not to have a screening panel;

3. to permit only medical reports be admissible to the screening panel;

4. to make the findings of the screening panel admissible in court;

5. to provide that relevant records pertaining to the care and treatment of the patient are the only evidence that can be presented to the screening panel (no other medical record shall be presented in court, unless presented to the screening panel, or unless the court determines the evidence was not reasonably available at the time of the screening panel);

6. to require good faith participation in the mandatory screening panel program by all physicians in the state of Kansas as a prerequisite for licensure in Kansas; and

7. to provide screening panel findings should be submitted for publication in an appropriate professional journal, submitted to the Board of Healing Arts, available for publication by the general press, and submitted to the Kansas Bar Association.

The peer review subcommittee recommended strengthening the reporting requirements for hospitals regarding incompetent doctors or the unethical conduct of doctors, to increase the amount of information available to the Board of Healing Arts and to provide that the information be made available sooner to the Board of Healing Arts. The Board of Healing Arts should have the authority to subpoena records and to be the depository of all information in the state of Kansas concerning health care providers. More people should be required to report suspected unethical conduct and substandard care such as hospital officials, medical staff, nursing staff, and hospital technical staff. State agencies should become actively involved in supporting medical risk and quality assurance programs. The subcommittee recommended a civil penalty which would be back pay for any person who reports a violation in a hospital who can show later they were terminated because of the report. The subcommittee also recommended additional staff for the Board of Healing Arts to take care of the increased functions.

The subcommittee on insurance recommended post-judgment interest rates be tied to the one-year U.S. Treasury Bill rate at the time of the judgment, that doctors be permitted to pay the Health Care Stabilization Fund surcharges on a monthly basis and that the surcharge not be based solely on the primary premium. The subcommittee suggested that a merit system for surcharges be developed and that levying of the surcharges within the classifications of medical licensees was needed.

Mr. Fay gave staff a copy of an Arizona statute that Kansas could use for the Board of Healing Arts concerning obtaining information and use of subpoena powers (Attachment I).

The Chairman requested the Committee be furnished written copies of the recommendations of the Citizens Committee which request was later complied with (see Attachment Ia).

Ron Smith, Legislative Counsel for the Kansas Bar Association (KBA), reported on the recommendations of the KBA's legislative committee and executive council (Attachment II). The KBA supported reducing the statutory limit on Health Care Stabilization Fund liability to $1,000,000. They also supported the concept of experience rating of health care providers. Regarding changes in the tort system, they supported requiring proof of the present value of future damages and itemized jury verdicts. They opposed artificial limits on awards. They further supported tying post-judgment interest rates to the annual U.S. Treasury Bill rate. They supported the concept of mandatory pretrial screening panels with results admissible in subsequent trials unless the plaintiff files an affidavit that he has consulted with a medical expert qualified to render an opinion who has determined the case has merit. The court, on its own motion, could order a screening panel and the results would be admissible in subsequent trials. It was also recommended there should be strong sanctions against attorneys for false verification.

In answer to Committee questions, Mr. Smith stated that the vote of the KBA legislative Committee was six to five in opposition to caps in general. The Executive Council had no opposition to the resolution.

Mr. Smith also handed out a memorandum concerning the Indiana Medical Malpractice Screening Panel Law (Attachment III).

Jerry Slaughter, Kansas Medical Society, explained to the Committee a bill the Medical Society proposed (Attachment IV). The bill would limit noneconomic losses, such as pain and suffering, to $100,000; overall damages, except for future medical care would be limited to $500,000, and, where future medical care increases damages to more than $500,000, the award could not exceed $1,000,000. The bill also provides for itemization of damages. Section 4 provides the jury, or the judge, may award a monthly sum for medical care. Should the plaintiff no longer need this care, or should need more, the amount could be modified by the court. Both parties could settle all future damages for a lump sum amount. Section 5 through 13 blend Kansas and Indiana laws creating screening panels whose function is to review a medical malpractice claim before it is filed as a lawsuit. Whenever the panel unanimously decides that the provider did not act below the standard of care and the claimant decides to file a lawsuit, the claimant must first submit his case to an expert and file an affidavit to this effect. The screening panel would be mandatory, and the panel opinion would be admissible in evidence if a lawsuit is filed. Section 14 provides an attorney cannot recover, as his contingent fee, more than 15 percent of any judgment against the Fund, and all fees must be fixed by a written agreement. Section 15 provides for mandatory settlement conferences. Section 16 states qualifications which an expert must meet prior to testifying in a medical malpractice case. Experts must devote 75 percent of their time to active clinical practice in the same area of medicine as the respondent. Section 17 broadens the definition and functions of peer review committees. Section 18 would eliminate the "sunset" provisions of S.B. 110. Section 19 would allow an insurance company to exclude from coverage another health care provider. Section 20 would include professional partnerships within the definition of health care provider. Section 21 would provide that only inactive health care providers who have contributed to the Fund for three consecutive years are protected by the Fund. The bill would allow the Commissioner of Insurance to purchase an annuity to pay a judgment or settlement. The bill would limit the Fund's liability to $800,000 and eliminate liability based upon the association of one health care provider with another. Section 22 provides a reporting system for health care providers. All reports and records shall remain confidential. Section 22 also provides that a person or Committee will not be subject to civil liability for making a report. Section 23 provides insurers must report all claims filed against a health care provider to the appropriate state licensing agency and to the Commissioner of Insurance.

Staff distributed copies of a revised working paper dated October 8, 1985 (Attachment V), a chart showing premiums plus surcharges for professional liability coverage for medical licensees (MD's and DO's) that were in force on June 6, 1985 (Attachment VI), and a booklet What Legislators Need to Know About Medical Malpractice, published by the National Conference of State Legislatures (Attachment VII).

Mike Heim explained the revised working paper is divided into three major topics, i.e., tort reform, insurance issues, and health care provider issues including peer review, risk management, and disciplinary oversight. The purpose of the working paper is to list the issues that have been raised prior to October 11, 1985, state the positions taken by the conferees on the issues, and list data, statistics, and other information relevant to the issues.

Mike Heim noted that in the publication "Washington Report on Medicine and Health Perspectives," published by McGraw-Hill, dated September 30, 1985, the American Medical Association (AMA) stated the average physician's malpractice insurance cost $8,400 annually and can cost ten times this amount for high risk specialties. The Chairman said he would like copies of the report for the Committee.

Mike Heim explained the information (Attachment VI) dealing with premiums and surcharges for doctors and osteopaths was compiled by staff from a computer printout furnished by the Office of the Commissioner of Insurance. Out of 3,684 licensees, 151 paid a 50 percent surcharge, one paid a 110 percent surcharge, and 3,532 paid an 80 percent surcharge. The figures apply to insurance premiums in force on June 6, 1985. Staff indicated there has been an increase in the basic premium and the surcharge for policies coming due after July 1, 1985. Staff noted also that professional associations also carry malpractice insurance, generally at a much lower rate, at approximately 20 percent of the individual physician's premium which the memo does not reflect. Staff explained they had requested, at the direction of the Committee, the Insurance Department furnish up-to-date actual premiums and surcharges paid and the number of licensees paying the different premiums and surcharges. The Insurance Department could only furnish the computer printout as of June 6, 1985. This information revealed that on June 6, 1985, of the 3,532 licensees, 1,544 paid under $3,000 for malpractice premiums and surcharges and only 71 licensees paid over $20,000 for such coveage.

Melinda Hanson reviewed a handout which lists the number of Kansas practitioners by specialty and county (Attachment VIII). The information was obtained from the Department of Health and Environment who receives it from the Board of Healing Arts who collects the information from the licensee's application. A second handout (Attachment IX), lists the Kansas practitioners by county, specialty, and the annual professional liability insurance rates effective July 1, 1985, including the 110 percent surcharge. Committee members requested staff incorporate in this report the incomes of the various specialties, if possible.

The Committee recessed for lunch.

Afternoon Session

Staff reviewed the nine objectives listed in the revised working paper on page 4. A Committee member recommended Item No. 1 should be changed to read "to stabilize" instead of "to reduce" medical malpractice premium costs. A Committee member said Kansas has created a closed shop by mandating physicians carry medical malpractice insurance. Physicians might be more careful in their practices if they did not carry malpractice insurance, as their assets would be at stake, the member noted.

The Chairman asked staff to check on how many states mandate medical malpractice insurance.

During Committee discussion it was suggested that the objective to promote reasonable patient expectations could be misleading. Also, the objective to control health care costs should be clarified to tie it to medical malpractice insurance. A Committee member questioned whether the suggested changes apply to the other professions besides health care providers.

Staff reviewed the "Tort Reform" portion of the working paper. On Item No. I dealing with a cap on damage awards, a Committee member requested information on how many verdicts and awards made in the last five years would have been affected by the various proposed caps. The member was referred to a listing of payments from the Health Care Stabilization Fund distributed at an earlier meeting by the Insurance Department.

The Chairman handed out copies of a letter in which he had asked several insurers how large an annuity would be needed in the factual situation that he had outlined in the letter and copies of the replies he received. See Attachment X.

On Item No. II dealing with a cap on attorneys' fees in medical malpractice cases, a Committee member mentioned that there is a statute now concerning attorney fees, and suggested requiring an evidentiary hearing on fees and that the plaintiff's attorney be required to file an itemized statement of all costs and all hours spent. The judge's order would contain this information, and whether the fee was consistent with legal code of ethics. Placing the contingency fee at 25 percent or 33 percent was also discussed as well as increasing the fee to 40 percent, subject to approval by the judge if a case were appealed.

Representative Solbach moved that the Committee consider an evidentiary hearing by the judge on attorney fees. A Committee member proposed the evidentiary hearing be only on cases filed for $50,000 or more. A Committee member stated contingent fees for attorneys should not be considered by this Committee, as attorney fees do not have anything to do with insurance premiums. A Committee member suggested the Committee should be apprised of the lawyer canons of ethics on contingency fees, and that maybe the canons of ethics should be included in the Kansas statute. A Committee member pointed out that in 1976 a law was passed that already requires what the Committee was discussing. It was also noted that since the law was already in place, setting a limit on the contingency fee should be considered.

Senator Steineger proposed amending the present statute to include reviewing the fees in accordance with the appropriate canons of ethics. Representative Solbach accepted Senator Steineger's proposal as an amendment to his motion. Representative Hoy seconded the motion.

A Committee member suggested that the Committee report reflect what the Committee feels should happen in regard to contingency fees.

Representative Solbach stated his motion, as amended, was to have staff pass out copies of the Canon of Ethics in regard to attorneys' fees and copies of the current law to the Committee. If the Committee then decides that the current law should be amended, the amendment should direct the court to consider the reasonableness of the fee.

Representative Snowbarger offered a substitute motion to draft legislation to amend the current medical malpractice attorneys' fee statute to incorporate the appropriate Canons of Ethics. In response to a question by a Committee member, Representative Snowbarger said he would be willing to amend his motion refer to all eight of the factors in the canons of ethics, not just two as in the current statute. Representative Solbach seconded the motion. The motion carried.

Staff reviewed testimony and material that has been presented on Item No. III, dealing with the mandatory appointment of screening panels with the results to be made admissible at trial, and on Item No. IV, dealing with whether settlement conferences should be mandated for all medical malpractice cases.

Representative Walker made a motion that it was the consensus of the Committee that settlement conferences will play a role in the Committee's ultimate proposal and that staff draft proposed legislation for the November meeting taking into consideration who will preside, the time the conference will take place, and what the sanction may be. Senator Walker seconded the motion and it passed.

Senator Gaines moved to refer back to Item No. I concerning caps and discuss the various options. Senator Talkington seconded the motion.

Senator Steineger made a substitute motion that the Committee continue to go through the working paper as outlined by staff and upon completion return to consideration of the Fund. The motion was seconded by Representative Solbach. A vote was taken and the substitute motion passed.

The Chairman recommended passing over Item No. V dealing with periodic payments or structured damage awards and settlements. He suggested Item No. V should be incorporated into the discussion of Item No. I at a later time. In regard to Item Va, concerning a uniform method of calculating future damages, Ron Smith of the Kansas Bar Association informed the Committee that New York has a law that was enacted in April 1985 which sets forth a method of calculating present value of future damages.

Senator Talkington moved that staff draft proposed legislation requiring some type of a uniform method of calculating future damages. Senator Walker seconded and the motion passed.

Representative Barkis made a motion that Item No. VI, concerning limiting expert witnesses to those from Kansas or the surrounding states, be deleted and that staff draft proposed legislation on Item No. VIa, to require medical experts devote at least 75 percent of their professional time to clinical practice for Committee consideration. Representative Snowbarger seconded and the motion carried.

Staff reviewed the testimony and material presented to the Committee on Item No. VII, concerning whether the Legislature should define the legal standard of care for health care providers or should this be left to the courts.

A Committee member suggested the Pattern Instructions for Kansas (PIK) should set out the medical standard of care in medical malpractice cases by Kansas standards. During Committee discussion, a Committee member stated all national board certified physicians use the same standard of care. Another member stated the medical profession has a standard of care and the proposed legislation being discussed might lower the standard of care. It was suggested that the standard of care for rural Kansas should not be the same as the standard of care for a large hospital in a metropolitan area. It was also suggested using the Oklahoma jury instructions as a guide. See Attachment XI.

A motion was made by Senator Gaines and seconded by Senator Winter that the Committee devote some time reviewing the standard of care and the PIK language to formulate statutory language related to the standard of care. The motion carried.

On Item No. VIIa, concerning requiring a claimant's attorney to file an affidavit with every malpractice case that a medical expert had reviewed the claim and found it meritorious, a Committee member recommended this should be considered with screening panels.

Representative Snowbarger moved that staff draft proposed legislation on Item No. VIII, requiring juries to itemize awards for Committee consideration. Representative O'Neal seconded the motion. The motion passed.

Senator Steineger moved to adopt the concept of tying the post-judgment interest rate to the Treasury Bill rate for Committee consideration. The motion was seconded by Senator Walker. The motion carried. During discussion of the motion it was suggested that the Treasury Bill rate be at the time of the judgment. It was also suggested the federal rule on this matter be followed.

On consideration of Item No. IX, concerning whether the Legislature should enact other reforms such as no fault, arbitration, panels of judges, mandatory summary judgment, directed verdict rulings, and modification of the standard of utilizing remittitur, and Item No. IXa, repealing the sunset provision (July 1, 1989) of 1985 S.B.

110, Representative Brady moved that the Committee pass over these at this time. Senator Walker seconded the motion and the motion carried.

On the "Insurance" portion of the revised working paper, the Chairman recommended the Committee pass over Item No. I, which asks why the malpractice premium rates have risen so dramatically.

On Item No. II, consideration of investment income by insurance companies as a factor in the ratemaking process or by the Insurance Commissioner as part of the review of rate filings, the Chairman suggested the Committee not make a ruling on Item No. II, but allow it to be a part of ratemaking on all insurance, not just medical malpractice insurance.

A motion was made by Representative O'Neal and seconded by Representative Hoy that the Committee not consider the issue of investment income of insurance companies at this time. The motion carried.

Representative Barkis moved that the Committee do nothing with Item No. III, the consideration of using some form of geographic rating, merit rating, or both in determining premium rates for health care providers, and that staff draft proposed legislation on Item No. IIIa, in regard to adding an experience rating factor to the surcharge for the Health Care Stabilization Fund, by using the mean average concept. Senator Parrish seconded the motion and the motion carried.

In regard to Item No. IIIc, should health care providers be permitted to pay Health Care Stabilization Fund surcharges on a monthly basis, Senator Walker stated he hoped to prefile a bill concerning this proposal that would allow the health care provider to obtain the money to pay the surcharges through a premium finance company. The premium finance company would pay the full amount to the Fund and the health care provider could make monthly payments to the premium finance company. It was noted a bill was introduced on the subject during the 1985 Session. This method would be advantageous for a young doctor establishing his practice. Staff for the Insurance Department stated the Department does invest the surcharges.

Senator Walker made a motion that legislation be drafted regarding periodic payment of Fund surcharges for consideration by the Committee. The motion was seconded by Representative Solbach and passed.

The Chairman recommended Item No. IIId should be considered as part of the cap.

The Committee decided to pass over Item Nos. IV, V, and Va at this time and take them up later when the Health Care Stabilization Fund is addressed.

In regard to Item No. VI, a Committee member suggested there should be some minimums for "right of underwriting" for insurance companies to do business in Kansas. It was also suggested requiring insurance companies to write high risk as well as low risk physicians. Mike Mullen, Medical Protective Company, stated the insurance companies would discontinue writing insurance in Kansas if they were forced to take uninsurable risks. A Committee member stated the purpose was to make insurance more available and affordable.

On Item No. VII dealing with whether procedures for defense of the Health Care Stabilization should be improved, it was suggested by a Committee member that this matter should be taken up after Committee consideration of the Fund.

The Chairman recommended for consideration when the Committee does discuss Item No. VII, that a statutory procedure be established which would require a five-member panel to evaluate each claim against the Fund that exceeds a certain amount, and there should be three attorneys on the panel.

In regard to Item No. VIIa, the staff distributed information from the Insurance Department on closed claims, a letter from Chairman Knopp requesting the information, and letters from Ron Todd dated September 26 and September 30 (see Attachment XII). The Committee discussed recommending that the Insurance Commissioner look at the system used in collecting data and see if it can be improved. A Committee member requested certain information be provided in writing by the Insurance Commissioner to the Committee concerning staff that has been added to the Health Care Stabilization Fund, staff still needed, and how the Fund should be properly funded.

Derenda Mitchell of the Insurance Department stated they had recently hired a claims adjuster who has 25 years of experience in medical malpractice claims adjusting. She said there had been a request for an additional file clerk in last year's budget request and that request was denied. The Citizens Committee on Tort Reform has recommended additional clerical staff, she said. The additional staff have been requested in their new budget proposal also, she noted.

Senator Walker made a motion that this Committee would like to see the recommendations of the Citizens Committee so they could be more informed in their decision making. The motion was seconded by Senator Feleciano and passed.

Staff reported the Insurance Department apparently does not have the capability to furnish the Committee with information regarding what doctors are paying for premiums, other than on certain limited dates since physicians' premiums are not due at the same time and relicensure does not occur until October each year.

Mike Mullen said his company could furnish the premium information the Committee desired as far as Medical Protective Company was concerned and they could design a program for use by the Legislature.

A Committee member requested an update on the average income of physicians. The Medical Society replied they do not have these figures, however, the AMA does conduct regional studies and these figures were presented to the Committee last month by the legislative staff. The newest figures by the AMA will be available after October 15, 1985, staff noted.

Kathleen Sebelius stated that malpractice insurance premium for corporations is a business expense and is irrelevant to what the individual pays for medical malpractice insurance. Mike Mullen said his company could provide information on how many doctors are incorporated or are in a partnership that are covered by Medical Protective. He noted that charges are based on the number of doctors involved in a corporation. A five-doctor corporation is charged more than a one-doctor corporation. He stated that St. Paul's rate may be computed different than the Medical Protective rate. During Committee discussion it was stated the Kansas Supreme Court recently upheld the Insurance Commissioner's position that a corporation, if involved where a doctor is found negligent, must pay before the Fund pays. A member said that one of the reasons doctors incorporate is to shield themselves from acts of their employees. A Committee member said this Committee should not concern itself with corporate insurance charges.

The Committee adjourned until 9:00 a.m., Friday, October 11, 1985.

October 11, 1985
Morning Session

Ted Fay introduced Bob Holmes, the new claims manager for the Health Care Stabilization Fund, to the Committee.

Anthony T. Valenti, President of Dani Associates, Inc., of Voorhees, New Jersey, testified he and Charles M. Lederman, President of Insurance Financial Services, Inc., of Plymouth Meeting, Pennsylvania, are independent consultants. They have provided actuarial services for the Health Care Stabilization Fund for the past three years. They also perform actuarial services for Pennsylvania's Fund which is similar to the Kansas Fund, and they provide management and actuarial consultant services for two medical malpractice insurance companies.

Mr. Valenti stated he has performed services in the past for joint underwriting associations in the states of Texas, Ohio, South Carolina, Pennsylvania, and Florida, and has also worked on the Patient Compensation Fund in Florida. He holds a Masters degree in mathematics from the University of Notre Dame and has 13 years of experience in the property and casualty actuary science. He stated Mr. Lederman is a fellow of the American Academy of Actuaries and has a very extensive background.

Mr. Valenti explained they were asked to examine the impact of Kansas implementing Indiana type legislation and to determine to what extent the Fund's liabilities might be affected. Specifically, they were asked to review the implementation of caps on awards, on a per incident basis, ranging from $500,000 per incident up to coverage that would allow for $1,000,000 supplemental benefits on medical expenses with $500,000 of additional indemnity allotted to other economic loss.

Mr. Valenti explained they were also asked to examine what effect the utilization of an arbitration or screening panel system would have, insofar as the Fund's liabilities, and what effect the restriction of plaintiff's attorney fees would have. Using these assumptions with caps, they estimated a 5 percent to 10 percent reduction in the surcharges that would be effective July 1, 1986 and a 20 percent to 50 percent reduction in the surcharges based upon retrospective implementation of various caps. It was estimated that it would take five to seven years longer to realize the full effects of the legislation if changes were prospective rather than retrospective.

Copies of the draft actuary report dated September 24, 1985 were distributed to the Committee (Attachment XIII). Mr. Valenti explained the exhibits in the report were prepared on claims occurring on or after July 1, 1986 and on claims outstanding as of July 1, 1986.

Also distributed were copies of Report to the Commissioner of Insurance regarding the Kansas Health Care Stabilization Fund, Final Report, dated February 22, 1985 (Attachment XIV).

Mr. Valenti replied to a question from the Committee that they were employed by the Commissioner of Insurance.

Mr. Valenti explained to the Committee the surcharge for 1986-87, (assuming a 3 percent base increase), if nothing is done to change the Fund, would be 100 percent. If a $500,000 cap is implemented effective July 1, 1986, then the surcharge would be 91 percent or 48 percent if made retroactive. Using a $750,000 cap, effective July 1, 1986, the surcharge would be 94 percent. Using a $1,000,000 cap, effective July 1, 1986, the surcharge would be 95 percent and if retroactive 72 percent. Using a $1,000,000 medical cap and a $500,000 nonmedical cap, effective July 1, 1986, the surcharge would be 97 percent and if retroactive 80 percent.

The surcharge for 1987-88 (assuming a 4 percent base increase), if nothing is done to change the Fund, would be 105 percent. Using a $500,000 cap, effective July 1, 1986, the surcharge would be 79 percent and if retroactive 47 percent. Using a $750,000 cap, effective July 1, 1986, the surcharge would be 85 percent. Using a $1,000,000 cap, effective July 1, 1986, the surcharge would be 88 percent. Using a $1,000,000 medical cap and a $500,000 nonmedical cap, effective July 1, 1986, the surcharge would be 95 percent and if retroactive 81 percent. See Attachment XV.

Charles Lederman explained to the Committee that in February of 1984 they had projected an 80 percent surcharge for 1985-86. Three or four months later they projected an added 30 percent increase in the surcharge for 1985-86 or a 110 percent surcharge.

Tony Valenti responded to questions from the Committee by stating the Fund was on a pay as you go basis when it was established instead of an accrual basis. Charles Lederman stated even if the Fund had been on full accrual basis in 1976, the Fund would still be catching up for 1985-86 claims. The problem is being faced by everyone in the medical malpractice field. Reinsurance companies worldwide stated at the end of the last year they would not write any more new business. Insurance management does not have as much to do with the problem as the inability to project losses in a volatile area, i.e., the excess over a given primary limit. The Fund is no different than any reinsurance company operating at a loss, he said. All areas of malpractice are affected. The surcharge has increased in Pennsylvania from 38 percent to 87 percent. They provide a $1,000,000-$3,000,000 excess coverage over primary policies of $200,000-$600,000. Their Fund is based on a pay as you go basis. They look at the payments made in the past year and reimburse the Fund.

Kathleen Sebelius, Kansas Trial Lawyers Association, distributed to the Committee an Analysis of the Indiana Patients Compensation Fund Report dated December 1984 (Attachment XVI), and a comparison of Indiana data and Kansas data. (Attachment XVII), She introduced Robin B. Stickney, an attorney from Indianapolis, Indiana. She said his primary practice is in the area of insurance defense, but that he does represent some plaintiffs in medical malpractice cases. He is also a medical doctor and graduated in 1972 from the University of Indiana School of Medicine. He practiced for nine years as a family practitioner and in emergency medicine in Northern Indiana.

Mr. Stickney testified that in 1984, the Indiana Patients Compensation Fund was infused with miscellaneous revenue of $7,209,467. After office expenses, salaries and judgments were paid in the Fund's balance on December 31, 1984 was $737,848. The surcharge for the Fund was 15 percent in 1975, 25 percent in 1980, 50 percent in 1982, and 75 percent in September 1985. Fund authorities have legislative permission to raise the surcharge to 100 percent in January 1986, he said.

Mr. Stickney said the $500,000 cap was unconscionable. He said the biggest problem to deal with is medical malpractice. Dealing with the symptoms just covers up the issue for awhile but will not solve the problem, he said. The medical profession will not get medical malpractice under control until they become convinced that the Legislature is not going to bail them out by granting them immunity for the damage they cause to their patients. He advocated preventive law in relation to medicine just as medical practitioners practice preventive medicine. Others should not bear the burden of the negligence of the medical profession, he said.

Jerry Slaughter of the Kansas Medical Society introduced Representative Paul Mannweiler of Indiana. Representative Mannweiler was Chairman of the Indiana Medical Malpractice Interim Study Committee in 1984 and is an attorney practicing in the area of labor law.

Representative Mannweiler said the Indiana plan will not solve all of the problems, that medical malpractice is a national societal problem. He explained, in Indiana, medical review panels have one attorney and three health care providers. The law requires that 180 days after the panel is selected they must render their decision. The panel decision is admissible but not conclusive in a court of law. Their patient compensation fund provides excess coverage not to exceed the $500,000 cap. Their surcharges have gone from 10 percent to 75 percent. The interim study authorized the 75 percent surcharge effective September 1, 1985, with authority for the Insurance Commissioner to raise the surcharge to 100 percent if it was deemed necessary. They have $100,000 basic coverage instead of the $200,000 basic coverage as in Kansas, which makes their surcharges less. The premium for a family practitioner is approximately $600 plus the 75 percent surcharge, or a little over $1,000 a year, he said. For a neurosurgeon, Class 8, the premium is approximately $8,000 plus the surcharge, or a little over $14,000 a year. Medical malpractice insurance is not mandatory in Indiana, he noted.

Mike Mullen said Medical Protective in Indiana rolls the corporate coverage into the individual's coverage. The statute of limitation is two years from the date of occurrence, and up to age eight on a child.

On attorney fees, Representative Mannweiler stated the first $100,000 is negotiable between the attorney and the individual. The Patient Compensation Fund restricts the attorney fees to 15 percent.

A consensus bill came out of the 1984 interim study committee, he said. It authorized periodic payments and the purchase of annuities from the Fund. It allowed the parties to by-pass the medical review panels if both sides wanted to. In regard to the makeup of the panels, they are required to have two health care providers of the same specialty as the defendant. The bill deleted the comparative fault application to medical malpractice.

Representative Mannweiler stated Indiana has experienced an increase in the number of doctors practicing in the state. In 1975 there were 5,600 doctors and in 1983 there were more than 8,000. Insurance rates

have stayed the same until recently, and they have five or six insurance companies doing 90 percent of the malpractice business.

In answer to Committee questions, Representative Mannweiler stated the Fund basically operates similar to workman's compensation. The issue of fault is dealt with only on the $100,000 primary coverage level by the insurance company. Once the Fund is involved, the question is only how much are the damages. For-profit hospitals can qualify as health care providers the same as nonprofit hospitals he said. Everyone except the medical profession is governed by comparative fault rules. Contributory negligence only applies to the $100,000 coverage, he noted. It does not apply to the Fund. Claims under $15,000 can go straight to court, he noted. Screening panels are composed of one attorney as chairman, and three voting members who are three health care providers. Each party selects one health care provider and those two select the third member. The panel is restricted to four findings, i.e. (1) the standard of care was provided; (2) the standard of care was not provided; (3) there exists a fact question which is outside the jurisdiction of the panel; and (4) there was malpractice that relates to the injury. Peer review records are confidential and the panel cannot subponea witnesses. To be covered under the Fund, the doctor or hospital has to qualify as a health care provider which requires insurance or a bond.

Marsha Harrison, a staff attorney for the Indiana Department of Insurance testified the Commissioner of Insurance is by statute the administrator and trustee of the Patients Compensation Fund. They have had problems keeping the Fund solvent. The 10 percent surcharge for the first three years of the Fund was actuarily unsound. At the present time there is $12,000,000 in the Fund. In 1984, the total collected was $9,545,000, so they are in much better shape this year due to the increase in the surcharge. They also believe the number of claims is leveling off. With the present surcharge, or with perhaps a little higher surcharge she said that they will be able to pay the claims for the year.

In answer to Committee questions, Ms. Harrison agreed that the average claim paid may be larger in Indiana than the average claim paid in Kansas because their Fund does not question liability whereas the Kansas Fund defends the same as any other excess insurer and does question liability.

In answer to further questions by the Committee, Ms. Harrison stated the Attorney General of Indiana is the counsel for all public officials, including the Commissioner of Insurance and the Fund. The 1985 Legislature gave specific authority to hire consultants and others to help defend the interests of the Fund. They are considering hiring outside defense counsel along with hiring a professional claims manager. Whether a physician has been reprimanded before would not be relevant to a screening panel, she said. The screening panel is not a regulatory agency. The screening panel determines whether the provider has complied with the applicable standard of care in a particular instance. If a provider has been reprimanded several times, it should be reported to the medical licensing board. Indiana has a medical licensing board that is responsible for licensing physicians and osteopaths and other boards that are responsible for licensing other health care professionals. The State Board of Health in Indiana regulates hospitals. If a screening panel report indicates that a health care provider has not complied with the standard of care, the finding is sent to the applicable licensing board and when there has been a judgment against a provider that information is sent to the applicable licensing board also. When a provider has accumulated three or more complaints, that information is sent to the Attorney General's Office which serves as the investigative arm of the licensing boards.

Mike Mullen, in answer to a Committee question, replied that any negligence is considered contributory negligence in Indiana.

Ms. Harrison said doctors serving on panels can be paid up to $250 each. The Chairman of the panel receives $1,000 per case. Panel members can be called as witnesses if the case goes to trial. She estimated only about 2 percent of the cases go to trial.

Representative Mannweiler, in answer to a question by a Committee member, replied the interim study committee decided not to change the $500,000 cap as the system was working well with the cap.

The Committee recessed for lunch.

Afternoon Session

Mike Heim reported that he had invited Mr. Hofflander, one of the authors of the Pennsylvania report dealing with medical malpractice insurance to testify before the Committee, but that he was not available for this meeting but would be available for the November 7-8 meeting. The Chairman explained the Pennsylvania study was funded by the Trial Lawyers and the Medical Society. It was the consensus of the Committee they were not prepared, at this time, to invest the time and the state's moneys to bring Mr. Hofflander to Kansas.

Tony Valenti explained that a 28 percent reduction might be achieved if the Kansas Fund's coverage was limited to $1,000,000 and the cap applied retroactively. Mr. Lederman explained the Fund needs the same amount of dollars regardless of how it is collected. They proposed the surcharge collections be based on actuarily determined basic coverage rates by type of provider and specialty. Each insured of a given specialty would be charged by their basic coverage insurer. Rating of physicians could be used in this sytem. The projections made on the changes in the Fund's surcharges were based on present laws only. It was estimated that the collateral source rule will save about 5 percent of the Fund's otherwise payable liabilities.

Robert Stickney stated that the question of liability does remain an issue with the Fund in Indiana. He stated that the way the panel system is set up in Indiana the ability to get a lawyer to continue your case and to prevail at trial is very critical. Without the panel, a lawyer normally takes two years to prepare a medical malpractice case. It is unreasonable to expect a lawyer to prepare a case in eight months for a panel. He said it could take three years to get a panel's opinion and two to four years after that to get a court date.

In answer to Committee questions, Mr. Stickney stated Indiana allows two strikes on the selection of the panel. The first doctors named are almost always struck. Mr. Stickney stated if the purpose of panels is to weed out frivolous lawsuits, their sole determination should be to determine if there is a reasonable basis to believe there may have been medical malpractice involved. If the panel is to help to determine that there are real medical issues and to be of assistance to the participants the panel should be advisory only and be a strong settlement participant. Most of the opinions by panels in Indiana find there has been no negligence he said. In many cases, the attorneys can flip the panel members by convincing them there is a material question of fact. There is no appeal process with panels. As soon as a panel renders its opinion, the participants become witnesses and can be contacted individually. If the attorney is successful in flipping a panel, then a settlement can be made. On a 3-0 panel decision for the defendant, the plaintiff pays all of the costs if the trial goes to court. The costs of the panel are borne by the winner. He stated the fees have been raised for the panel members to $50 a day or a total of $500 each, and the Chairman's fee was raised to $1,000.

Mr. Stickney stated the best purpose of a panel is to clarify the medical issues so everyone understands what the case is about. If everyone understands the issues then settlements can be discussed and expedited.

He explained that the emphasis has been on the cost of insuring the risk in the medical malpractice area. There has not been a definitive study done on medical malpractice insurance policies in the last ten years in Indiana. He recommended that the Committee conduct an in-depth study, not only the Fund, but also of the insurance carriers in Kansas. He also suggested studying the reserve policies of insurance companies.

In answer to a question by a Committee member, Mr. Stickney stated the $500,000 cap is not sufficient for catastrophic cases. Society has to help foot the bill. He thought there should not be a cap on medical expenses and lost wages.

A Committee member questioned whether defense costs are deducted from the medical malpractice policy limit in Kansas. Bob Hays, Insurance Department, stated defense costs are not within the policy limits.

Emalene Correll reviewed the "Providers" issues of the working paper.

Representative Beuhler moved and Senator Parrish seconded a motion directing staff to draft legislation regarding Item Nos. I and II. The motion passed.

Representative Luzzati moved to draft legislation to amend the Kansas Healing Arts Act to provide penalties, such as fines, for organizations or licensees that fail to report to the Board when required to do so. Representative Walker seconded the motion. The motion passed.

Representative Brady made a motion directing staff to draft legislation requiring state agencies, law enforcement agencies, and medical associations to report to the Board of Healing Arts concerning licensees who may be incompetent, impaired or otherwise in violation of the Kansas Healing Arts Act. Representative Walker seconded the motion. During Committee discussion of the motion, it was decided to take no action on the motion and to pass over this issue.

Senator Feleciano moved to direct staff to draft legislation to require professional liability insurance carriers to report incidents of medical malpractice to the Board of Healing Arts or other appropriate state agencies. The motion was seconded by Representative Sprague and passed.

Senator Feleciano made a motion that proposed legislation be drafted to require hospitals, by state law, to maintain medical staff peer review programs and to report on such programs annually to the licensing agency. The motion was seconded by Representative Hoy and passed.

Emalene Correll passed out to the Committee (Attachment XVIII) "Guide to the Essentials of a Modern Medical Practice Act."

Representative Solbach moved that legislation be drafted giving the Board of Healing Arts authority to adopt rules and regulations or guidelines establishing minimum standards of medical practice, using the Guide to the Essentials of a Modern Medical Practice Act. Senator Feleciano seconded the motion and the motion passed.

Representative Solbach moved that the rest of the items, under the Providers issues section of the working paper be drafted as proposed legislation for consideration by the Committee at the next meeting. The motion was seconded by Representative Walker. The motion passed.

Senator Feleciano stated there was an error in the minutes of September 13. On page 10 he seconded the motion, not Senator Gaines.

The meeting was adjourned.

Prepared by Mike Heim

Approved by Committee on:

11-8-85

Arizona

§ 32-1451.01. Right to examine and copy evidence; summoning witnesses and documents; taking testimony; right to counsel; court aid; process

A. In connection with the investigation by the board on its own motion, or as the result of information received pursuant to § 32-1451, subsection A, the board or its duly authorized agents or employees shall at all reasonable times have access to, for the purpose of examination, and the right to copy any documents, reports, records or any other physical evidence of any person being investigated, or the reports, records and any other documents maintained by and in possession of any hospital, clinic, physician's office, laboratory, pharmacy or any other public or private agency, and any health care institution as defined in § 36-401, if such documents, reports, records or evidence relate to medical competence, unprofessional conduct, or the mental or physical ability of a doctor of medicine safely to practice medicine.

B. For the purpose of all investigations and proceedings conducted by the board:

1. The board on its own initiative, or upon application of any person involved in the investigation, may issue subpoenas compelling the attendance and testimony of witnesses, or demanding the production for examination or copying of documents or any other physical evidence if such evidence relates to medical competence, unprofessional conduct, or the mental or physical ability of a doctor of medicine safely to practice medicine. Within five days after the service of a subpoena on any person requiring the production of any evidence in his possession or under his control, such person may petition the board to revoke, limit or modify the subpoena. The board shall revoke, limit or modify such subpoena if in its opinion the evidence required does not relate to unlawful practices covered by this chapter, is not relevant to the charge which is the subject matter of the hearing or investigation, or does not describe with sufficient particularity the physical evidence whose production is required. Any member of the board, or any agent designated by the board may administer oaths or affirmations, examine witnesses and receive such evidence.

2. Any person appearing before the board shall have the right to be represented by counsel.

3. The superior court, upon application by the board or by the person subpoenaed, shall have jurisdiction to issue an order:

(a) Requiring such person to appear before the board or the duly authorized agent to produce evidence relating to the matter under investigation; or

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Attachment I.

(b) Revoking, limiting or modifying the subpoena if in the court's opinion the evidence demanded does not relate to unlawful practices covered by this chapter, is not relevant to the charge which is the subject matter of the hearing or investigation, or does not describe with sufficient particularity the evidence whose production is required. Any failure to obey such order of the court may be punished by such court as a contempt.

C. Patient records, including clinical records, medical reports, laboratory statements and reports, any file, film, any other report or oral statement relating to diagnostic findings or treatment of patients, any information from which a patient or his family might be identified or information received and records kept by the board as a result of the investigation procedure outlined in this chapter shall not be available to the public.

D. Nothing in this section or any other provision of law making communications between a physician and his patient a privileged communication shall apply to investigations or proceedings conducted pursuant to this chapter. The board and its employees, agents and representatives shall keep in confidence the names of any patients whose records are reviewed during the course of investigations and proceedings pursuant to this chapter.

E. Hospital records, medical staff records, medical staff review committee records, and testimony concerning such records and proceedings related to the creation of such records shall not be available to the public, shall be kept confidential by the board and shall be subject to the same provisions concerning discovery and use in legal actions as are the original records in the possession and control of hospitals, their medical staffs, and their medical staff review committees. The board shall use such records and testimony during the course of investigations and proceedings pursuant to this chapter.

Added Laws 1976, 1st S.S., Ch. 1, § 10, eff. Feb. 27, 1976.

Historical Note

1976 Reviser's Note:

Pursuant to authority of section 41-1304.02: In subsection A, "the" was inserted preceding "result", "shall have" preceding "the right to copy" was omitted, and "relate" was substituted for "relates"; in subsection B, paragraph 3, a comma was inserted following "subpoenaed"; and in subsection E "and" following "medical staff records" was omitted.

Cross References

Medical practices, confidential information, see § 36-445.01.

Library References

Physicians and Surgeons ⇐10.

C.J.S. Physicians and Surgeons §§ 31 to 35.

§ 32-1451.02. Insurers to report medical malpractice claims and actions

A. Any insurer providing professional liability insurance to a doctor of medicine licensed by the board of medical examiners pursuant to this chapter shall report to the board, within thirty days of its receipt, any written or oral claim or action for damages for personal injuries claimed to have been caused by an error, omission or negligence in the performance of such insured's professional services, or based on a claimed performance of professional services without consent or based upon breach of contract for professional services by a doctor of medicine.

B. Reports required by subsection A shall contain:

1. The name and address of the insured.

2. The insured's policy number.

3. The date of the occurrence which created the claim.

4. The date of claim if suit is not simultaneously filed.

5. The date suit is filed.

6. A summary of the occurrence which created the claim as stated by claimant.

7. Such other reasonable information related to the claim as the board may require.

C. Every insurer required to report to the board pursuant to this section shall also be required to advise the board of any settlements or judgments against a doctor of medicine within thirty days after such settlement or judgment of any trial court.

D. The board shall maintain the reports filed in accordance with this section as confidential records. Statistical data derived from these reports shall be released only for bona fide research or educational purposes.

E. The board shall institute procedures for an annual review of all records kept in accordance with this chapter in order to determine whether it shall be necessary for the board to take rehabilitative or disciplinary measures prior to the renewal of a medical doctor's license to practice.

F. The board shall annually report to the director of insurance the following statistical information reported by insurers pursuant to subsection B:

1. The number of claims.

2. The dates of the acts or omissions which form the basis of claims.

3. The final disposition of claims.

G. There shall be no liability on the part of and no cause of action of any nature shall arise against any insurer reporting hereunder or its agents or employees, or the board or its representatives, for any action taken by them in good faith pursuant to this section.

Added Laws 1976, 1st S.S., Ch. 1, § 10, eff. Feb. 27, 1976.

Historical Note

1976 Reviser's Note:

Pursuant to authority of section 41-1304.02: in subsection A, "chapter" was substituted for "article" and an apostrophe was inserted in "insured's"; "the" was inserted in three places in subsection B and in one place in subsection F, paragraph 3.

Cross References

Immunity, see §§ 12-567, 20-1711, 20-1731, 32-1402, 32-1403, 32-1451, 32-1855, 32-1855.02, and 36-445.02.

Medical practices, confidential information, see § 36-445.01.

§ 32-1452. Reinstatement of a suspended license; reissuance of a revoked license

A. A doctor whose license to practice medicine has been suspended for an indefinite period of time, or revoked, may make application to the board for the termination of such suspension or reissuance of such revoked license under the following terms and conditions:

1. Such application shall be submitted in writing, verified under oath, and shall contain therein or have attached thereto substantial evidence that the basis for suspension or revocation has been removed and that the termination of suspension or reissuance of license will no longer constitute a threat to the public health or safety.

2. If it is an application for the termination of a suspension for an indefinite period, the same may be applied for no more frequently than once in any six-month period.

3. If it is an application for the reissuance of a revoked license, such license may be applied for no more frequently than once in any twenty-four month period.

B. The board may, in its discretion, grant or deny an interview to an applicant under subsection A of this section.

C. The board shall make such determination of each such application as it deems consistent with the public health and safety and just in the premises.

Added Laws 1964, Ch. 27, § 2.

Attachment 1-A

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STATE OF KANSAS

FLETCHER BELL
Commissioner

October 17, 1985

The Honorable Joe Knopp, Chairman
Special Committee on Medical Malpractice
Representative, 67th District
1201 Houston Street
Manhattan, Kansas 66502

RE: Kansas Citizens Committee For The Review
Of The Tort System

Dear Chairman Knopp:

Pursuant to your request, I have attempted to summarize the recommendations made by the Kansas Citizens Committee for the Review of the Tort System.

Please note that the final written report of the Citizens Committee has not been completed. The recommendations shown on the attached document may be modified or expanded on the final report in order to incorporate the editorial directions provided to me by the Committee at the time of their vote.

If you have any questions, please feel free to contact me at (913) 296-7811.

Very truly yours,

Fletcher Bell
Commissioner of Insurance

Ted F. Fay

Ted F. Fay, Attorney
Kansas Citizens Committee

TFF:jlb
Enclosure
cc: All Members of the Special Committee
on Medical Malpractice

All Members of the Kansas Citizens
Committee for the Review of the Tort System

Mike Heim
Legislative Research

The Honorable Mike Hayden
Representative, 120th District
LE/2590

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KANSAS CITIZENS COMMITTEE FOR THE REVIEW OF THE TORT SYSTEM
Recommendations
October 8, 1985
[Official Final Report To Be Prepared]

On January 23, 1985, Fletcher Bell, Kansas Commissioner of Insurance, appointed the Kansas Citizens Committee for the Review of the Tort System as it Affects Insurance and Related Matters. The Committee was appointed 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 was asked 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.

The Committee was composed of twenty-five (25) members, including some of the most prominent members of the legal, medical, business, labor, and academic communities in Kansas. The Committee was chaired by John Anderson, Jr., former Governor of the State of Kansas.

The Committee met at least once each month, beginning in February of 1985 and concluding with the Committee meeting in October of 1985. The witnesses who appeared before the full Committee included Griffin Bell, former U.S. Attorney General and for four years Chair of the American Bar Association Committee which studied, among other matters, the medical malpractice system. Other witnesses included medical malpractice experts from the American Medical Association and from the insurance industry. Witnesses also appeared on behalf of the Kansas Insurance Department to discuss the Health Care Stabilization Fund, the Health Care Provider Insurance Availability Act and general principles relating to the rating of primary medical malpractice insurance carriers in Kansas. Representatives of the Kansas Defense Lawyers Association, Kansas Trial Lawyers Association, Kansas Bar Association, and Kansas Medical Society also appeared as witnesses.

Beginning in July of 1985, the full Committee divided into four Subcommittees to study four individual areas of concern. The four Subcommittees were: (1) Legal; (2) Screening Panel; (3) Peer Review; and (4) Insurance. The recommendations of these four Subcommittees were orally presented to the full Committee on September 11, 1985 and furnished in writing to the full Committee prior to their vote on October 8, 1985.

The recommendations of the Kansas Citizens Committee for the Review of the Tort System are listed according to the Subcommittees that had primary responsibility in the individual area. They are as follows:

A. LEGAL SUBCOMMITTEE -- Recommendations As Amended By The Full Committee

1. $500,000 total per incident cap in medical actions with the exception of expenses for future medical and custodial care, if the Legislature provides a means for Courts to structure awards and judgements for these expenses.

2. Deleted. [A recommendation to abolish punitive damages was defeated].

3. Contractual contingent attorney fees for judgments in medical malpractice to $100,000 -- maximum 25% contingent fees above $100,000.

B. SCREENING PANEL SUBCOMMITTEE -- Recommendations As Amended By The Full Committee

Adopt Indiana Screening Panel System with the following modifications.

1. Mandatory participation in the screening panel review process for all cases above $50,000 to be completed in ninety days from the time the complaint letter requests the panel, if evidence supporting claim is filed with the letter. Mandatory participation would be excluded in all cases where the parties mutually agree to waive the panel requirements.

2. Findings of the screening panel to be admissible in Court if a party decides to pursue the case.

3. Evidence to be presented to screening panel limited to relevant medical records pertaining to the care and treatment of the relevant patient.

3a. No other medical records shall be presented in Court unless presented to the screening panel, unless the Court determines the evidence was not reasonably available at that time.

4. Require mandatory good faith participation in the screening panel program by all physicians in the State as a pre-requisite for licensure.

5. Screening panel findings should be:

(a) Submitted for publication in appropriate professional journal.
(b) Submitted to the Board of Healing Arts.
(c) Available for publication in the general press.
(d) Submitted to the Kansas Bar Association.

C. INSURANCE SUBCOMMITTEE -- Recommendations As Amended By The Full Committee

1. Post judgement interest rates to be the same as the U.S. Treasury Bill rate as of date of judgment.

2. Legislation be adopted to provide for posting an appeal bond or other security for a judgment against a provider covered by the Health Care Stabilization Fund.

3. Legislation be adopted to amend Premium Finance Act to allow installment payment of surcharge.

4. The support staff for the HCSF be increased to include at least, in addition to present employees:

(a) One assistant (para-legal if available).
(b) One full-time secretary.
(c) One full-time file clerk.

5. The HCSF be encouraged to employ medical consultants for pending cases when necessary.

6. An independent actuarial review of the surcharge projections of the HCSF to be conducted at least once every three years.

7. A merit system for surcharges be introduced that more accurately reflects the risk to the HCSF.

8. Subject to recommendation #7 above, a level surcharge be maintained within classifications.

9. Insurance Department collect surcharge directly from health care provider and/or penalty be provided for flagrant failure of primary insurance carrier to forward surcharges to the HCSF in a timely manner.

10. HCSF to remain under the direction and supervision of the Kansas Commissioner of Insurance.

11. Board of Healing Arts obtain official residence address of providers and furnish same to HCSF.

12. Legislation to establish and/or clarify standards for review for Board of Governors for HCSF. Specifically, clarify K.S.A. 40-3405(g) by defining or establishing standards to identify providers that present "a material risk of significant liability to the Fund."

13. Legislation to grant immunity to Board of HCSF.

14. Additional study to determine if meetings of Board of HCSF should be public or private.

15. Clarify how rates will be affected by exclusion of coverage for some procedures.

16. Legislation to authorize the Board of Governors of HCSF to terminate both Fund and Health Care Provider Insurance Availability Plan (The Plan a/k/a the JUA) coverage for an individual provider.

17. Legislation to make Board of Governors of HCSF more autonomous, with Board to elect own Chairman, and Insurance Commissioner to act in ex officio capacity only.

18. No legislative action to change methods of setting insurance rates, or handling HCSF claims, or hiring outside attorneys by HCSF.

19. Investigation of providing tail coverage to health care providers who have not made an "adequate" contribution to HCSF.

20. Legislation to reduce liability of HCSF to $1 million from $3 million.

D. PEER REVIEW SUBCOMMITTEE -- Recommendations As Amended By The Full Committee

1. The Board of Healing Arts should be empowered to examine and copy documents,

reports or records relating to the practice of any licensee. This includes the right to issue subpoenas, enforceable through the District Court.

The Board of Healing Arts is presently being denied information by omission (ignoring incidents) and commission (failure to disclose suspected deficiencies or complaints). Present laws should be amended to encourage reporting of suspected violations as soon as they are known to hospitals and/or their peer review committees.

The Committee does not believe that the Board of Healing Arts should or be expected to delay investigations or hearings until lawsuits or other matters pending against a licensee are resolved. We realize that this policy will at times be in conflict with the economic or personal interests of individuals (or their insurers), however, the public interest in good medical care should be paramount.

This recommendation is specifically intended to include records of peer review committees, hospitals, the HCSF and insurance companies, and follows the Arizona statutes. (See A.R.S. 32-1451.01). The Committee believes that concealment of malpractice perpetuates malpractice and may result in more claims in the long run. The Committee wishes to require the mandatory exchange of information between the Board of Healing Arts, the HCSF, and the Board of Governors or the Health Care Providers Insurance Availability Plan (The Plan a/k/a the JUA).

2. It is recommended that the present Board of Healing Arts statute K.S.A. 1984 Supp. 65-2840(c) be amended to provide that upon conclusion of an investigation by the staff of the Board, the report first must be presented to a review committee of three persons who possess similar training and practice to the licensee being investigated. The review committee will make the initial determination from the investigative report whether the case should be referred to hearing or closed. Either the staff or party being investigated may request the entire Board (without hearing) to review the investigative report and review committee decision on whether a case should be referred to hearing.

The three member review committee would be appointed by the Board of Healing Arts from a list of physicians provided by the specialty society for a term of three years. Membership should be staggered. The Board of Healing Arts should be directed to form review committees from the 23 recognized medical, and for the osteopathic and chiropractic specialties. In areas of ambiguity or when sufficient specialty members cannot be recruited to serve, the Board should be authorized to appoint persons whose practice is generally similar to the person being investigated. This is an expansion of the present review committee process already in place, but which would give the Board more expertise in the specialty areas.

3. The budget of the Board of Healing Arts should be expanded for more investigators, hearing examiners, support staff and equipment which is necessary to undertake the program outlined in these recommendations. We acknowledge that some improvements have recently been made in the Board's funding, however, a more effective investigation and processing of complaints will require much more financial support. Funding should come first from monies generated by licensing fees, and if necessary, consideration should be given to a supplement from the State General Fund.

4. Impaired physicians committees that are formally recognized by the Board of Healing Arts should receive exemption from the reporting statutes and have

confidentiality in their work. These exceptions should not extend beyond the first referral for each physician, i.e., if a physician being treated and monitored by a recognized impaired physician committee violates the agreement made with that committee, the committee should then be required to report that violation to the Board.

5. A specific statutory civil cause of action should be enacted to give protection to persons who report deficiencies to a hospital peer review committee or the Board of Healing Arts. The concern here is to prevent retaliation by physicians or hospital management against persons who, in good faith, report malpractice or unethical conduct. A provision for equitable relief would permit a Court to order an employee's reinstatement with back pay if it is established that discharge or adverse action was due to filing the complaint and levy a civil penalty not to exceed twice the amount of damages.

6. The State, through the Health Department as to hospitals, and the Board of Healing Arts as to physicians, should become actively involved in supporting medical risk management and quality assurance programs. These State agencies should undertake or encourage research to identify problem areas, facilities and practitioners if good professional trade association programs are not quickly put in place.

7. The Board of Healing Arts should be prohibited by statute from renewal of a license of a person in active practice in Kansas until it is in receipt of evidence of current malpractice insurance. The statute should further specifically provide that the burden to show current malpractice insurance (eligibility for renewal) is on the licensee. In addition, the Board shall immediately suspend an active licensee who cancels insurance and continues to practice.

8. Amend reporting requirements for less than minimum standards of care to provide that hospital officials, medical staff, nursing staff, and hospital technician staff are required to report circumstances reasonably believed to constitute below standard care or unethical conduct to peer review committees of their institution. Intentional failure to do so can result in suspension of license by the appropriate licensing board.

9. Amend K.S.A. 1984 Supp. 65-28,121 and 28,122 to require hospital officials, medical staff and peer review committees to report any evidence of incompetent conduct to the Board of Healing Arts within a reasonable period of time. Authorize Board to assess fines or suspend for failure to report (See Arizona law, A.R.S. 32-1451(A)).

10. Specifically permit the Board of Healing Arts to order a licensee to complete further education or training as part of other disciplinary action.

11. Amend K.S.A. 1984 Supp. 65-28,121 to require hospitals, medical staffs, or other similar institutions to report the voluntary surrender or limitation of staff privileges to the Board of Healing Arts. Presently, only involuntary terminations, suspensions or restrictions are reported.

12. Amend K.S.A. 65-2836(1) to include as reason for disciplinary action the voluntary surrender or limitation of a licensee in another State, territory, or District of Columbia, or other country, if the surrender was in lieu of prosecution or revocation.

The above recommendations have been submitted to Ted F. Fay, Attorney for the Citizens Committee, for preparation of a final written report. The above recommendations may be altered editorially in the final report in order to more fully reflect the views, conclusions, and recommendations of the Committee.

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Presentation to
The Kansas Legislature
Interim Committee on Medical Malpractice

October 9, 1985

Mr. Chairman; Members of the committee. I am Ron Smith, Legislative Counsel for the KBA.

At our midyear conference September 27th, KBA's Legislative Committee and Executive Council discussed many of the issues you're discussing regarding this complex issue. Our committee and the Council have lawyers from all different philosophies and client mix. We think KBA's program, when combined with other suggestions, will give Kansas health care providers positive, long-term relief from high malpractice premiums in Kansas.

I'd like to briefly review what KBA now recommends to you with regard to this problem.

1. Peer Review

KBA supports most recommendations of the Healing Arts Board to strengthen peer review of health care providers. A true medical malpractice solution begins with solid peer review.

2. Insurance related Issues

(a) KBA supports reducing the statutory limit on Health Care Stabilization Fund liability from the current $3 million to $1 million. No other state has liability limits in its "excess coverage" fund exceeding $1 million. Insurance officials estimate this will achieve an 18% reduction in medical malpractice surcharges.

(b) KBA supports the concept of experience rating of health care providers. Doctors with significant paid malpractice claims experience represent about 1% of the physicians of Kansas, but a much larger percent of total awards. Without experience ratings, health care providers with good records will continue to unduly subsidize the rest.

3. Changes in the tort system

(a) KBA supports requiring proof of the present value of future damages. Such a requirement would make the principle

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of structured settlements applicable to verdicts, and when this principle is combined with collateral source adjustments you made last year, it should do for verdicts what structured settlements have done for the cost of settlements. We believe that this recommendation has the best chance of true reduction of excessive verdicts, and this change is constitutional.

(b) KBA supports requiring itemized jury verdicts. With itemized instead of lump sum verdicts, judges can better determine whether verdicts are excessive, whether the evidence supports the award, and whether awards of damages for future expenses were reduced to present value. In addition, we recommend legislation that requires state District Court clerks to send copies of such verdicts to the Judicial Administrator so that a statistics base can be created.

(c) KBA opposes artificial limits on awards. In addition to the unfairness, such a provision is probably unconstitutional. Medical Malpractice actions are part of our common law experience, and as such, Article 18 of the Kansas Constitution is important to this discussion. Other less restrictive alternatives, which are constitutional, have not yet been tried.

(d) KBA supports tying post-judgment interest rate to annual T-bill rate. The current 15% statutory rate is unfairly high in current markets, and such rates adversely impact the solvency of the Health Care Stabilization Fund.

(e) KBA supports medical malpractice screening panel reform:

KBA has consistently favored legislation which eliminates frivolous lawsuits from our system. Statistics indicate total medical malpractice claims are increasing, but the number of paid malpractice remains about the same. KBA supports the concept of mandatory pretrial screening with results admissible in subsequent trials UNLESS:

(1) the plaintiff files an affidavit that he has consulted with a medical expert qualified to render an opinion who has determined the case has merit. At the initial discovery conference, the sufficiency of the affidaciency of the affidavit arises, the Court, on its own motion can order a screening panel, and if so ordered, the results are admissible in subsequent trial.

(2) There should be strong sanctions against attorneys for false verification.

(3) Doctors are granted immunity to serve on panels, and are available to testify at trial. If a panel is requested, the statute of limitations stops.

KBA recognizes that mandatory screening will weed out some unwanted cases. But screening all cases adds additional costs to the insur-

ance process in many cases which those added costs need not be incurred by either side. What we recommend would help screen the marginal cases, but not added expenses to the meritorious claims.

4. Let Current Law Have A Chance To Work

The 1984 and 1985 legislatures made significant changes in our law regarding medical malpractice cases. With the further changes suggested above, and recent changes in law, we believe it is an appropriate time to see what effect these cumulative actions have on premiums.

Conclusion

Medicine and the Law both exist to serve the public interest. We do agree with health care providers that their problem is substantial and that something needs to be done in 1986. We are concerned, however, that what is enacted be constitutional. If what you do in 1986 is later declared unconstitutional, precious time needed to speak to this problem will be lost. Thus, KBA believes less drastic measures, which still have positive economic impact on malpractice rates, should be your focus.

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MEMORANDUM

To: Members, Interim Committee on Medical Malpractice

From: Ron Smith, Legislative Counsel

Subj: Indiana Medical Malpractice Screening Panel Law

Date: October 9, 1985

Proponents of major change in our medical malpractice law have offered the "Indiana Plan" as a model. At your October meeting, you may hear from persons from Indiana about their system. I'm certainly not an expert, but a cursory reading of the Indiana Code of Civil Procedure and malpractice law indicates some surprises.

If the legislature assumes that by adopting the Indiana Medical Malpractice Plan Kansas health care providers will see lower premiums, then the comparison of systems must be total, not partial. If only parts of Indiana malpractice and negligence law are adopted, it stands to reason only part of the premium reductions, if any, will be obtained.

The Indiana Plan has four parts: (1) a $500,000 absolute limit on malpractice awards, (2) Mandatory use of screening panels and admissibility of results; (3) attorney fee limitations; and (4) periodic payment of judgments.

Generally

1. Indiana "health care providers" include all nurses and dentists (I.R.C. 16-9.5-1-1(a)(1). Kansas' definition does not include most dentists and nurses. Thus, the pool of "health care providers" for actuarial purposes in Indiana is much larger than Kansas, and their database would have claims against dentists and nurses, which we don't have in Kansas.

2. Indiana does not require mandatory medical malpractice insurance. To be a "qualified" participant, however, HCPs must purchase the minimum $100,000 commercial insurance, and pay a surcharge to their Patient's Compensation Fund. The effect of

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not being a "qualified health care provider" in Indiana means that if sued, a recovery against a doctor is not limited under the law, nor does the screening panel have to be impaneled. Because Kansas requires mandatory insurance, and Indiana does not, the premiums may have a different base, and any comparison of premium rates between Kansas and Indiana may be unfair.

3. Indiana has recently enacted Comparative Fault (I.R.C. 34-4-33-1). However, medical malpractice actions are specifically excluded from its coverage (I.R.C. 34-4-33-1(a)). Indiana HCPs under the act thus can use a "contributory negligence" rule in determining a physician's liability. If the plaintiff is found to be partially negligent and that negligence contributes to his injury, the defendant physician is absolved of ALL liability. Kansas' comparative negligence rule applies to all personal injury defendants, including doctors. This is an important difference in systems.

4. Indiana's statute of limitations on malpractice actions is two years " . . . from the date of the alleged act, omission or neglect"; children have until their 8th birthday to file (I.R.C. 16-9.5-3-1). This appears to mean two years from the date of the incident. The only exception to the strict two-year rule is "fraudulent concealment" by the physician of information that gives the patient the ability to discovery the malpractice. In any event, the end of the physician - patient relationship ends this exception, and the statute begins to run (see Spoljaric v. Pangan, ___ Ind. ___, 466 NE 2d 37 (1984)). Kansas has a discovery rule, that is, the action must be brought within two years of discovery, or 4 years total, with similar provisions for minor children. This time difference is important to premium rate structure.

5. In Indiana, if the commercial insurance carrier concedes that the health care provider was negligent, then the Indiana Patient's Compensation Fund cannot separately contest liability. All that is then determined is a proper amount of damages. Kansas gives more flexibility to its fund to separately defend negligence claims than does Indiana.

6. In Indiana, statutes limit the surcharge which can be required for the Patient's Compensation Fund to 75%, unless the Fund is less than $15 million, at which time the Indiana Insurance Commissioner, by regulation, can implement a higher surcharge (I.R.C. 16-9.5-4-1.1). Currently, Indiana's surcharge is 75%. In Kansas, the Insurance Commissioner has always determine the applicable surcharge, which is currently 110%. A surcharge history in both states is below:

FY	Indiana Surcharge %	Kansas Surcharge %
1976	10%	NA
1977	10%	45%
1978	10%	45%
1979	10%	40%
1980	10%	15%
1981	10%	0%
1982	25%	0%
1983	25%	0%
1984	50%	50%
1985	75%	80%

1986	75%	110%

(Source: Indiana and Kansas Insurance Departments. NOTE that while our statute set up a system where for 3 years no premium surcharge was collected to help finance the Health Care Stabilization Fund, Indiana increased their surcharge 150%.)

Limits on Awards

1. Indiana limits total malpractice awards to $500,000 (I.R.C. 16-9.5-2-2). The limit was enacted in 1975. Kansas has no statutory limit on the award, although the Health Care Stabilization Patient's Compensation Fund will pay a limit of $3 million per provider per injury.

2. The $500,000 limited recovery appears to be on the plaintiff, not the Indiana Patient's Compensation Fund itself (I.R.C. 16-9.5-2-2(a)). If two physicians both share 50-50 responsibility for the injury to the patient, and that injury totals $1 million, the total amount that can be awarded is still $500,000. No Kansas law exists which makes this distinction, primarily because there is no statutory cap on awards.

Screening Panels

1. In Indiana screening panels are mandatory before plaintiffs can proceed to court. However, two important exceptions exist:

(a) If all parties to the action agree in writing, they can proceed to court without a screening panel (I.R.C. 16-9.5-9-2(b)) and;

(b) If the amount of damages sought is less than $15,000 (I.R.C. 16-9.5-9.2.1)

2. In Indiana, three health care providers are chosen for each mandatory panel. When the act was originally passed, any provider could sit on any panel without regard to speciality. The Indiana law was amended in 1985 to require 2/3rds of the panel must be from similar specialities (I.R.C. 16-9.5-9-3(b)(1)), but this provision was not effective until September 1, 1985. The makeup of the panel is important because the report of the panel, by operation of law, becomes "expert testimony" to be used in subsequent litigation (I.R.C. 16-9.5-9-7). It is curious that for nearly ten years in Indiana, surgeons were "experts" to give opinion testimony for or against OB-GYNs in Indiana courts, a situation which Kansas case law has not allowed.

3. In Indiana, fees and costs of the screening panel, including travel costs, are paid by the winning side (I.R.C. 16-9.5-9-10(c)). In Kansas, each party pays their own costs.

4. Statutorily, the evidence an Indiana panel can review is usually submitted only in writing. It is not a hard and fast rule. They may include medical charts, X-rays, lab tests, treatises, depositions of

witnesses and "any other form of evidence allowable by the review panel." (I.R.C. 16-9.5-9-4) Depositions of the parties and witnesses may be taken prior to the panel convening (ibid). Thus, considerable discovery expense can be incurred by all parties prior to the Indiana panel ever making a decision.

Further, the Indiana statute limits only the type of evidence the screening panel may see to construct their screening panel opinion. At trial, however, Indiana case law indicates hearsay conversations between physicians can be the basis of a screening panel finding, and any panelist later can testify in court as to the substance of the hearsay and whether the hearsay became the basis of their opinion (see Kranda v. Houser-Norborg Medical Corp., ___ Ind. ___, 419 NE 2nd 1024 (1981). Because Kansas does not make the finding of its panels admissible, this question has not arisen.

5. The Indiana screening panel has the "sole duty to express its expert opinion" whether the evidence supports the conclusion the defendants acted within appropriate medical standards of care. (I.R.C. 16-9.5-9-7) This appears to prohibit the presentation of written opinions from expert witnesses hired by the parties during screening panel proceedings. In Kansas, the screening panel can consider written opinions of expert witnesses to help arrive at a conclusion.

6. Interestingly, if the Indiana Screening Panel makes a finding that the negligence of the provider was a factor in resulting damages, it also determines whether the plaintiff suffered any "disability, the extent and duration of the disability, any permanent impairment and the extent and duration of the impairment." (I.R.C. 16-9.5-9-7(d)). Determining disability and functional impairment is an element of proving damages. Thus, Indiana screening panels begin to make decisions regarding damages as well as liability. If the parties proceed to trial, these "experts" have their opinion as to disability and impairment introduced into evidence. Kansas panels render opinions solely on the liability and causation issues, not damages.

cc: KBA Executive Council
and Legislative Committee

KANSAS MEDICAL SOCIETY

Recommendations to the Special Committee on Medical Malpractice

October 10, 1985

10/10-11/85
Attachment IV

Section 1

The purpose of this bill is to assure that quality health care services will be available to Kansas residents. The availability and affordability of such services are threatened by escalating malpractice insurance rates. This bill is designed to lower premiums while providing just compensation to injured persons.

Section 2

Section 2 defines terms used in the bill.

Section 3

Section 3 limits damages in medical malpractice actions in three ways:

(1) Damages for noneconomic losses, such as "pain and suffering" are limited to $100,000;

(2) Overall damages except for future medical care are limited to $500,000; and

(3) Where future medical care increases damages to more than $500,000, the award may not exceed $1,000,000.

Section 4

The jury, or the judge, may award a monthly sum for medical care under Section 4. Should the plaintiff no longer need this care, or should he need more care, this amount may be modified by the court.

Sections 5-13

Sections five through thirteen blend Kansas and Indiana laws creating screening panels to review a medical malpractice claim before it is filed as a lawsuit. The panels each consist of three health care providers and an attorney chairman. The panel looks at evidence presented and determines whether the provider acted beneath the standard of care, and whether the actions caused the injury. The panel opinion is admissible evidence if a lawsuit is filed. Whenever the panel unanimously decides that the provider did not act beneath the standard of care and the claimant decides to file a lawsuit, the claimant must first submit his case to an expert and file an affidavit to this effect.

Section 14

Under the bill, an attorney may not recover as his contingency fee more than 15% of any judgment against the fund. All fees must be fixed by a written agreement.

Section 15

This section provides that the court must hold, and all parties (including persons with authority to settle the claim) must attend a settlement conference prior to trial.

Section 16

Section 16 states qualifications which an expert must meet prior to testifying in a medical malpractice case. Experts who testify in an action against a nonspecialist must devote 75% of their time to active clinical practice.

Section 17

Amending K.S.A. 65-4915, Section 17 broadens the definition and function of peer review committees. The section also provides that a provider who unsuccessfully contests a peer review decision concerning staff privileges, must pay costs and attorney fees of the party creating the committee.

Section 18

Section 18 eliminates the "sunset" provision of S.B. 110, so that the provisions of that bill will not automatically be repealed on July 1, 1989.

Section 19

This provision amends K.S.A. 40-3408 to allow an insurance company to exclude from coverage another health care provider. To demonstrate, imagine that Dr. A, an obstetrician, associates with Dr. B, a pediatrician, to consult with his patients. If Dr. B is sued for malpractice, Dr. A's insurance carrier need not cover Dr. B since Dr. B is a health care provider and must maintain insurance in his own right.

Section 20

Section 20 amends K.S.A. 40-3401 to include professional partnerships within the definition of health care provider.

Section 21

Section 21 amends K.S.A. 40-3403 in several ways. First, it provides that only inactive health care providers who have contributed to the fund for three (3) consecutive years are protected by the fund. Second, it allows the commissioner to purchase an annuity to pay a judgment or settlement. Third, it limits the fund's liability to $800,000. Fourth, it relates back to Section 19 and eliminates liability based upon the association of one health care provider with another.

Section 22

Because maintaining professional competence is crucial to maintaining quality health care, Section 22 provides a reporting system for health care providers. When a licensed health care provider has information that another provider acted beneath the appropriate standard of care, that provider must report to the appropriate professional society or licensing agency hospital administrator. If the report is to an agency, they may refer it to the appropriate professional society for investigation. The society or hospital committee must refer to the licensing agency any report which after investigation reveals that the provider acted beneath the standard of care. There are procedures to insure that proper investigations are being made.

When the report deals with an impaired provider the state licensing agency may agree with the professional society that the society provide treatment through its own program.

Section 22 also provides that a person or committee will not be subject to civil liability for making a report.

Section 23

Under Section 23, insurers must report all claims filed against a health care provider. The reports are made to the appropriate state licensing agency and the commissioner of insurance.

Bill No. _____

AN ACT concerning health care providers; relating to actions for damages based on professional liability; providing for certain procedures and limitations relating thereto; providing for the convening of screening panels and the duties thereof; relating to attorney's fees; providing for mandatory settlement conferences and expert witness qualifications; providing procedures to maintain the quality of health care in Kansas; amending K.S.A. 40-3401, 40-3403, 40-3408, 65-4915, 1985 Kan. Sess. Laws Ch. 197 and repealing the existing sections; repealing K.S.A. 65-4901 through 65-4908, 7-121b.

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

Purpose

Sec. 1. Recent dramatic increases in rates for health care provider professional liability insurance have created a crisis of affordability and availability of such insurance. This crisis poses a serious threat to the continued quality and availability of health care for Kansas citizens. In the interest of the public health and welfare, new measures are required to assure that affordable professional liability insurance will be available to health care providers in Kansas, while maintaining adequate compensation to those injured by the negligence of a health care provider and ensuring the quality of care. This act shall be liberally construed and applied to promote the foregoing purpose.

Definitions

Sec. 2. In this act, unless the context otherwise requires:

(a) "Basic coverage," "commissioner," "fund," "health care provider," "insurer," and "professional liability insurance" have the meanings provided by K.S.A. 40-3401 and amendments thereto.

(b) "Claimant" means any person asserting a claim for damages for medical malpractice.

(c) "Future medical care and related benefits" means all reasonable medical, surgical, hospitalization, physical rehabilitation and custodial services, including drugs, prosthetic devices and other similar materials reasonably necessary in the provision of medical services caused by the medical malpractice of the liable health care provider. "Future medical care and related benefits" does not mean nonessential specialty items or devices of convenience.

(d) "Medical malpractice" means the negligent rendering or failure to render professional services by a health care provider in a manner which causes injury to a patient.

(e) "Respondent" means a health care provider against whom a claim for damages on account of medical malpractice is asserted in a proceeding commenced before a screening panel.

Sec. 3.

Limitation on awards

(a) (1) In any action for medical malpractice the total amount recoverable for all claims, exclusive of future medical care and related benefits, shall not exceed five hundred thousand dollars ($500,000).

Total limitation

(2) Payments for future medical care and related benefits shall be paid pursuant to the provisions of section four of this act, and shall be paid without regard to the five hundred thousand dollar ($500,000) limitation on recovery. However, the total amount which may be recoverable for all malpractice claims for injuries to or death of a patient, inclusive of future medical care and related benefits, shall not exceed one million dollars ($1,000,000).

Limitation on future medical care

(3) If a health care provider has qualified for and paid the applicable premium surcharge levied pursuant to K.S.A. 40-3404 and amendments thereto, the health care provider shall in no event be personally liable for an award of compensatory damages in any amount.

Limitation on nonpecuniary losses

(4) Notwithstanding the foregoing limitations, damages other than for pecuniary losses sustained by all parties, cannot exceed in the aggregate one hundred thousand dollars ($100,000).

(b) When a malpractice action is tried to a jury, the court shall not instruct the jury on the monetary limitations imposed. If the verdict results in an award of damages for pecuniary losses which, after deduction of any amounts pursuant to K.S.A. 60-258a and amendments thereto, exceeds the $500,000 limitation imposed by this section, the court shall enter judgment for damages of $500,000 and apportion the same among the parties. If the verdict results in an award of damages for nonpecuniary losses which, after deduction of any amounts pursuant to K.S.A. 60-258a and amendments thereto, exceeds the $100,000 limitation imposed by this section, the court shall enter judgment for nonpecuniary losses in the amount of $100,000 and apportion the same among the parties.

Itemization of damages

(c) In every case where damages under this section are assessed by the jury or the court the verdict or finding shall be itemized to reflect the monetary distribution among pecuniary loss and nonpecuniary loss. Pecuniary loss shall be further itemized by category to include:

(1) amounts intended to compensate for damages incurred prior to the verdict for necessary medical care and related benefits;

(2) amounts intended to compensate for damages for lost wages, or loss of earnings;

(3) other economic losses;

(4) the amount of the current monthly future medical care and related benefits.

(d) The provisions of this section shall not be construed to repeal or modify the limitation in wrongful death actions authorized by K.S.A. 1984 Supp. 60-1903.

Sec. 4.

Future medical care and related benefits

(a) (1) In arriving at the amount of future medical care and related benefits, the court or jury shall consider all other benefits available to the claimant from other sources to make the amount of future medical care and related benefits supplementary to any amounts of collateral source benefits and avoid duplication of such amounts.

(2) The amount of future medical care and related benefits shall be reduced or apportioned pursuant to the provisions of K.S.A. 60-258a and amendments thereto as they may be applied by the court or jury.

(b) Subject to the limitations imposed by section three and K.S.A. 40-3403 and amendments thereto the court shall enter judgment for the amount of the verdict exclusive of future medical care and related benefits. The court shall separately enter judgment for the current monthly amount of damages for future medical care and related benefits. The amount of monthly future medical care and

related benefits shall automatically become a judgment each month thereafter until either modified by the court or abated, as provided by this section.

Modification of award

(c) (1) The court shall retain jurisdiction of the action and may modify the amount of future medical care and related benefits from time to time as reasonably required by the needs of the patient.

(2) Any party may seek modification at any time by filing a motion for modification with the court. If the court:

A. fails to modify the judgment when requested by the judgment debtor, or

B. increases the judgment amount upon request by the claimant beyond an amount which the judgment debtor was willing to pay upon written demand and tender of proof regarding changed circumstances by the claimant,

the court may award reasonable attorney fees to the claimant.

(3) In no event shall a modification of a judgment exceed the limitations imposed by this section of this act.

(4) If there is reason to believe that claimant's need for medical care and related benefits has substantially changed, the court may order the claimant to submit to a physical examination upon written request by the judgment obligor. The claimant shall not be ordered to submit to a physical examination more than once annually. The judgment obligor shall pay all reasonable expenses of the examination, and shall furnish a copy of the examination report to the claimant. The claimant shall, upon request, furnish authorizations permitting the judgment obligor to

obtain copies of medical records from health care providers providing treatment to the claimant.

(d) The obligation to reimburse the claimant for future medical care and related benefits shall abate upon the death of the claimant or at such time as the claimant no longer requires future medical care and related benefits or has received the total amount of recovery allowed under this act.

(e) If the health care provider has obtained the basic limits of professional liability insurance required by K.S.A. 40-3402 and amendments thereto and has paid the applicable premium surcharge levied pursuant to K.S.A. 40-3404 and amendments thereto, for the period in which the claimant's claim is made, the provider's insurer and the fund shall pay the amount of the judgment, to the extent of the limits of the applicable policy, this act and subsection (e) of K.S.A. 40-3403 and amendments thereto. After any such judgment becomes final, the insurer or the commissioner may be substituted for the judgment obligor upon motion of any party. The insurer or commissioner shall thereafter be the judgment obligor as to any judgments entered under subsection (d). Upon such substitution any judgment lien rendered against a health care provider pursuant to K.S.A. 60-2202 and amendments thereto shall be released.

(f) Any determination by a court or jury of the amount of future medical care and related benefits or any modification thereof, shall be subject to appellate review. In the event any insurer or the fund fails for a period of sixty (60) days, to pay the amount of future medical and related benefits finally determined to be due, the court may award reasonable attorney fees to the claimant's attorney for services incurred in collecting such amount.

(g) Notwithstanding any provisions of this act, the insurer of a health care provider or the fund may contract with the claimant or his representative to compromise and settle all or part of the claim. Any agreement which requires payment by the fund shall not be effective until approved by the court, with notice to the commissioner. Such agreement shall be a final determination of liability to the claimant, and may fully or partially modify any obligation to provide future medical care and related benefits.

Sec. 5.

Screening panel

(a) Any party making a claim for damages on account of alleged medical malpractice shall request, by filing a memorandum with a district court of this state having proper jurisdiction and venue under the Kansas Code of Civil Procedure, that a screening panel be convened, and the judge of the district court or, if the district court has more than one division, the administrative judge of such court shall convene a screening panel. The judge shall then notify all parties. The notice shall include the name of the attorney selected as chairperson and the need to select the other members as provided by subsection (C).

The state agency which licenses, registers, certifies or otherwise is responsible for the practice of any group of health care providers shall maintain and make available to the parties to the proceeding a current list of health care providers available to serve on the screening panel. The persons appointed shall constitute the screening panel for the particular medical malpractice claim to be heard.

Members of the screening panel

(b) The screening panel shall consist of one (1) attorney and three (3) health care providers. The attorney shall act as chairman of the panel and in an advisory capacity, but shall have no vote. It is the duty of the chairman to expedite the selection of the other panel members, to convene the panel, and expedite the panel's review of the proposed petition or request. The chairman may establish a reasonable schedule for submission of evidence to the screening panel but must allow sufficient time for the parties to make full and adequate presentation of related facts and authorities.

Selection of panel members

(c) The screening panel shall be selected in the following manner:

(1) Within fifteen (15) days after the memorandum is filed with the district court, the judge shall select an attorney to serve as chairman of the panel.

(2) Within fifteen (15) days after the chairman is selected, both parties shall select a health care provider and they shall notify the other party and the chairman of their selection. The panelists shall be from the same class of health care provider as the respondent. When a respondent is a health care facility or a health care organization, it shall have the option of selecting as a panelist a health care provider, the administrator

of a facility or organization of the same class as respondent, or a nurse. The non-attorney panelists must have expertise in the subject matter of the claim. If a party fails to make a selection within the time provided, the chairman shall make the selection and notify both parties. Within fifteen (15) days after their selection, the health care provider members shall select the third member within the time provided and notify the chairman and the parties. If they fail to make a selection, the chairman shall make the selection and notify both parties.

(3) Within ten (10) days after any selection written challenge without cause may be made to the panel member. Upon challenge or excuse the party whose appointee was challenged or dismissed shall select another panelist. If the challenged or dismissed panel member was selected by the other two (2) panel members, they shall make a new selection. If two (2) such challenges are made and submitted, the chairman shall within ten (10) days appoint a panel consisting of three (3) qualified panelists and each side shall within ten (10) days after the appointment strike one (1) with the party whose appointment was challenged striking last, and the remaining member shall serve.

(4) When the screening panel is formed, the chairman shall within five (5) days notify the court and the parties by registered or certified mail of the names and addresses of the panel members and the date on which the last member was selected.

(d) A panelist shall serve unless the parties by agreement excuse him or for good cause shown he may be excused as provided in this subsection.

(1) To show good cause for relief from serving, the attorney selected as chairman must serve an affidavit upon the judge of the court. The affidavit shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. The judge may excuse the attorney from serving and shall then select a new chairman as provided in subsection (c)(1) of this section.

To show good cause for relief from serving, non-attorney panelists must serve an affidavit upon the panel chairman. The affidavit shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. The chairman may excuse the member from serving and notify all parties.

(2) Members of the screening panel shall certify under oath that they are without bias or conflict of interest with respect to any matter under consideration and have no knowledge of the facts of the claim. Members of the panel may disqualify themselves only upon approval of the court.

Sec. 6. In claims where there are multiple respondents, the court shall determine whether the claim against each health care provider may be reviewed by a separate panel or whether a single combined panel may review the claims against all respondents.

Compensation for panel members

Sec. 7. Each health care provider member of the screening panel shall be paid a total of one hundred fifty dollars [$150.00], for all work performed as a member of the panel exclusive of time involved if called as a witness to testify in court, and in addition thereto, reasonable travel expense.

The chairman of the panel shall be paid a total of two hundred fifty dollars ($250) for all work performed as a member of the panel exclusive of time involved if called as a witness to testify in court, and in addition thereto reasonable travel expenses. The chairman shall keep an accurate record of the time and expenses of all the members of the panel, and the record shall be submitted to the parties for payment with the panel's report.

Fees of the panel including travel expenses and other expenses of the review shall be paid by the side in whose favor the majority opinion is written. If there is no majority opinion, then each side shall pay one-half [1/2] of the cost.

Items which may be included in the taxation of costs shall be those items enumerated by K.S.A. 60-2003.

Procedure

Sec. 8. The screening panel shall convene with notice in writing to all parties and their counsel and shall consider medical records and medical care facility records, contentions of the parties, examination of x-rays, test results and treatises. All meetings of the screening panel shall be held in-camera. The screening panel shall give notice, organize and conduct their meetings as follows:

(a) The chairperson of the screening panel, as soon as practicable after his selection, shall convene the screening panel at a time and place to be mutually agreed upon for a conference.

(b) The chairperson shall notify the parties of the date of such conference. The claimant shall file with the chairperson at least thirty (30) days before the conference all medical records, medical care facility records, x-rays, test results, treatises, and contentions upon which the claimant relies. A copy thereof shall be provided to the other party except x-rays, the original of which shall be made available to all parties by the chairperson.

(c) The claimant shall furnish to all health care providers who have provided health services or treatment to the claimant in connection with the injuries or disease out of which the claim arose, an authorization releasing records to the screening panel or parties. Such authorization shall not be a waiver for any other purpose.

(d) Parties shall not discuss material facts of the case with any panel members.

(e) Within twenty (20) days after claimant's filing the respondent shall in like manner provide the chairperson and the claimant a copy of all medical records, medical care facility records, x-rays, test results, treatises, and contentions not theretofore provided.

(f) The contention of the parties shall contain a statement of the issues of fact and law; a brief statement of the facts in support of and in opposition to the claim; and a brief statement of the law that is applicable with citation of authority in support thereof. Contentions shall not contain a statement of facts not included in the records filed with the chairperson.

(g) If the screening panel determines that further information or legal authority is required, the screening panel at the discretion of the chairperson shall within five (5) days notify the parties of the additional material required and may submit written questions to the parties the answers to which need not be verified under oath. The requested additional material shall be limited to the issues of fact as contained in the contentions. Such additional material and answers shall be filed with the chairperson within ten (10) days after receipt of the written questions by mailing a copy of such answers to all parties and the chairperson. Upon receipt of the requested material, the chairperson shall then reconvene the screening panel.

Sec. 9.

Form of opinion

(a) Within ninety (90) days of receiving all necessary information the panel shall render one or more of the following expert opinions based upon reasonable degree of probability, which shall be in writing and signed by the panelists:

(1) The evidence supports the conclusion that respondent or respondents failed to comply with the appropriate standard of care as charged in the memorandum.

(2) The evidence does not support the conclusion that the respondent or respondents failed to meet the applicable standard of care as charged in the memorandum.

(3) That there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury.

(b) In the event the panel finds that the respondent failed to comply with the appropriate standard of care, it shall also find the conduct complained of was or was not a cause of the resultant damages.

(c) A concurring or dissenting member of the screening panel may file a written concurring or dissenting opinion.

(d) The screening panel shall notify all parties within seven (7) days of its decision and shall provide a copy of its opinion and any concurring or dissenting opinion to each party and each attorney of record and to the judge of the district court or, if the district court has more than one division, the administrative judge of such court. The screening panel shall also provide a copy of its opinion and any concurring or dissenting opinions, and the reasons therefor, to the commissioner.

(e) Any report of the expert opinion reached by the screening panel shall be admissible as evidence in any action subsequently brought by the claimant in a court of law, but such expert opinion shall not be conclusive and either party shall have the right to call, at his cost, any member of the screening panel as a witness. If called, the witness shall be required to appear and testify.

Sec. 10. In the event that one or more of the parties rejects the final determination of the screening panel, the claimant may proceed with the action in the district court, subject to the provisions of Sec. 13 of this act.

Sec. 11. No member of the screening panel shall be subject to a civil action for damages as a result of any action taken or recommendation made by such member acting without malice and in good faith within the scope of such member's official capacity as a member of the screening panel.

Sec. 12. The filing of a memorandum requesting the convening of a screening panel shall toll any applicable statute of limitations and such statute of limitations shall remain tolled until thirty (30) days after the screening panel has issued its written recommendations.

Sec. 13.

Conditions precedent to suit after panel decision

(a) When a screening panel reaches a unanimous recommendation that the evidence presented does not support the conclusion that the respondent or respondents failed to meet the standard of care as charged in the memorandum, or that the conduct complained of was not a factor of the resultant damages, and the claimant proceeds with suit, the claimant's attorney, or the claimant if proceeding pro se, shall file an affidavit, attached to the original and all copies of the petition. The affidavit shall declare that the affiant has consulted and reviewed the facts of the case with a health professional, who the affiant believes is knowledgeable in the relevant issues comprising the claim; that the reviewing health care professional has determined in a written report after a review of medical records and other relevant material that there is a reasonable and meritorious cause for the filing of the action. A copy of the report that clearly identifies the claimant and clearly states the reasons for the reviewer's determination that a reasonable and meritorious cause for filing the action exists, must be attached to the affidavit.

(b) When the affiant is unable to obtain a consultation because the statute of limitations would impair the action, and the consultation could not be obtained prior to the expiration of the statute of limitations, the affiant must declare why such consultation could not be obtained, and state the date upon which claimant requested legal services regarding his claim. The affidavit must also state that the claim is being brought in good faith and upon a reasonable belief in its validity. The affiant shall have ninety (90) days to obtain and file the report. The respondent shall be

excused from filing his answer or otherwise pleading until twenty (20) days after being served by mail with the report.

(c) A separate affidavit and report shall be filed for each respondent named in the action, and for each respondent joined at a later time.

(d) The failure to file an affidavit and report under this section shall be grounds for dismissal of the suit without prejudice.

(e) Allegations and denials made in the affidavit or report without reasonable cause and found to be untrue shall subject the party pleading them or his attorney, or both, to the payment of reasonable costs and attorney fees actually incurred by the other party by reason of the untrue pleading.

Sec. 14.

Attorneys' fee limitations

(a) Compensation for reasonable attorneys' fees to be paid by each litigant in a medical malpractice action shall be approved by the judge prior to final disposition of the case by the district court. Compensation for reasonable attorneys' fees for services performed in an appeal of a judgment in any such action to the court of appeals shall be approved by the chief judge or by the presiding judge of the panel hearing the case. Compensation for reasonable attorneys' fees for services performed in an appeal of a judgment in any such action to the supreme court shall be approved by the departmental justice for the department in which the appeal originated. In approving such compensation, the judge or justice shall examine the same and make such determination considering the nature and difficulty of the issues involved in the case and the time reasonably necessary to prepare and present the same.

(b) Attorney fees shall be fixed pursuant to a written contract between the attorney and the claimant. The contract shall be filed with the court in which the action is pending and the court shall approve attorney fees only if they are in accordance with the provisions of this section, and are fair and reasonable.

Payment of attorney fees pursuant to a contingent fee agreement shall not exceed 15% of any judgment against, or settlement with, the fund. The limitations on payment of attorney fees under this section shall not be circumvented by contractual provisions permitting an inordinate or unreasonable fee upon that portion of the recovery payable from the basic limits of insurance.

Contracts for attorney fees not in excess of the limits provided in this section and approved by the court shall be enforceable as a lien on the compensation due or to become due.

Sec. 15.

Mandatory settlement conferences

(a) In any action for medical malpractice the court shall require a settlement conference to be held at least two (2) weeks prior to the date set for trial. Attorneys who will conduct the trial, all parties, and all persons with authority to settle the claim shall attend the settlement conference unless excused by the court for good cause.

(b) Offers, admissions and statements made in conjunction with the settlement conference shall not be admissible in subsequent litigation.

(c) Notwithstanding the provisions of K.S.A. 60-2002,

(1) If a defendant proposes an offer of settlement during the settlement conference which is rejected by the plaintiff and the judgment at trial is at least 25% less than said offer, the defendant shall be entitled to recover reasonable costs and attorney fees incurred on a per diem basis, from the date of said offer.

(2) If a plaintiff proposes an offer of settlement during the settlement conference which is not accepted by the defendant, and the judgment at trial is at least 25% greater than said offer, the plaintiff shall be entitled to recover reasonable costs and attorney fees incurred on a per diem basis from the date of said offer.

(d) The court may in its discretion relieve any party of the penalty imposed by this act if the witnesses, exhibits or evidence presented at trial were not reasonably available to the opposing party at the time of the settlement conference.

Sec. 16. In any action for medical malpractice no person shall qualify as an expert and testify concerning the appropriate standard of care unless that person is familiar with the appropriate standard of care in the locale where the incident occurred at the time the incident occurred.

With respect to an action against a nonspecialist, persons seeking to testify as expert witnesses must devote not less than 75% of their professional time to the active clinical practice of medicine. When the action is against a specialist, persons seeking to testify as expert witnesses must specialize in the same area of medicine as the respondent and must devote not less than 75% of their time to active clinical practice in that specialty.

Peer review committee definition and functions

Sec. 17. K.S.A. 65-4915 is hereby amended to read as follows:

65-4915. (a) As used in this section, "health care provider" has the same meaning as the definition of that term in K.S.A. 40-3401 and amendments thereto.

(b) As used in this section, "peer review committee" means one or more individuals authorized to perform any of the functions described in subsection (c) when ~~a committee of, or~~ appointed by: (1) A state or local association of health care providers (2) the board of governors created under K.S.A. 1984 Supp. 40-3403; (3) an organization of health care providers formed pursuant to state or federal law and authorized to evaluate medical and health care services; (4) a review committee operating pursuant to K.S.A. 1984 Supp. 65-2840b to 65-2840d, inclusive; or (5) an organized medical staff of a licensed medical care facility as defined by K.S.A. 65-425 and amendments thereto, which committee provides peer review pursuant to written bylaws that have been approved by the governing board of such medical care facility; or by (6) a health care provider. ~~as defined in K.S.A. 40-3401 and amendments thereto, which committee provides peer review pursuant to written bylaws that have been approved by the governing board of such medical care facility or health care provider as defined in K.S.A. 40-3401 and amendments thereto, if the committee so formed by organizations described in parts (1), (2), (3), (4) or (5) of this subsection (b) is authorized to perform any of the following functions:~~

(c) A "peer review committee" is authorized to perform any of the following functions:

(1) Evaluate and improve the quality of health care services rendered by health care providers;

(2) determine that health services rendered were professional indicated or were performed in compliance with the application standard of care;

(3) determine that the cost of health care rendered was considered reasonable by the providers of professional health services in this area;

(4) evaluate the qualifications, competence and performance of the providers of health care or to act upon matters relating to the discipline of any individual provider of health care;

(5) reduce morbidity or mortality;

(6) establish and enforce guidelines designed to keep within reasonable bounds the cost of health care;

(7) conduct of research;

(8) determine if a hospital's facilities are being properly utilized;

(9) supervise, discipline, admit, determine privileges or control members of a hospital's medical staff;

(10) review the professional qualifications or activities of health care providers;

(11) evaluate the quantity, quality and timeliness of health care services rendered to patients in the facility;

(12) evaluate, review or improve methods, procedures or treatments being utilized by the medical care facility or by health care providers in a facility rendering health care.

(13) investigate incidents involving the care and treatment of particular patients and report such incidents to insurance companies or other parties independent of the health care provider who is entitled to receive such reports.

~~(c)~~(d) Except as provided ~~by K.S.A. 60-437 and amendments thereto and~~ by subsections ~~(d)~~(e) and ~~(e)~~(f) of this section, the reports, statements, memoranda, proceedings, findings and records of peer review committees shall be privileged and shall not be subject to discovery, subpoena or other means of legal compulsion for their release to any person or entity or be admissible in evidence in any judicial or administrative proceeding. This privilege may be claimed by the legal entity creating the peer review committee, or by the commissioner of insurance for any records or proceedings of the board of governors.

~~(d)~~(e) Subsection ~~(c)~~(d) of this section shall not apply to proceedings in which a health care provider contests the revocation, denial, restriction or termination of staff privileges or the license, registration, certification or other authorization to practice of the health care provider.

~~(e)~~(f) Nothing in this section shall limit the authority, which may otherwise be provided by law, of the commissioner of insurance, the state board of healing arts or other health care provider licensing or disciplinary boards of this state to require a peer review committee to report to it any disciplinary action or recommendation of such committee, or to transfer to it records of such committee's proceedings or actions to restrict or revoke the license, registration, certification or other authorization to practice of a health care provider or to terminate the liability of the fund for all claims against a specific health care provider for damages for death or personal injury pursuant to subsection (j) of K.S.A. 40-3403 and amendments thereto. ~~Prior to the filing of an action initiating a formal disciplinary proceeding against a health care provider by the state board of healing arts or other health care provider licensing or disciplinary boards of this state,~~ Reports and records so furnished shall not be

subject to discovery, subpoena or other means of legal compulsion and their release to any persons or entity will not be admissible in evidence in any judicial proceeding for bodily injury or death. ~~or administrative proceedings. After such an action is filed, the reports and records dealing with the licensee and related to the action shall be deemed public records.~~

Contesting peer review decisions regarding staff privileges

In the event a health care provider contests the decision of a peer review committee to deny, revoke, restrict or terminate the health care provider's staff privileges, license, registration, certification or other authorization to practice, and a decision is rendered upholding the peer review committee's decision, the provider shall be liable for the reasonable costs and attorney fees of the members of the committee or the party creating the peer review committee.

Elimination of "sunset" clause in S.B. 110

Sec. 18. 1985 Kan. Sess. Laws Ch. 197 is hereby amended as follows:

(1) As used in this act:

(a) "Claimant" means any person asserting a claim for damages in a medical malpractice liability action.

(b) "Fraud" means an intentional misrepresentation, deceipt or concealment of material fact known to the defendant to deprive a person of property or legal rights or otherwise cause injury.

(c) "Health care provider" has the meaning provided by K.S.A. 40-3401 and amendments thereto.

(d) "Malice" means a state of mind characterized by an intent to do a harmful act without a reasonable justification or excuse.

(e) "Medical malpractice liability action" means any action for damages for personal injury or death arising out of the rendering of or failure to render professional services by a health care provider.

(f) "Wanton conduct" means an act performed with a realization of the imminence of danger and a reckless disregard or complete indifference to the probable consequences of the act.

(g) "Willful conduct" means an act performed with a designed purpose or intent on the part of a person to do wrong or to cause injury to another.

(2) (a) In any medical malpractice liability action in which exemplary or punitive damages are recoverable, the trier of fact shall determine, concurrent with all other issues presented, whether such damages shall be allowed. If such damages are allowed, a separate proceeding shall be conducted to the court to determine the amount of such damages to be awarded.

(b) At a proceeding to determine the amount of exemplary or punitive damages to be awarded under this section, the court shall hear evidence of the financial condition of any party against whom such damages have been allowed. Such evidence may include the party's gross income earned from professional services as health care provider but shall not include any such income for more than five years immediately before the act for which such damages under this section are awarded. At the conclusion of the proceeding, the court shall determine the amount of exemplary or punitive damages to be awarded, but not exceeding the amount provided by subsection (d), and shall enter judgment for that amount.

(c) In any medical malpractice liability action where claims for punitive damages are included, the plaintiff shall have the burden of proving by clear and convincing evidence in the initial phase of the trial, that the defendant acted toward the plaintiff with willful conduct, wanton conduct, fraud or malice.

(d) No award of exemplary or punitive damages shall exceed the lesser of: (1) Twenty-five percent of the annual gross income earned by the party against whom the damages are awarded from professional services as a health care provider, as determined by the court based upon the party's highest gross annual income earned from such services for any one of the five years immediately before the act for which such damages are awarded; or (2) three million dollars.

(e) If exemplary or punitive damages are awarded pursuant to this section, 50% of such damages recovered and collected shall be paid to the party awarded them and 50% shall be paid to the state treasurer for deposit in the state treasury and shall be credited to the health care stabilization fund established pursuant to K.S.A. 40-3403 and amendments thereto.

(f) In no case shall punitive damages be assessed pursuant to this section against:

(1) A principal or employer for the acts of an agent or employee unless the questioned conduct was authorized or ratified by a person expressly empowered to do so on behalf of the principal or employer; or

(2) a professional corporation for the acts of a shareholder of that corporation unless such professional corporation authorized or ratified the questioned conduct.

(g) The provisions of this section shall apply only to an action based upon a cause of action accruing on or after July 1, 1985.

(3) (a) In any medical malpractice liability action, evidence of the amount of reimbursement or indemnification paid or to be paid to or for the benefit of a claimant under the following shall be admissible: (1) Medical, disability or other insurance coverage except life insurance coverage; or (2) workers' compensation, military service benefit plan, employment wage continuation plan, social welfare benefit program or other benefit plan or program provided by law.

(b) When evidence of reimbursement for indemnification of a claimant is admitted pursuant to subsection (a), the claimant may present evidence of any amounts paid to secure the right to such reimbursement or indemnification and the extent to which the right to recovery is subject to a lien or subrogation right.

(c) In determining damages in a medical malpractice action, the trier of fact shall consider: (1) The extent to which damages awarded will duplicate reimbursement or indemnification specified in subsection (a); and (2) the extent to which such reimbursement or indemnification is offset by amounts or rights specified in subsection (b).

(d) The provisions of this section shall apply to any action pending or brought on or after July 1, 1985, regardless of when the cause of action accrued.

(4) ~~(a) The provisions of sections 1 through 3 shall expire on July 1, 1989.~~

~~(b)~~ This act shall be part of and supplemental to the code of civil procedure.

(5) K.S.A. 60-471 is hereby repealed.

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

Sec. 19. K.S.A. 40-3408 is hereby amended to read as follows:

40-3408. The insurer of a health care provider covered by the fund or self-insurer shall be liable only for the first $200,000 of a claim for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider, subject to an annual aggregate of $600,000 for all such claims against the health care provider. However, if any liability insurance in excess of such amounts is applicable to any claim or would be applicable in the absence of this act, any payments from the fund shall be excess over such amounts paid, payable or that would have been payable in the absence of this act. The liability of an insurer for claims made prior to July 1, 1984, shall not exceed those limits of insurance provided by such policy prior to July 1, 1984.

If any inactive health care provider has liability insurance in effect which is applicable to any claim or would be applicable in the absence of this act, any payments from the fund shall be excess over such amounts paid, payable or that would have been payable in the absence of this act.

Notwithstanding anything herein to the contrary, an insurer that provides coverage to a health care provider may exclude from coverage any liability incurred by such provider from the rendering of or the

failure to render professional services by any other health care provider who is required by K.S.A. 1984 Supp. 40-3402 and any amendments thereto to maintain professional liability insurance in effect as a condition to rendering professional services as a health care provider in this state.

Business organizations

Sec. 20. K.S.A. 40-3401 (amended by 1985 Kan. Sess. Laws Ch. 166) is hereby amended to read as follows: 40-3401. As used in this act the following terms shall have the meanings respectively ascribed to them herein:

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

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

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

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

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

(f) "Health care provider" means a person licensed to practice any branch of the healing arts by the state board of healing arts, a person who holds a temporary permit to practice any branch of the healing arts issued by the state board of healing arts, a person engaged in a postgraduate training program approved by the state board of healing arts, a medical care facility licensed by the department of health and environment, a health maintenance organization issued a certificate of authority by the commissioner of insurance, an optometrist licensed by the board of examiners in optometry, a podiatrist registered by the state board of healing arts, a pharmacist registered by the state board of pharmacy, a licensed professional nurse who is licensed by the board of nursing and certified as a nurse anesthetist by the American association of nurse anesthetists, a professional corporation organized pursuant to the professional corporation law of Kansas by persons who are authorized by such law to form such a corporation and who are health care providers as defined by this subsection, a partnership of persons who are health care providers under this subsection, a Kansas not-for-profit corporation organized for the purpose of rendering

professional services by persons who are health care providers as defined by this subsection (f), a dentist certified by the state board of healing arts to administer anesthetics under K.S.A. 65-2899 and amendments thereto, a physical therapist registered by the state board of healing arts, or a mental health center or mental health clinic licensed by the secretary of social and rehabilitation services, except that health care provider does not include (1) any state institution for the mentally retarded or (2) any state psychiatric hospital;

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

(h) "Insurer: means any corporation, association, reciprocal exchange, inter-insurer and any other legal entity authorized to write bodily injury or property damage liability insurance in this state, including workmen's compensation and automobile liability insurance, pursuant to the provisions of the acts contained in article 9, 11, 12 or 16 of chapter 40 of Kansas Statutes Annotated;

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

(j) "Professional liability insurance" means insurance providing coverage for legal liability arising out of the performance of professional services rendered or which should have been rendered by a health care provider;

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

(l) ""Self-insurer" means a health care provider who has qualified as a self-insurer pursuant to K.S.A. 40-3414 and amendments thereto or the university of Kansas medical center for persons who are engaged, under the supervision of the clinical faculty member of the university of Kansas school of medicine, in a post-graduate training program approved by the state board of healing arts and operated by the university of Kansas medical center;

(m) "Medical care facility" means the same when used in the health care provider insurance availability act as the meaning ascribed to that term in K.S.A. 65-425 and amendments thereto, except that as used in the health care provider insurance availability act such term, as it relates to insurance coverage under the health care provider insurance availability act, also includes any director, trustee, officer or administrator of a medical care facility;

(n) "Mental health center" means a mental health center licensed by the secretary of social and rehabilitation services under K.S.A. 75-3307b and amendments thereto, except that as used in the health care provider insurance availability act such term, as it relates to insurance coverage under the health care provider insurance availability act, also includes any director, trustee, officer or administrator of a mental health center;

(o) "Mental health clinic" means a mental health clinic licensed by the secretary of social and rehabilitation services under K.S.A. 75-3307b and amendments thereto, except that as used in the health care provider insurance availability act such term, as it relates to insurance coverage under the health care provider insurance availability act, also includes any director, trustee, officer or administrator of a mental health clinic.

(p) "State institution for the mentally retarded" means Norton state hospital, Winfield state hospital and training center, Parsons state hospital and training center and the Kansas neurological institute;

(q) "State psychiatric hospital" means Larned state hospital, Osawatomie state hospital, Rainbow mental health facility and Topeka state hospital.

Sec. 21. K.S.A. 40-3403 (1984 Supp.) is hereby amended to read as follows:

Retired providers-payment into fund

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

(b) (1) There is hereby created a board of governors. The board of governors shall provide:

(A) Technical assistance with respect to administration of the fund;

(B) Such expertise as the commissioner may reasonably request with respect to evaluation of claims or potential claims;

(C) Advice, information and testimony to the appropriate licensing or disciplinary authority regarding the qualifications of a health care provider.

(2) The board shall consist of thirteen (13) persons appointed by the commissioner of insurance, as follows: (A) The commissioner of insurance, or the designee of the commissioner, who shall act as chairperson; (B) One (1) member appointed from the public at large who is not affiliated with any health care provider; (C) Three (3) members licensed to practice medicine and surgery in Kansas who are doctors of medicine; (D) Three (3) members who are representatives of Kansas hospitals; (E) Two (2) members licensed to practice medicine and surgery in Kansas who are doctors of osteopathic medicine; (F) One (1) member licensed to practice chiropractics in Kansas; and (G) Two (2) members of other categories of health care providers. Meetings shall be called by the chairperson or by a written notice signed by three (3) members of the board. The board, in addition to other duties imposed by this act, shall study and evaluate the operation of the fund and make such recommendations to the legislature as may be appropriate to ensure the viability of the fund.

(3) The board shall be attached to the insurance department and shall be within the insurance department as a part thereof. All budgeting, purchasing and related management functions of the board shall be administered under the direction and supervision of the commissioner of insurance. All vouchers for expenditures of the board shall be approved by the commissioner of insurance or a person designated by the commissioner.

c. Subject to subsections (d), (e) ~~and (g)~~, (f) and (h), the fund shall be liable to pay: (1) any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable resident health care providers or resident self-insurers for any such injury or death arising out of the rendering of or the failure to

render professional services within or without this state; (2) any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable nonresident health care providers or nonresident self-insurers for any such injury or death arising out of the rendering or the failure to render professional services within this state. In no event shall the fund be obligated for claims against nonresident health care providers or nonresident self-insurers who have not complied with this act or for claims against nonresident health care providers or nonresident self-insurers that arose outside of this state; (3) any amount due from a judgment or settlement against a resident inactive health care provider for any such injury or death occurring as a result of the rendering of or failure to render professional services prior to July 1, 1986; (4) any amount due from a judgment or settlement against a nonresident inactive health care provider for any injury or death arising out of the rendering or failure to render professional services within this state which occurred prior to July 1, 1986. In no event shall the fund be obligated for claims against: (A) nonresident inactive health care providers who have not complied with this act; or (B) nonresident inactive health care providers for claims that arose outside of this state, unless such health care provider was a resident health care provider or resident self-insurer at the time such act occurred; (5) any amount due for a judgment or settlement against a resident or nonresident inactive health care provider for any injury or death arising out of the rendering or failure to render professional services within this state on or after July 1, 1986 if such inactive health care provider has paid the applicable surcharge to the fund for at least three consecutive years; ~~(5)~~ (6) reasonable and necessary expenses for attorney fees incurred in defending the fund against claims; ~~(6)~~ (7) any amounts expended for reinsurance obtained to protect the best interests of the fund purchased by the commissioner, which purchase shall be subject to the provisions of K.S.A. 75-3738 ~~to~~ through 75-3744, ~~inclusive~~, and amendments thereto but shall not be subject to the provisions of K.S.A. 75-4101 and amendments thereto; ~~(7)~~ (8) reasonable and necessary actuarial expenses incurred in administering the act, which expenditures shall not be subject to the provisions of K.S.A. 75-3738 ~~to~~ through 75-3744, ~~inclusive~~, and amendments thereto; ~~(8)~~ (9) annually to the plan or plans, any amount due pursuant to subjection (a)(3) of K.S.A. 40-3413, and amendments thereto; and ~~(9)~~ (10) reasonable and necessary expenses incurred by the insurance department and the board of governors in the administration of the fund.

(d) All amounts for which the fund is liable pursuant to paragraphs (1), (2), (3), (4) or (5) of subsection (c) of this section shall be paid promptly and in full if less than $300,000, or if $300,000 or more, by installment payments of $300,000 or 10% of the amount of the judgment, including

interest thereon, whichever is greater, per fiscal year, the first installment to be paid within sixty (60) days after the fund becomes liable and each subsequent installment to be paid annually on the same date of the year the first installment was paid, until the claim has been paid in full. Any attorney's fees payable from such installment shall be similarly prorated.

Annuity

(e) The commissioner may purchase an annuity to pay any amounts for which the fund is liable pursuant to subsections (c)(1), (2), (3), (4) or (5). Any annuity so purchased shall be exempt from the provisions of subsection (d).

(f) In no event shall the fund be liable to pay in excess of $3,000,000 pursuant to any one judgment or settlement against any one health care provider relating to any injury or death arising out of the rendering of or the failure to render professional services from and after July 1, 1984 and prior to July 1, 1986, subject to any aggregate limitation for all judgments or settlements arising from all claims made in any one fiscal year in the amount of $6,000,000 for each provider; (g) In no event shall the fund be liable to pay in excess of $800,000 pursuant to any one judgment or settlement against one health care provider relating to any injury or death arising out of the rendering of or the failure to render professional services from and after July 1, 1986, subject to an aggregate limitation for all judgments or settlements arising from all claims made in any one fiscal year in the amount of $2,400,000 for each provider; ~~f~~(h) a health care provider shall be deemed to have qualified for coverage under the fund: (1) On and after the effective date of this act if basic coverage is then in effect; (2) subsequent to the effective date of this act, at such time as basic coverage becomes effective or (3) upon qualifying as a self-insurer pursuant to K.S.A. 40-3414 and amendments thereto. (i) A health care provider who has qualified for coverage under the fund shall have no vicarious liability or responsibility for any injury or death arising out of the rendering of or the failure to render professional services within or without this state by any other health care provider who has also qualified for coverage under the fund; ~~g~~(j) Notwithstanding the provisions of K.S.A. 40-3403 and amendments thereto, if the board of governors determines due to the number of claims filed against a health care provider and the outcome of those claims that an individual health care provider presents a material risk of significant ~~future~~ liability to the fund, the board of governors is authorized by a vote of a majority of the members thereof, after notice and an opportunity for hearing, to terminate the liability of the fund for all claims against the health care provider for damages for death or personal injury arising out of the rendering of or the failure to render professional services after the date of termination. The date of termination shall be thirty (30) days after the date of the determination by the board of governors. The board of governors, upon termination of

Limitation on liability

Vicarious liability

the liability of the fund under this subsection ~~(6)~~, shall notify the licensing or other disciplinary board having jurisdiction over the health care provider involved of the name of the health care provider and the reasons for the termination.

Sec. 22.

Reporting of negligent acts

(a) Any licensed health care provider or any other person shall report any information that a licensee has committed an act that is or may be below the applicable standard of care. The reports shall be made as follows:

(1) In the event the licensee is not affiliated with a hospital as defined by K.S.A. 65-425 the party making the report shall report to the applicable state or county professional society or organization who shall refer the matter to a professional practices review committee duly constituted pursuant to the society's or organization's bylaws. The review committee shall investigate all reports and shall have the obligation of reporting to the appropriate state licensing agency information that a licensee acted below the applicable standard of care so that the agency may take appropriate disciplinary measures.

(2) In the event the licensee is affiliated with a hospital as defined by K.S.A. 65-425 under the laws of Kansas and the incident reported occurred at that institution, the party making the report shall report to the chief of the medical staff or the chief administrative officer of the hospital. The chief of the medical staff or the chief administrative officer shall refer the report to the appropriate executive committee or professional practices peer review committee which is duly constituted pursuant to the bylaws of said hospital for investigation. In making their investigation, the review committee may also consider treatment rendered outside the institution. The review committee shall have the obligation of reporting to the appropriate state licensing agency information that a licensee acted below the applicable standard of care so that the agency may take appropriate disciplinary measures.

(3) In the event the licensee is a hospital as defined by K.S.A. 65-425 and the incident reported occurred at that institution, the party making the report shall report to the chief of the medical

staff or the chief administrative officer of the hospital. The chief of the medical staff or the chief administrative officer shall refer the report to the appropriate executive committee which is duly constituted pursuant to the bylaws of said hospital for investigation. The review committee shall have the obligation of reporting to the Department of Health and Environment that the facility acted below the applicable standard of care so that appropriate disciplinary measures may be taken.

(4) If a report is made to the state licensing agency, the agency through its disciplinary counsel may investigate on its own or may refer to a review committee designated under (a) (1), (2) or (3) of this section, investigation of any complaint received.

Review committees authorized by (a) and (b) of this section shall function as investigative committees of the state licensing agency, pursuant to the Kansas Administrative Procedure Act.

(5) Committees with a reporting obligation under section (a) (1), (2) or (3) of this act shall disclose at least once every three months to the appropriate licensing agency the number of reports received, whether investigations have been made and the disposition of each report.

In the event the licensing agency determines that the review committee is not fulfilling its obligation under this act the agency may upon notice and hearing require all reports be made directly to its office.

(6) The appropriate state licensing agency may require a licensee whose license to practice the healing arts has been revoked or suspended to take a competency examination prior to re-issuance of a license. In the event the licensee fails to pass the examination, the agency may require the party to complete additional coursework or training.

(7) All reports made under this Act and all records made under this Act by a review committee under section (a) (1), (2) or (3) or by the state licensing agency shall remain confidential and shall not be admitted into evidence in any action for death or bodily injury. No member of any such committee, nor any person making such report, nor any person in attendance at meetings held pursuant

to the duties imposed by this Act shall be compelled to testify in any action for death or bodily injury.

Impaired providers

(b) In the event the review committee report made to the state licensing agency pursuant to section (a) (1) or (2) of this Act or other complaint, relates to the inability to practice a health care provider's profession with reasonable skill and safety due to physical or mental disabilities including deterioration through the aging process; loss of motor skill; or abuse of drugs or alcohol, the agency may refer the matter to an impaired provider committee of a private association, society or organization of the healing arts.

(1) The state licensing agency shall have the authority to enter into an agreement with the impaired provider committee of a private association, society or organization of the healing arts to undertake those functions and responsibilities specified in the agreement. Such functions and responsibilities may include any or all of the following: (A) contracting with providers of treatment programs; (B) receiving and evaluating reports of suspected impairment from any source; (C) intervening in cases of verified impairment; (D) referring impaired providers to treatment programs; (E) monitoring the treatment and rehabilitation of impaired health care providers; (F) providing post-treatment monitoring and support of rehabilitated impaired health care providers; and (G) performing such other activities as agreed upon by the licensing agency and the impaired providers committee.

(2) An agreement entered into pursuant to section (b)(1) shall provide for the use of state funds for payment of expenses of administration of the impaired provider committee.

(3) The provider committee shall develop procedures in consultation with the licensing agency for: (A) periodic reporting of statistical information regarding impaired provider program activity; (B) periodic disclosure and joint review of such information as the licensing agency may deem appropriate regarding reports received, contacts or investigations made and the disposition of each report, provided, however, that the committee shall not disclose any personally identifiable information except as provided in subsection (b)(3)(C) and (3)(D); (C) immediate reporting to the licensing agency of the name and results of

any contact or investigation regarding any impaired provider who is believed to constitute an imminent danger to the public or to himself; (D) reporting to the licensing agency, in a timely fashion, any impaired provider who refuses to cooperate with the committee, refuses to submit to treatment, or whose impairment is not substantially alleviated through treatment, and who in the opinion of the committee exhibits professional incompetence; (E) informing each participant of the impaired provider committee of the procedures, the responsibilities of participants, and the possible consequences of noncompliance.

(4) If the licensing agency has reasonable cause to believe that a physician is impaired, the licensing agency may cause an evaluation of such physician to be conducted by the provider committee for the purpose of determining if there is an impairment. The provider committee shall report the findings of its evaluation to the licensing agency.

(5) An impaired health care provider may request in writing to the licensing agency a restriction of his license. The agency may grant such request for restriction and shall have authority to attach conditions to the licensure of the provider to practice within specified limitations. Removal of a voluntary restriction on licensure to practice shall be subject to the procedure for reinstatement of license in the State licensure statute.

(6) A report to the provider committee shall be deemed to be a report to the licensing agency for the purposes of any mandated reporting of provider impairment otherwise provided for by the statutes of this State.

(7) Notwithstanding any other provision of state law, all licensing agency and impaired providers committee records pertaining to impaired providers shall be kept confidential and are not subject to discovery or subpoena. No person in attendance at any meeting of a provider committee shall be required to testify as to any committee discussions or proceedings.

(8) An impaired provider who is participating in, or has successfully completed, a treatment program pursuant to this act, shall not be excluded from any hospital staff solely because of such participation.

(9) Notwithstanding any other provision of law, a private association, society or organization of the healing arts and the impaired provider committee members thereof shall not be liable in damages to any person for any acts, omissions or recommendations made by him in good faith while acting within the scope of his responsibilities pursuant to this act.

(c) Any person, organization, institution, insurance company or medical society that reports or provides information or investigates any party authorized under (a) (1), (2) or (3) of this act or the state licensing agency shall not be liable in a civil action for damages or other relief because of the providing of such report or other information except upon clear and convincing proof that such report or information was completely false and that such falsity was actually known to and the report or information intentionally submitted by the respondent. No claim arising from the providing of such report or information shall proceed to trial unless the court first determines that a substantial probability exists that the person making the claim will prevail.

(d) No party shall be subject to liability in a civil action for failure to report as required by sections two and three of this act. A party failing to report may be subject to a disciplinary action by the state licensing agency. Willful and knowing failure to make a report required by this act is a class C misdemeanor.

(e) The provisions in this act shall be supplemental to K.S.A. 1984 Supp. 65-28,121 and 65-28,122 and K.S.A. 65-4909 and shall not be construed to repeal or modify those sections.

Insurance reporting

Sec. 23. Each self-insurer, insurer or joint underwriting association providing professional liability insurance coverage to a health care provider licensed in Kansas shall report to the appropriate state licensing agency and the Department of Insurance any claim or action for damages for medical malpractice. Reports shall be filed no later than thirty (30) days following the insurer's receipt of notice of the claim. Reports shall contain:

(a) the name, address, area of practice or specialty, policy coverage and policy number;

(b) the date of the occurrence creating the claim, the date the occurrence was reported to the insurer, and the date legal action, if any, was initiated;

(c) the names of all defendants involved in the claim;

(d) a summary of the occurrences including the name of the institution at which the incident occurred, the final diagnosis for which treatment was sought or rendered, the patient's actual condition, the incident, treatment or diagnosis giving rise to the claim, and a description of the principal injury giving rise to the claim.

The appropriate state licensing agency shall forward to its Disciplinary Counsel or to any committee authorized by (a) (1), (2) or (3) of this act, reports that merit further investigation.

Sec. 24. K.S.A. 7-121b, K.S.A. 40-3401 (as amended by 1985 Kan. Sess. Laws ch. 166, sec. 1), K.S.A. 1984 Supp. 40-3403, K.S.A. 40-3408, K.S.A. 65-4901 through 65-4908, K.S.A. 65-4915 and 1985 Kan. Sess. Laws Ch. 197 are hereby repealed.

Sec. 25. This act shall take effect and be in force from and after its publication in the statute book.

REVISED
WORKING PAPER

October 8, 1985

TO: Special Committee on Medical Malpractice

FROM: Kansas Legislative Research Department

RE: A Working Paper on Medical Malpractice Issues

The Special Committee on Medical Malpractice has met for a total of eight days as of September 13. The Committee has heard from a number of persons expressing diverse points of view and has been exposed to numerous articles, reports, data, and statistics.

The purpose of this paper is to list the issues that have been raised prior to October 11, briefly state the positions taken by the conferees on the issues, and note data, statistics, or other information that have been presented to support the position or that have relevance to the issue.

The paper begins with a discussion of what seems to be the basic issue of whether there is a medical malpractice problem or crisis at this time. The issues are then categorized under three major topics, i.e., tort reform; insurance issues; and health care provider issues, including peer review, risk management, and disciplinary oversight. The format is a general heading, then a Roman numeral followed by a statement of the issue, a general statement of the position of conferees, and information noting the statistics, data, or studies which are relevant to the issue. The staff has added issues raised at the September meeting of the Committee, and such additions are identified by brackets.

10/10-11/85
Attachment V

GENERAL

I. Is there a medical malpractice problem or crisis that now exists in Kansas?

Testimony and Material Presented to the Committee. Representatives of the Kansas Medical Society, other health care provider groups, and the insurance industry have said there is a crisis and that it is one of affordability rather than availability. It is alleged that the high cost of malpractice premiums is causing providers to curtail medical practices and procedures, to practice defensive medicine, and to consider quitting practice. Some say that the problem could become especially acute in rural areas. The culprits are said to be the increasing frequency of claims and the growing size of jury awards and settlements.

Representatives of the Kansas Bar Association and the Kansas Trial Lawyers Association dispute there is a problem of affordability, stating the cost of premiums represents about the same percentage of a physician's income as it did ten years ago. They contend that the problem, if there is one, is that malpractice is being committed and the health care professions need to better police their members. They also note that health care providers received unlimited excess coverage for three years (1981-83) free of any charge. They urge caution to assess the impact of recent legislative changes (1985 S.B. 110) and recommend no further changes in the tort system unless the cost impact of the 1985 changes on health care provider insurance premiums is known.

The number of claims filed against the Health Care Stabilization Fund has increased steadily. For example in FY 1983 there were 156 claims filed compared to 230 in FY 1985. The surcharge assessments for the Fund have been as follows:

Fiscal Year	Percent
1977	45
1978	45
1979	40
1980	15
1981	0
1982	0
1983	0
1984	50
1985	80
1986	110

Source: Kansas Insurance Department materials presented July 1 and 2, 1985.

Data compiled by the American Medical Association from physician-owned insurers shows the average paid loss going from $20,396 in 1979 to $72,243 in 1983. (See "What Legislators Need to Know About Medical Malpractice," National Conference of State Legislatures (NCSL), August, 1985, p. 7). Note also page 6 of the same publication which shows that for 1978-83 the malpractice premiums earned by insurance companies were $7.3 billion, insurance company reserves were $5.8 billion; insurance company investment income was $1.7 billion, incurred losses (meaning actual plus estimated losses) were $8.6 billion, but actual losses paid were $1.4 billion.

The mean insurance premium rate level for Kansas physicians and surgeons for the Medical Protective Company went from $2,394 in 1982 based on $100,000/ $300,000 coverage to $6,815 in 1985 based on $200,000/$600,000 coverage. St. Paul Fire and Marine mean rates for 1982 were $4,599 and for 1985 were $14,022. The Insurance Department has estimated the average premium which will be paid by Kansas physicians and surgeons when the new rate filings, approved as of July 1, 1985, are fully in effect will be $5,743 for primary coverage, and $6,317 for the $3 million excess coverage, for a total average premium cost of $12,060.

The average physician's income for the West North Central states (Kansas, Nebraska, Missouri, Iowa, North Dakota, South Dakota, and Minnesota) was $110,500 annually in 1983, compared to $106,300 annually nationwide, according to a survey conducted by the AMA. See the memorandum distributed to the Committee at the September meeting.

An article in the February 6, 1984, issue of Medical Economics which has been made available to the Committee shows information regarding the median expenditures for major expense items including medical malpractice insurance in 13 states (Florida, Texas, California, Ohio, North Carolina, Illinois, Georgia, Pennsylvania, Michigan, New Jersey, New York, Massachusetts, Virginia) as a percent of the doctors' gross income for 1982. A copy of the article was distributed to the Committee at the September meeting.

Data from the NCSL's publication "What Legislators Need to Know About Medical Malpractice" (page 9) indicate that physicians' malpractice insurance rates rose at a rate considerably less than other health care cost components (hospital room prices, medical care price index, consumer price index, and average loss per claim) from 1976 until 1983.

Before proceeding, preliminary issues need to be raised. First, if the Committee concludes there is a medical malpractice insurance problem, then it may be useful for the Committee to discuss what objectives they would like legislation to accomplish. Certain possible objectives are listed in the NCSL publication on pages 15-16 and may be useful for focusing the Committee's discussion and judging whether certain changes should be recommended. The objectives include the following:

1. to reduce medical malpractice premium costs;

2. to deter negligent practice and improve the quality of health care;

3. to assure consumer access to needed care;

4. to control health care costs;

5. to promote reasonable patient expectations;

6. to assure equitable and adequate patient redress for negligent injury;

7. to encourage timely resolution of malpractice suits;

8. to discourage frivolous, nuisance, or groundless claims; or

9. to develop legislation that can withstand constitutional challenge.

Second, it is important to note that Kansas and a number of other states responded to an earlier medical malpractice crisis in the mid 1970s by passing a number of tort reforms and other measures designed to insure malpractice insurance availability. The new NCSL publication notes (page 13) state legislation in the mid 1970s was effective in solving malpractice insurance availability problems, but the effect of tort reforms on claims and recoveries is far less clear. Two studies are noted in the above cited publication including one done by Frank Sloan, economist of Vanderbilt University, who concluded that the results of his study give no indication that state legislative actions have had their intended effects on premiums.

A study by Dr. Patricia Danzon for the Rand Corporation analyzed closed claims by insurers in the mid to late 1970s. Her conclusions based on a theoretical model were that caps cut the average settlement by 25 percent, raised the proportion of cases dropped from 43 to 48 percent and reduced slightly the number of cases going to verdict. Her study concluded collateral source changes appeared to reduce settlements although the statistical significance of this finding was low. Finally, limits on attorney fees cut the average settlement by 9 percent, raised somewhat the number of cases dropped without payment and slightly reduced the percentage of cases going to verdict.

Finally, a representative of the Medical Protective Company at an earlier meeting noted a $500,000 overall cap on awards would have no immediate effect on primary insurer malpractice premiums since they are now limited to $200,000 per claim but after several years the impact of the cap would be felt.

The Committee has not had any actuarial information presented to date on the effect of any proposed tort reforms.

TORT REFORM

I. Should a cap be established on damage awards in medical malpractice cases?

Testimony and Material Presented to the Committee. Representatives of health care providers and insurers are in general agreement that a cap on damage awards will decrease the size of such awards, hopefully reduce medical malpractice premiums and possibly have the effect of discouraging the filing of claims by reducing the so called "lottery atmosphere."

Not all groups are in agreement regarding the type of cap that should be imposed. For example, a representative of the Medical Protective Company proposes an overall cap of $500,000 on all damages, whereas, a representative of the Western Insurance Companies has advocated a $500,000 cap on nonpecuniary damages with no cap on actual damages. St. Paul Fire and Marine has recommended a $100,000 cap on pain and suffering but no cap on pecuniary losses or future medical expenses. It would be well for the Committee to get clarification from the various interest groups as to exactly what kind of cap they advocate.

The two lawyer groups and the judges who appeared opposed caps on awards saying that large medical malpractice awards are rare and that when they occur they are justified due to the extent of the injuries. They argue that large awards do not drive up malpractice insurance costs but malpractice does. [A representative of the American Association of Retired Persons (AARP) has stated that those who are truly victims must be adequately compensated for their injuries.]

The Medical Protective Company presented charts showing that the average loss severity per claim paid in Kansas by Medical Protective in 1984 was $32,478 or more than twice the amount paid in Indiana ($14,125). The company representative said the $500,000 cap in Indiana plus the mandatory screening panel provision in that state were factors accounting for the difference.

The lawyer groups argue there is no need for a cap and point to the 136 claims (as of July 1 of this year) paid by the Health Care Stabilization Fund (HCSF) since its inception in 1976. They note that the average amount paid out of the HCSF

has been approximately $260,000 per claim and the fact that only 12 jury awards have been sustained against the Fund, with the average jury award being slightly more than $500,000. Claims paid by the HCSF represent the more severe injuries or deaths attributed to medical malpractice.

The NCSL publication (page 20) indicates Indiana has a $500,000 cap and Nebraska and Virginia both have $1 million caps on the total recovery a malpractice victim may receive. Illinois and North Dakota have ruled caps on total recoveries unconstitutional. The American Medical Association's (AMA) "Limits on Liability" (April, 1985) publication notes 17 states have enacted some type of limit on awards in malpractice actions. The publication notes a total of five states have found the limits unconstitutional but limits have been upheld in three states.

II. Should a cap be established on attorneys fees in medical malpractice cases?

Testimony and Material Presented to the Committee. Representatives of various health care provider groups and the Medical Protective Company have advocated a cap on contingency fees for plaintiffs' attorneys. Medical Protective has proposed a 15 percent cap on contigency fees on awards above $200,000. A representative of Western Insurance Companies has proposed plaintiffs' attorneys be paid at a "contract" price or hourly rate. United States District Judge Patrick Kelly stated plaintiffs' attorneys should not be partners in a case and stated a 50 percent contingency fee was too high, but one-third was fine. All judges who appeared indicated no one had ever complained about a contingency fee in a medical malpractice case and the fees had been routinely approved as required by statute.

Proponents of a limit say the current system is unfair to successful plaintiffs who have to share too much of their recovery with their attorney, and encourages the filing of questionable suits.

Representatives of the legal profession oppose statutory limits on attorneys fees and point to an existing statute which requires the judge to approve only reasonable fees in medical malpractice cases. Both groups point to the dual purpose of the tort system as one of compensation and deterrence and say the contingency fee is an integral part of this system. They note that only one in four plaintiffs is successful

at trial and the contingency fee system permits the spreading of costs of litigation over both successful and unsuccessful plaintiffs. They also argue that a limit would be an unfair advantage to the defense bar who would not be so limited.

Testimony from the Medical Protective Company indicated that approximately 28 percent of the premium dollar it collects goes to plaintiffs' attorneys and 30 percent to the defense bar. Other testimony has indicated plaintiff and defense legal expenses are approximately equal.

Five states, according to the AMA publication, "Attorneys Fee Regulation" (April, 1985) provide a sliding scale for plaintiffs' attorneys fees in malpractice cases.

III. Should the appointment of screening panels be made mandatory with the results made admissible at trial?

Testimony and Material Presented to the Committee. Representatives of health care provider groups and the Medical Protective Company support the appointment of mandatory screening panels. Medical Protective advocates the Indiana system where the panel consists of three health care providers and a nonvoting attorney serving as chairman. Proponents say these panels will weed out questionable claims and encourage the settlement of clear cases of malpractice.

The Kansas Bar Association, St. Paul Fire and Marine and several judges questioned the use of mandatory screening panels saying they feared added costs and more lengthy litigation would result. [The Kansas Trial Lawyers Association has advocated screening panels as presently constituted in Kansas law be required if a case were filed without an accompanying affidavit by a medical expert.]

Twenty-three states, including Kansas, currently have some type of screening panel. The screening panels in Kansas are permissive as they are in eight other states and the decisions are not admissible into evidence in Kansas or in ten other states. Five states have found these panels to be unconstitutional while they have been upheld in eight states according to the AMAs publication "Pretrial Screening Panels" (April, 1985).

IV. Should settlement conferences be mandated for all medical malpractice cases?

Testimony and Material Presented to the Committee. Judge Patrick Kelly, U.S. District Judge, supported the use of settlement conferences but did not support making this mandatory in all courts although they are mandatory for all cases before his court as part of a pilot project. Several Kansas district court judges thought mandatory settlement conferences would be beneficial. [The Kansas Medical Society and the Kansas Trial Lawyers Association have advocated mandatory settlement conferences. The Trial Lawyers suggest that a judge other than the trial judge conduct the conference within 90 days.]

Two district court judges indicated mandatory settlement conferences were not needed since most cases (95 percent) were settled before trial anyway.

Judge Kelly stated 13 out of 22 cases which were heard by a magistrate were settled and five out of ten which were heard by a mediator were settled. He noted each of five medical malpractice cases filed since January in his court has been settled.

V. Should periodic payments or structured damage awards and settlements be required?

Testimony and Material Presented to the Committee. The Kansas Medical Society and some other health care provider groups and several insurers have supported this idea. A representative of the Kansas Bar Association has expressed reservations saying this would lead to endless litigation and the representative of Providers Insurance Company said the Legislature should not mandate structured settlements but should leave the structuring of settlements to private industry. [The Kansas Trial Lawyers Association favors structuring payments for future medical care only.]

Eighteen states, including Kansas, have enacted periodic payment provisions, according to the AMA publication "Periodic Payments" (April, 1985). K.S.A. 60-2609 permits the court to require damages to be awarded by installment or periodic payment in malpractice actions. New Hampshire found a periodic payment provision unconstitutional. Other courts, including California, North Dakota (entire act found unconstitutional, however) and Wisconsin have upheld those provisions.

[Va. Should a uniform method of calculating future damages be required?

Testimony and Material Presented to the Committee. The Kansas Medical Society advocated that a law requiring a uniform method of calculating future damages be passed.]

VI. Should expert witnesses be limited to those from Kansas or the surrounding states?

Testimony and Material Presented to the Committee. The Kansas Medical Society, a representative of the Western Insurance Companies, and several others have advocated limiting expert witnesses to those persons residing in Kansas or the surrounding states. Their argument is that Kansas health care providers should be judged by those familiar with standards of practice here and should not be subject to scrutiny from so-called experts from large urban centers or universities far from Kansas. Some such experts are said to make their livelihood from court testimony.

Representatives of the legal profession and others argue that the standards of medicine practiced in Kansas should not be different from those in any other area, that often local experts are unwilling to testify against colleagues and there is a national standard for physician providers who are board certified.

Eleven states according to the AMA publication "Standard of Care and Expert Witness Qualification" (April, 1985) have statutory provisions regarding expert witnesses. Tennessee, for example, requires experts to be from that or a continguous state and to have been engaged in the active practice of medicine during the past year. Ten states, according to the NCSL's publication (page 23), have established qualifications for the use of expert witnesses in malpractice actions.

[VIa. Should a qualification for medical experts be that they devote at least 75 percent of their professional time to clinical practice?

Testimony and Material Presented to the Committee. The Kansas Medical Society made the above suggestion. Ohio has a 75 percent requirement according to the AMA publication "Standard of Care and Expert Witness Qualifications," April, 1985.]

VII. Should the Legislature define the legal standard of care for health care providers or should this be left to the courts? (See also Providers Issues Section, XII.)

Testimony and Material Presented to the Committee. A representative of the Western Insurance Companies and several others have supported "tightening up" jury instructions regarding the standard of care by legislation. An argument made is that the current Pattern Instructions for Kansas (P.I.K.) are too broad, lead to confusion, and facilitate a finding of negligence.

Representatives of the Kansas Bar Association and several district judges have pointed out that PIK instructions can and often are supplemented by jury instructions tailored for a particular case, that the PIK instructions are based on case law and that this area is properly the province of the judiciary and not the Legislature.

Twenty-one states statutorily set out the medical standard of care according to the AMA's publication "Standard of Care and Expert Witness Qualification" (April, 1985). According to the NCSL publication (page 23) there are 18 states which have by statute established a medical standard of care, i.e., defined negligence or malpractice. The same publication suggests that the adoption of prospective payment systems, which incorporate utilization review and quality control may bring about more uniformity in standards of care.

[VIIa. Should a claimant's attorney be required to file an affidavit with every malpractice case that a medical expert had reviewed the claim and found it meritorious?

The Kansas Trial Lawyers Association supported the above concept. A recently enacted law in Illinois requires such an affidavit.]

VIII. Should juries be required to itemize awards?

Testimony and Material Presented to the Committee. There seemed to be general consensus that requiring itemization by juries was either a good idea or would not create problems.

[VIIIa. Should the post-judgement interest rate be tied to the treasury-bill rate?

Testimony and Material Presented to the Committee. The Kansas Medical Society and the Kansas Bar Association have advocated trying the post-judgement interest rate to the treasury-bill rate.]

IX. Should the Legislature enact other reforms such as no fault, arbitration, panels of judges, mandatory summary judgment and directed verdict rulings, and modification of the standard for utilizing remittur.

Testimony and Material Presented to the Committee. There seemed to be little enthusiasm or little discussion by any of the conferees on the above suggestions. Several district judges pointed out state constitutional problems with arbitration of claims. A plaintiff's attorney noted in most cases a medical expert's opinion has been obtained prior to filing a petition by his law firm.

Eleven states have laws permitting arbitration of medical malpractice cases according to the AMAs publication "Arbitration" (April, 1985). The Kansas Constitution Bill of Rights §5 provides the right of trial by jury shall be inviolate. Apparently this provision would not permit arbitration short of a constitutional amendment.

[IXa. Should the sunset provision (July 1, 1989) of 1985 S.B. 110 be repealed?

Testimony and Material Presented to the Committee. The Kansas Medical Society has advocated the sunset provision of S.B. 110 be repealed.]

INSURANCE

Introduction

Issues and questions related to insurance are among the most prevalent encountered in discussions of the medical malpractice "crisis." To the extent that the well-documented escalation in medical malpractice insurance premiums has been the catalyst spurring physicians to approach state legislatures in many states, the most basic question might well be:

I. Why have medical malpractice premium rates risen so dramatically?

Testimony and Material Presented to the Committee. It is undisputed that premium rates have risen, but conferees have provided differing explanations as to the reasons. The legal community suggests that physicians have deviated from the appropriate standard of care and have caused harm, leading to claims, which result in premium increases. It has also been alleged that the insurance industry has generated this crisis.

The insurance industry has expressed the opinion that the higher rates derive from an environment of increased frequency and severity of claims, as well as increasing defense costs.

The National Conference of State Legislatures' (NCSL) 1985 publication "What Legislators Need to Know About Medical Malpractice" includes an overview of how medical malpractice insurance functions generally (see especially pages 4-6) and traces recent trends in medical malpractice premiums, claims, and awards (see pages 7-11). The report points out that the frequency of claims, the size of awards, and the cost of insurance have steadily increased and suggests explanations to account for this trend, including greater awareness of the potential for legal remedies, new developments in health care technology, and changes in patient-provider relationships.

Another informative overview is found in "Kansas Medical Professional Liability Insurance," prepared by the Kansas Insurance Department, March 13, 1985.

This report reviews the availability crisis that led to the passage by the Kansas Legislature in 1976 of the Health Care Provider Insurance Availability Act, traces the recent premium and loss experience of the major medical malpractice insurers in Kansas, and describes the ratemaking procedures applicable to professional liability insurance in the state.

II.* Should investment income be considered by insurance companies as a factor in the ratemaking process or by the Insurance Commissioner as part of the review of rate filings?

Testimony and Material Presented to the Committee. The Insurance Department indicated that in Kansas there is no statutory requirement that investment income be included in the ratemaking process or in review of rate filings, although the Commissioner has supported the idea in the past. Some insurance companies do include these data in their ratemaking procedures, but the practice is not uniform.

Those opposed to inclusion of investment income in the documentation in support of rate filings urge that this income be looked upon as distinct from underwriting.

Insurance company representatives pointed out that investment income is not a significant factor in Kansas, because policies for professional liability insurance are issued on a claims-made basis, thus permitting only a short time for investment earning potential. Companies use investment income as a buffer against underwriting losses.

It was noted that a task force of the National Association of Insurance Commissioners (NAIC) recently adopted a report recommending that investment income remain independent of the ratemaking process. The alternative, it is claimed, would lead to premium rate dependence on either the interest rate or rate of return on investment.

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*In an earlier draft, this issue was III.

A roundtable discussion among five insurance company officers, contained in Report No. 2 of the publication "Professional Liability in the '80s," published in November, 1984, by the American Medical Association Special Task Force on Professional Liability and Insurance, includes a brief discussion concerning insurance company investment income and the relationship between investment income and loss ratios (page 5).

III.* Should some form of geographic rating, merit rating, or both be instituted in determining premium rates for health care providers?

Testimony and Material Presented to the Committee. Insurance companies reported that territorial pricing is done in some states (New York, Florida, Illinois, Michigan, Texas) but that claims and loss experience in Kansas would not justify such a practice because there is no apparent distinction between the claim/loss experience in urban and rural areas of the state.

It was also pointed out that geographic factors are sometimes indirectly included in ratemaking, because physician classifications tend to reflect the difference between, for example, a general practitioner who delivers a small number of babies and an obstetrician delivering many babies, in the sense that the OB/GYN specialist is more likely to be practicing in an urban setting.

Representatives of the Kansas Bar and some Committee members have suggested that the claims and loss experience of individual practitioners should be taken into account in setting their premium rates, especially since this is the practice in the case of other professions, including attorneys. In addition, the Joint Underwriting Association (JUA) employs individual provider claim and loss experience as a factor in its determination of physician insurance costs. The JUA insures those providers, approximately 250 doctors at this time, who are not able to obtain coverage in the private market.

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* In an earlier draft, this issue was II.

A position paper submitted on behalf of the Kansas Bar Association supports merit rating for physicians as a possible means of assuring stablized premium rates for most Kansas physicians. The paper includes the observation that a de facto merit or experience rating system already exists because of the underwriting practices of the major medical malpractice insurers operating in Kansas. It also suggests the kinds of statistical information that might be useful in evaluating merit rating as a possible insurance reform.

A report issued by the National Conference of State Legislatures in July, 1985, indicates that no state has enacted experience rating of physicians for malpractice insurance premiums (see "What Legislators Need to Know About Medical Malpractice," p. 26). The same publication states that most hospitals and health maintenance organizations (HMOs) pay premiums based on malpractice experience (pp. 27-28).

The insurance industry has testified that merit rating of physicians would create a breach of trust and good faith in the insurer-insured relationship making communication difficult and encumbering the defense of the insured. The medical community has indicated it is against merit rating because it has a negative effect on the sense of unity and solidarity of the medical profession. It is also argued that number of claims may not correlate directly with competence. Rather, the type of claim and the outcome are of more significance.

The concept of "deviation type rating" described in Medical Malpractice Insurance in Pennsylvania (the Nye report) assumes the integrity of malpractice claims experience as a factor in the ratesetting process. Under this sytem, emphasis would be placed on the estimated risk of an individual physician rather than on a specific classification of activity. It is argued that such experience rating will increase the cost allocation efficiency of losses due to malpractice claims and that premium rates for most physicians would be lower, not necessarily in dollars, but as a reflection of the fact that the losses of a few practitioners would be paid for more by those responsible than by all physicians. (See p. xii of the summary report.)

[IIIa. Should an experience rating factor be added to the surcharge for the Health Care Stabilization Fund?

Testimony and Material Presented to the Committee. The Kansas Trial Lawyers Association has recommended an experience rating factor be added to those health care providers with claims settlements or judgements against them. The Bell Subcommittee on Insurance has recommended this issue be studied.]

[IIIb. Should a risk management program be implemented by the Health Care Stabilization Fund?

Testimony and Material Presented to the Committee. The Kansas Trial Lawyers Association has advocated the above change.]

[IIIc. Should health care providers be permitted to pay Health Care Stabilization Fund surcharges on a monthly basis?

Testimony and Material Presented to the Committee. Several conferees including a spokesman for the Eureka Area Chamber of Commerce advocated health care providers be allowed to pay surcharges on a monthly basis.]

[IIId. Should the liability of the Health Care Stabilization Fund be reduced from $3 million to $1 million?

Testimony and Material Presented to the Committee. The Kansas Trial Lawyers Association has advocated that the HCSF liability be reduced from $3 million to $1 million as an alternative to any type of cap on awards.]

IV. Should the Joint Underwriting Association (JUA) or the Health Care Stabilization Fund or both be abolished?

Testimony and Material Presented to the Committee. It has been suggested that perhaps the state should not be engaged in the business of insurance.

A representative of Western Insurance Companies, the administering carrier of the JUA, indicated that if the JUA were eliminated, additional professional liability insurance providers might do business in Kansas. He also testified that the JUA is probably keeping afloat some providers who would otherwise be uninsurable.

It is likely that if the Fund and the JUA were eliminated, both availability and affordability would be implicated because physicians would determine the extent of their primary and "excess" coverage; there would be no automatic excess carrier and there would be no guaranteed availability.

The report on the Board of Healing Arts done by Legislative Post Audit indicates that the annual number of claims filed against the Fund, the number of claims paid by the Fund, and the average amount per award have increased each year since 1980. Because there is no statutory limitation on the amount that may be assessed as a surcharge by the Insurance Commissioner, physicians must pay whatever percentage of premium is assessed, currently 110 percent. Actuarial estimates envision that the assessment will remain at approximately 100 percent over the next two years. The medical community has expressed concern about what it perceives to be an unending spiral of high surcharges that, coupled with increasing premiums, poses affordability threats to many health care providers. The Kansas Medical Society has suggested that these high rates also threaten access to health care, because some physicians may restrict their practice or retire early from practice.

Reports No. 1 and No. 2 of "Professional Liability in the '80s," published in November, 1984 by the American Medical Association Special Task Force on Professional Liability and Insurance, contain information related to availability and affordability of physician malpractice insurance. Part 1 notes: an increase in medical malpractice litigation over the past 40 years; the withdrawal of many insurance carriers from the malpractice insurance market; medical community response in sponsoring alternative insuring mechanisms for physicians and in encouraging tort reform legislation; increasing frequency and severity of claims against physicians and hospitals; escalation in malpractice premium rates; and the impact of all of these trends on health care costs generally. Part 2 includes an informal roundtable discussion among insurance company officers as to ways to approach the medical malpractice problem. No conclusion is reached, but it is suggested that "[T] here probably is no single remedy."

V. Are health care providers required to participate in the Health Care Stabilization Fund as a condition precedent to practice in Kansas?

Testimony and Material Presented to the Committee. This issue has been raised by Committee members and a request for an Attorney General's opinion was discussed, but no request has been made.

This question arose during Committee discussion addressing the issue of whether the Board of Governors of the Health Care Stabilization Fund should be more aggressive in terminating fund liability for providers who present "material risk of significant future liability to the fund." (See minutes of this Board, November 27, 1984, pp. 2-3.) Committee members expressed concern that such action by the Board could raise serious due process questions if fund participation were seen to be required as a condition for practicing medicine in Kansas.

[Va.* Should the mandate that all providers carry basic coverage and participate in the Fund be repealed?

Testimony and Material Presented to the Committee. It has been suggested that since providers are mandated to carry insurance, this leads to the filing of additional suits, since potential claimants know that recovery is possible from provider insurance, i.e., there is a deep-pocket to tap. It has also been suggested that petitioners may request higher damages because of mandated coverage.

Both the Health Care Stabilization Fund and the JUA exist as corollaries to the mandate, providing excess coverage and availability, respectively, to Kansas health care providers. No such mechanisms exist for other professional groups in the state, and one might speculate as to whether the public needs protection from uninsured physicians more than from, for example, uninsured attorneys.

The insurance industry generally argues that any mandated coverages increase premium costs. This cost is, presumably, at least partially passed on to the consumer, adding to the already problematic high cost of health care.]

* This issue has been reworded and has replaced what was VIII.

VI. Should insurance companies be required to provide coverage to a wider group of insureds?

Testimony and Material Presented to the Committee. The Insurance Department has pointed out that insurance companies have a "right of underwriting" by which they may select those they wish to insure, eliminating any person or groups they do not wish to insure.

The Medical Society indicated that the Pennsylvania Casualty Company will not write malpractice insurance if there are fewer than five physicians in a group and that Medical Protective is very restrictive on physicians in high-risk practices. The representative of Medical Protective stated that in Kansas that company writes only medical doctors, dentists, and, to a limited extent, osteopathic practitioners.

The osteopathic doctors pointed out that they face an availability problem because of the restrictive practice of Medical Protective, which will insure only those osteopaths who are in practice with a group of medical doctors. At the September meeting, a representative of Medical Protective indicated a change in the latter policy is being implemented, and Medical Protective will insure osteopaths. Although St. Paul Fire and Marine will insure osteopaths, that company's premiums are higher than those of Medical Protective, and the availability problem becomes one of affordability as well.

VII. Should procedures for defense of the Health Care Stabilization Fund be improved?

Testimony and Material Presented to the Committee. Several judges, a plaintiffs' attorney, and others have complained about the Fund's legal representation. Some have said that at times those representing the Fund had not cooperated with defendants in settling cases or had not become involved in cases until the time of trial. It was also noted, however, by several judges, that the quality of Fund defense seemed to be improving, and that the Fund is currently receiving good quality representation. It was recommended that the Fund be represented, perhaps by being named as a party in a case, and that counsel for the Fund have some control over the defense as early as discovery and during the time of any settlement conference.

Minutes of the July 5, 1984 meeting of the Board of Governors of the Fund include the suggestion by one Board member that occasionally the interests of defense counsel, the primary carrier, and the Fund are different and that it might be advisable to have the Fund represented at an earlier stage of any claims proceedings to determine which cases should be settled rapidly and which were more serious. The same Board member expressed his opinion that it might be worthwhile to explore hiring claims management personnel to evaluate claims for the Fund.

The Insurance Department testified that independent counsel is hired to review claims to determine potential Fund liability and to ascertain whether there might be a conflict of interest between defense of the Fund and of the private insurer. A representative of the Fund pointed out that a claims review position has been requested to monitor the paperwork and oversee proper reserve maintenance. She also indicated that those working on Fund defense feel capable of handling their responsibility, although there is a need for additional clerical staff. Fund staff also pointed out that attorneys appointed to evaluate cases are well qualified and experienced in medical malpractice. Also, files are reviewed every 30 days by the Fund, and attorneys are requested to provide ongoing evaluation of a case on a regular basis. (See handout "Defense of the Health Care Stabilization Fund.")

[VIIa. Should the Kansas Insurance Department be required to monitor insurance rates more effectively and keep more specific data on individual health care provider claims experience?

Testimony and Material Presented to the Committee. The Kansas Trial Lawyers Association advocated better monitoring of insurance rates.

The Committee staff's efforts to obtain specific data on the claims experience of individual health care providers from the Kansas Insurance Department has been lengthy and the product to date has been incomplete. If the Committee believes these data are relevant then a more clear statutory directive to gather and report the data without disclosing the identity of the provider may be necessary. The data, among other things, can be used to gauge in part the effectiveness of risk management and peer review programs, the performance of the State Board of Healing Arts and the amount of dollars an individual health care provider costs the system.]

PROVIDER ISSUES

I. Should hospital medical staffs be required to report to the Board of Healing Arts whenever (1) they receive information that a licensee may have committed an act which is or may be grounds for disciplinary action; and (2) whenever licensees voluntarily surrender or limit their hospital privileges while under formal or informal investigation by the hospital?

Testimony and Material Presented to the Committee. The above items were recommended in Performance Audit Report: Board of Healing Arts, pages six through 8, agreed to by Board of Healing Arts in its response to the audit, and recommended in a memorandum from Mr. Strole dated July 8, 1985. The Federation of State Medical Boards in a 1985 publication recommends the reporting of any information which appears to show that a licensee "is or may be medical incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safety in the practice of medicine." The AMA report, "Professional Liability in the '80s, Part III" states on page 16 that the AMA will ask physicians to be alert to procedures and physicians who do not conform to appropriate standards of care and to be active in reviewing their peers. Hospital medical staffs, in particular, can be most effective in self-regulation according to the report. At the August 15-16 meeting, the general counsel for the Board recommended that the law be amended to require hospitals to report resignations from the medical staff. See page 6 of minutes.

K.S.A. 65-28,121 currently requires the reporting by the medical staff of any firm, facility, corporation, institution, or association which has granted practice privileges to any person credentialed by the Board when the medical staff recommends that practice privileges be terminated, suspended, or restricted for reasons relating to professional competence. In addition a report must be made when the medical staff finds that an individual has committed an act which is a ground for disciplinary action under a practice act administered by the Board.

II. Should licensees of the Board of Healing Arts be required to report whenever they receive information that another licensee may have committed an act which is or may be a ground for disciplinary action by the Board?

Testimony and Material Presented to the Committee. This recommendation is found at page eight of the audit report and references K.S.A. 65-28,122, a statute that requires reporting by licensees in the healing arts who possess knowledge not subject to the physician-patient privilege that another person licensed to practice the healing arts has committed an act set out in K.S.A. 65-2836 (grounds for disciplinary action against a licensee) to the Board. The statute further requires the reporting licensee to fully reveal such knowledge on request of the Board. See also other materials referenced under I and the July 8, 1985 memorandum from Don Strole.

III. Should the Kansas Healing Arts Act be amended to provide penalties, such as fines, for organizations or licensees that fail to report to the Board when required by law to do so?

Testimony and Material Presented to the Committee. The recommendation appears at page nine of the audit report which notes the Federation of State Medical Boards' Guide to the Essentials of a Modern Medical Practice Act recommends specific penalties for failure to report. See also other material noted under I. Under K.S.A. 65-28,122 licensees in the healing arts are currently required to report certain acts to the Board of Healing Arts. Thus, failure to report is a violation of the act and constitutes a ground for the suspension, revocation, or limitation of a license or the imposition of a misdemeanor penalty. No civil penalties are authorized by the act.

While hospital and other institutional medical staffs are required to report by K.S.A. 65-28,121, there is no penalty which accrues to the medical staff as an entity since the "medical staff" is not subject to regulation by any agency of the state, but only by the hospital or organizational governing body. Who or what agency would impose a penalty against what is essentially a private function or, in the case of county and district hospital boards, a governmental entity?

IV. Should other state agencies, law enforcement agencies, and medical associations be required to report to the Board of Healing Arts concerning licensees who may be incompetent, impaired, or otherwise in violation of the Kansas Healing Arts Act?

Testimony and Material Presented to the Committee. See page eight of the audit report for the above recommendation. Note also that K.S.A. 65-2898 already provides immunity for reporting for any person who in good faith, reports alleged incidents of malpractice or information relating to the qualifications, fitness, or character of or a disciplinary action against a person credentialed by the Board. The Kansas rules of statutory construction provide that "person" as used in K.S.A. 65-2898 includes other than natural persons.

V. Should professional liability insurance carriers be required to report incidents of medical malpractice to the Board of Healing Arts or other appropriate state agencies?

Testimony and Material Presented to the Committee. This question arose from Committee discussion and questions at the July 18-19 meeting. Representatives of Medical Protective and the Western Insurance Companies responded that insurers could report incidents of medical malpractice they are aware of if immunity is provided to insurance companies. Note the discussion of K.S.A. 65-2898 under IV, and note further that under the Kansas rules of statutory construction "person" includes corporate persons.

VI. Are the current laws which give qualified immunity to persons and organizations that report incidents of alleged malpractice or alleged incompetency or impairment sufficient to encourage reporting?

Testimony and Material Presented to the Committee. It has been noted that persons who participate in peer review or reporting of incidents of malpractice or professional incompetency which result in a practitioner losing medical staff privileges or a license may be subject to actions alleging restraint of trade or constitutional claims relating to due process. See article attached to memorandum from Don Strole to the Committee dated July 8, 1985. Professions are now subject to challenges on restraint of trade. See Goldfarb v. Virginia State Bar, 421 U.S. 773, (1975). There are several cases that pertain to judging violations of antitrust laws which could be reviewed for applicability in Kansas and, in its recommendations (No. 15) in Professional Liability in the '80s: Report 3, the AMA agreed to work with government

agencies such as the Federal Trade Commission in regard to self-regulation and peer review. The AMA could be contacted in regard to additional legal issues.

VII. Should hospitals be required by state law to maintain medical staff peer review programs and to report on such programs annually to the licensing agency?

Testimony and Material Presented to the Committee. In testimony dated July 2, 1985, the Kansas Hospital Association reported that the Joint Commission on the Accreditation of Hospitals (JCAH) requires accredited hospitals to maintain an ongoing quality assurance program designed to monitor and evaluate the quality and appropriateness of patient care and to pursue opportunities to improve patient care and resolve identified problems. JCAH accreditation is voluntary and thus does not apply to all Kansas hospitals. Additionally, Medicare participation requires that hospitals meet standards set by the Health Care Financing Administration relating to quality assurance in order to be certified as a Medicare and Medicaid provider. Would state statutory directives and supervision of hospital quality assurance programs by the state licensing agency strengthen the positions of governing boards and committes in respect to suits alleging antitrust violations? Would statutory requirements strengthen the state's ability to discipline committees or governing boards that fail to report?

VIII. Should the Board of Healing Arts be required by statute to review the practice of healing arts licensees who have a specified number of malpractice petitions filed against them in a specified time period?

Testimony and Material Presented to the Committee. In their report, the auditors recommend (see page 25) that the Board of Healing Arts give high priority to investigating and taking disciplinary action against doctors who have had multiple malpractice petitions filed against them, or who have allegedly committed an act of gross negligence. A Florida Governor's Task Force on Medical Malpractice, for example, recommended that when an individual licensee has three claims paid in excess of $10,000 over a five-year period, the professional regulatory agency be required to treat that as a complaint against the provider and conduct an investigation. There appears to be agreement among conferees that there should be a mechanism established to trigger a review mechanism of a provider's practice when there is evidence of

negligence and agreement that multiple malpractice claims may be one indicator that a licensee's practice should be upgraded or investigated. Testimony presented to the Committee indicates that only about 10 percent of claims filed go to trial and that between 60 and 75 percent of all malpractice claims are settled in favor of the defendant. This testimony indicates consideration should be given to whether it will be cost effective to conduct a full investigation and review each time a professional liability action is filed.

[The Kansas Trial Lawyers Association has advocated automatically referring to the Board every settlement or judgement of malpractice against a provider.]

IX. Should failure to carry basic coverage or to participate in the Health Care Stabilization Fund be a ground for revocation, suspension, or limitation of a license?

Testimony and Material Presented to the Committee. The above question arises from the recommendation of the auditors that the Board of Healing Arts should seek legislation making it a violation of the Kansas Healing Arts Act for an active licensee to fail to comply with liability insurance requirements established by law. See pages 25 and 26 of the audit. It should be noted that K.S.A. 40-3416 requires any state agency that receives a report of a violation of the Health Care Provider Insurance Availability Act to: (1) make an investigation and take any official action it deems appropriate, and (2) notify the Attorney General or county attorney who, upon notice, must institute an action to enjoin the health care provider from rendering professional services in Kansas.

X. Should the Board of Healing Arts be authorized to levy fines against licensees who have violated the Kansas Healing Arts Act? (See also III this section.)

Testimony and Material Presented to the Committee. The post audit study of the Board's disciplinary activities resulted in the above recommendation found on page 26 of the audit report. Similar legislation was requested by the Board of Healing Arts in legislation introduced in 1985 as noted in the memorandum dated July 8, 1985 from general counsel for the Board. One question which should be considered is

whether a fine will be as effective as an action against the license of a practitioner of the healing arts in discouraging violations of the Kansas Healing Arts Act.

XI. Should additional public members be added to the Board of Healing Arts?

Testimony and Material Presented to the Committee. The suggestion that additional public members be added to the Board is found in the audit report at page 26. The auditors found that public representation on the Kansas board is less than the average of similar boards in other states. [See page 23 of the audit. A representative of the AARP supported adding more public members to the Board.]

XII. Should the Board of Healing Arts be given authority to adopt rules and regulations or guidelines establishing minimum standards of medical practice in particular areas? Should the Board be exempt from some or all of the provisions of law concerning rules and regulations in such case? (See Tort Reform Section, VII.)

Testimony and Material Presented to the Committee. The above recommendation is from the memorandum from Don Strole, General Counsel of the Board of Healing Arts to the Committee and dated July 8, 1985 "What Legislators Need to Know About Medical Malpractice," notes that 18 states have statutes establishing a medical standard of care. These statutes are general in nature and do not vary greatly from the current Kansas provisions. The AMA paper entitled "Standard of Care and Expert Witness Qualification" (April, 1985) lists 21 states which statutorily set out a medical standard of care and notes that such state legislation has often sought to define the locality upon which the applicable standard is based. Arkansas, Florida, and Virginia statutes are discussed in the AMA paper as are court decisions concerning the Alabama, Idaho, New Hampshire, North Dakota, and Washington statutes. The Florida statute, for example, [§768.45 (1)] defines the standard of care as that level of skill, care, and treatment which is recognized by a reasonably prudent similar health care provider as being acceptable under similar conditions and circumstances. This type of statutory definition is designed to reflect differences in the resources available in different communities and can change over time to reflect changes in medical practice. Maryland's law sets out 30 acts that constitute professional misconduct, and Arizona lists 20 acts that constitute professional misconduct.

In Kansas, K.S.A. 1984 Supp. 65-2837 defines professional incompetency and unprofessional conduct. The former includes one or more instances involving gross negligence or repeated instances of ordinary negligence. The Legislature has also set practice standards in K.S.A 65-2836 which sets out grounds for the revocation, suspension, or limitation of a license, including failure to inform patients with breast abnormalities of certain alternate forms of treatment. In K.S.A. 1984 Supp. 65-3237a, the entire statute sets out standards for ordering, dispensing, administering, selling, or supplying certain amphetamines or sympathmimetic substances. Thus, there is a precedent for statutorily prescribing minimum standards of care rather than using rules and regulations in what may be a very sensitive area in which different points of view and practice should be represented. See the Association of State Medical Boards guidelines for possible amendments to the Kansas Act.

It is assumed that the General Counsel's recommendation that any standards be exempt from provisions of the rules and regulations statutes refers to exempting any standards adopted by rules and regulations from the definition contained in K.S.A. 77-415(4) which would result in the Board's acting pursuant to K.S.A. 77-421a and thus exempt the Board from filing the rules and regulations, from legislative review, from the statutorily prescribed effective dates, and from review by the State Board on Administrative Rules and Regulations as to the need for temporary rules.

XIII. Should legislation be enacted which requires licensees of the healing arts to report to an appropriate person in the hospital any hospital staff member, regardless of health care occupation, who falls below a minimum standard of care? Should failure to carry out such reporting result in the Board being able to suspend the license of the healing arts licensee immediately?

Testimony and Material Presented to the Committee. The General Counsel for the Board of Healing Arts recommended the above noted actions in a memorandum to the Committee dated July 8, 1985. No other recommendations or material supporting the above noted type of legislation has been submitted to the Committee.

[XIIIa. Should a specified number of the required continuing education hours mandated for practitioners of the healing arts be required to be in the area of risk management?

Testimony and Material Presented to the Committee. This recommendation arises from Committee discussion and a member of the Committee. Currently, the Kansas Healing Arts Act requires MDs, DOs, and chiropractors to complete continuing education requirements as set by the Board through rules and regulations. The Board has adopted rules and regulations which generally conform with requirements of the AMA and other provider groups and which also allow practitioners to meet speciality board continuing education requirements. The Legislature could mandate that some portion of continuing education hours be devoted to physician-patient relations, peer review, risk management in hospital and office settings, etc.]

XIV. Should legislation be enacted which allows the Board of Healing Arts to use and defer action to impaired physician committees of private associations of the healing arts and to make any information received by such committees absolutely confidential?

Testimony and Material Presented to the Committee. See Memorandum from Don Strole to the Committee dated July 8, 1985, page two.

[XIVa. Should health care providers who treat patients while under the influence of alcohol or drugs be subject to criminal sanctions?

Testimony and Material Presented to the Committee. The Kansas Trial Lawyers Association advocated providers who treat patients under the influence of alcohol or drugs be subject to a class E felony.]

XV. Should legislation be enacted to authorize the Board, upon probable cause, to require a licensee to take a competency examination approved by the Board and, in the event of failure on the examination, to require the licensee to attend courses in the area of the deficiency or to take other disciplinary action?

Testimony and Material Presented to the Committee. See Memorandum from Don Strole to the Committee dated July 8, 1985, page three.

XVI. Should legislative action be taken to require hospitals to submit peer review records on doctors when the hospital makes reports pursuant to K.S.A. 1984 Supp. 65-28,121 [that they have suspended, terminated, or restricted a provider's practice?]

Testimony and Material Presented to the Committee. See Memorandum from Don Strole to the Committee dated July 8, 1985. See also K.S.A. 1984 Supp. 65-4915, particularly subsection (e).

XVII. Should a special committee be established to review peer review records submitted to the Board and any other records it chooses to review?

Testimony and Material Presented to the Committee. See Memorandum from Don Strole dated July 8, 1985. Apparently the purpose of this recommendation is to see that institutional medical staffs and others are doing adequate peer review. In this context see VII, and note that the JCAH reviews quality control (peer review) programs in the larger hospitals in Kansas (60 beds and over), that the Professional Review Organization (PRO) is supposed to do patient care quality reviews of all hospital patients that are Medicare-related and that the Department of Health and Environment, the hospital licensing agency, also does inspections for licensing purposes. Is this the appropriate agency to adopt regulations concerning and review of peer review activities in hospitals?

[XVIIa. Should the statute providing for the confidentiality of peer review records be repealed?

Testimony and Material Presented to the Committee. The Kansas Trial Lawyers Association advocated the above idea.]

Kansas Legislative Research Department October 8, 1985

TOTAL CHARGES (BASIC COVERAGE PREMIUM PLUS SURCHARGE*)
FOR PROFESSIONAL LIABILITY COVERAGE — PERSONS
LICENSED TO PRACTICE MEDICINE AND SURGERY
(MD, DO) IN FORCE ON JUNE 6, 1985

Premium Plus Surcharge*	Number of Licensees
Under $3,000	1,544
3,001-5,000	686
5,001-7,000	459
7,001-9,000	175
9,001-11,000	239
11,001-13,000	113
13,001-15,000	160
15,001-17,000	130
17,001-19,000	76
19,001-20,000	31
20,001-30,000	58
30,001-40,000	6
40,001-50,000	5
50,001-60,000	2

15

* Surcharge at 50 percent for 151 licensees, at 110 percent for one licensee, and at 80 percent for the remainder.

Source: Office of the Commissioner of Insurance.

W85-280/EC

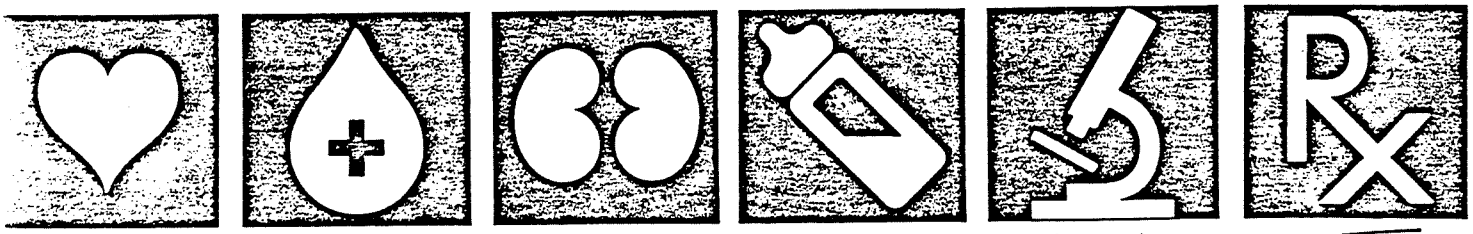
10/10-11/85
Attachment VI

What Legislators Need to Know About Medical Malpractice

National Conference of State Legislatures

Foundation for State Legislatures

10/10-11/85



Attachment VII

What Legislators Need to Know About Medical Malpractice was written by Robert Pierce, senior research analyst, National Conference of State Legislatures (NCSL). Randall R. Bovbjerg of The Urban Institute, Professor Clark C. Havighurst of the Duke University School of Law, and Ellen Hekman, formerly of NCSL, made significant contributions.

This booklet is based in part on presentations made at a national conference sponsored by The Urban Institute, February 1985, in Washington, D.C. The conference—entitled "Medical Malpractice: Can the Private Sector Find Relief?"—offered a forum for discussion of malpractice issues by academicians, providers, insurers, lawyers, and public policymakers. The conference was chaired by Randall R. Bovbjerg and Clark C. Havighurst. Eleven state legislators participated in the conference, including Senator Dempsey J. Barron of Florida, Senator Prescott Bloom of Illinois, Senator Chuck Chvala of Wisconsin, Senator David Helbach of Wisconsin, Senator Anne Lindeman of Arizona, Senator C. R. Montgomery of Mississippi, Representative Paul Starnes of Tennessee, Assemblyman James Tallon of New York, Representative Louise M. Tesmer of Wisconsin, Senator Jerome Van Sistine of Wisconsin, and Representative Joseph E. Wimmer of Wisconsin.

The following individuals made presentations at the conference:

Patrick Atiyah, Oxford University; Patricia M. Danzon, Ph.D., Center for Health Policy Research and Education, Duke University; Richard A. Epstein, University of Chicago Law School; Max Fine, Max Fine Associates, Inc., Washington, D.C.; William H. Ginsburg, Esquire, Wood, Lucksinger & Epstein, Los Angeles; James Lewis Griffith, Esquire, Griffith & Burr, P.C., Philadelphia; James A. Henderson, Cornell Law School; John S. Hoff, Esquire, Swidler, Berlin & Strelow, Washington, D.C.; John Horty, Esquire, Horty, Springer & Mattern, Pittsburgh; Sylvia Law, New York University School of Law; Arthur J. Mannix, M.D., Medical Liability Insurance Co., New York; Don Harper Mills, M.D., J.D., University of Southern California School of Medicine; Hon. W. Henson Moore, U.S. House of Representatives; Jeffrey O'Connell, University of Virginia School of Law; Joseph N. Onek, Esquire, Onek, Klein & Farr, Washington, D.C.; James R. Posner, Ph.D., Marsh & McLennan, Inc., New York; Elvoy Raines, J.D., American Society of Law and Medicine, Boston; John B. Reiss, Esquire, Dechert, Price & Rhoads, Philadelphia; Glen O. Robinson, University of Virginia School of Law; Peter Sweetland, The Medical Inter-Insurance Exchange of New Jersey; Laurence R. Tancredi, M.D., J.D., University of Texas Health Science Center at Houston; and James S. Todd, M.D., Trustee, American Medical Association, Ridgewood, New Jersey.

In early 1986, papers from the conference proceedings will be published in a symposium of the journal, *Law and Contemporary Problems*, a publication of the Duke University School of Law.

Funds for the organization of The Urban Institute conference were provided by General Reinsurance Corporation, the Hospital Corporation of America Foundation, and St. Paul Fire and Marine Insurance Company.

This booklet also draws on materials from the American Medical Association, the Association of Trial Lawyers of America, The Rand Corporation, and the Health Policy Analysis Program of the University of Washington.

Reviewers of the booklet were Gordon Anderson, Wisconsin Legislative Council; Nancy Bannon, American Medical Association; Patricia Danzon, Duke University; Thomas Goddard, Association of Trial Lawyers of America; Steve Krafchick, Medical Legal Consultants of Washington, Seattle; Doug Reese, Intergovernmental Health Policy Project; and Carl Tubbesing, Lanny Proffer, Cindy Simon, Candace Romig, and Barbara Yondorf of the National Conference of State Legislatures.

In addition, Sharon Bjorkman's editing and Michelle Polchow's word processing led to the successful completion of this project.

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July 1985

Introduction

Medical malpractice is once again prominent on the legislative agenda—just 10 years after a crisis in the availability of malpractice insurance inspired reform legislation in almost every state in 1975 and 1976.

Providers of medical care and malpractice insurers are lobbying for new legislation to address the problem of a growing number of malpractice lawsuits and increasingly large damage awards and settlements. The American Medical Association (AMA) has described the current malpractice situation as a crisis, not of availability as in 1975-76, but of affordability. Among the social costs of the system, say the critics, are the costs of "defensive medicine."

Attorneys who represent those filing malpractice actions challenge the assumption that there is a crisis. They argue that malpractice settlements reflect provider negligence and fair compensation for injuries. They also argue that the system raises the standards of medical practice and that most of what is called "defensive medicine" reflects taking desirable precautions.

The issues in the malpractice debate once again are being discussed before state legislatures. This booklet provides an overview of the issues, some relevant data, and a review of possible legislative and private sector actions to improve or replace the medical malpractice system.

Question One: What Is Medical Malpractice?

Medical malpractice is negligent care by a health care provider that causes injury to a patient. A bad treatment result, no matter how severe, is not grounds for malpractice action unless the provider was at fault.

Medical malpractice actions are brought by injured parties who believe that they are the victims of negligence. Relatives or dependents of the claimant also may be party to the lawsuit. Suits may be brought against a doctor, other health care personnel, a hospital, equipment manufacturers, pharmaceutical companies, and others involved directly or indirectly in patient care.

To be compensated for medical malpractice, the injured party must establish a breach of the legal standard of care, compensable injury to the patient, and a causal connection between such breach and such injury.

Malpractice law has two major goals: a) to provide compensation to victims of malpractice, and b) to deter substandard care through the threat of legal action. It does not seek to cover all injuries that occur in the course of medical care. Nor does it systematically police all poor-quality care.

Question Two: How Does the Medical Malpractice System Function?

The medical malpractice system encompasses both the formal legal process and the mechanisms of liability insurance. Although most incidents are resolved without full recourse to the legal system, legal doctrine and institutions determine which claims will be brought, whether settlements will be reached, and at what level of payment.

The Legal Process

Medical malpractice lawsuits are resolved through the tort system. Plaintiffs usually seek compensation for both economic and noneconomic damages. Economic damages include the cost of medical and rehabilitative care and lost wages. Noneconomic damages include pain, suffering, and impairment of the quality of life.

Providers and insurers usually are notified of a claim before a lawsuit is actually filed. A study by The Rand Corporation showed that one-half of all claims are dropped without any payment and that two-thirds of those are dropped before a lawsuit is filed.[1] In 22 states, a screening panel reviews claims that result in formal lawsuits before they can go to trial.

A majority of lawsuits that are filed are settled without a trial; many others are settled during trial. A Rand Corporation review of 6,000 national malpractice claims closed in 1974 and 1976 found that less than 10 percent were tried all the way to verdict.[2] Lawsuits involving more severe injuries and those likely to win larger settlements are more apt to be tried to verdict. The probability of the plaintiff's winning is greater if the case involves a permanent or fatal injury and if there are multiple defendants. Of those cases resolved by a jury verdict, The Rand Corporation analysis showed that such verdicts favored providers (defendants) 75 percent of the time; a 12-year review of California Superior Court records showed that verdicts favored providers in 60 to 74 percent of malpractice cases.[3]

The Patient as Plaintiff

Whether any claim will be made depends upon a patient's initiative in identifying possible malpractice and seeking redress. Estimates are that only one in 10 victims of malpractice files a claim.[4] A 1972 study for the U.S. Department of Health, Education and Welfare found that 7.5 percent of discharged patients had been injured in some way as a result of their medical treatment and that 29 percent of these injuries were due to demonstrable malpractice or negligence.[5] But injured people may not recognize the malpractice, may consider the result merely unfortunate, may accept a provider's remedial efforts, or may simply elect not to become involved in a lawsuit debilitating to the provider.

Most commonly, lawsuits are filed because of bad treatment results, injuries resulting from medical treatment, misdiagnosis, failure to treat or improper treatment, or a fall in a hospital or a doctor's office. A patient also may sue a provider for failing to obtain "informed consent"—that is, for withholding information that probably would have led the patient to refuse the injurious treatment.

For the most part, a patient may pursue a claim without concern for paying an attorney in advance because malpractice lawyers usually are paid on a contingent fee basis. In such an arrangement, the attorney agrees to accept a percentage of the settlement or award, if any, as a fee. The plaintiff is still responsible for other expenses such as court costs and the cost of obtaining evidence.

The Liability Insurance System

Doctors and hospitals purchase malpractice insurance to protect themselves from malpractice claims. Premium costs for doctors are based on the experience rating for their medical specialty and geographic area. Surgeons, obstetricians, and anesthesiologists are more likely than other specialists to pay high premiums. On Long Island, New York, some neurosurgeons reportedly pay as much as $101,000 and obstetricians $82,000 for malpractice coverage.

Malpractice insurance is offered by several national liability insurers and by provider-owned and -operated companies. Self insurance is also an option for large hospitals and other entities; a few physicians have elected to practice without insurance. Although there was a fear in the 1970s that malpractice insurance would become unavailable, availability is not a significant problem now, in part because, beginning in the 1970s, providers formed their own insurers. These "bedpan mutuals" insured more than 87,000 physicians in 1983. States also have established joint underwriting associations to guarantee availability.

Two-thirds of insurance claims are resolved within two years of filing. Of the cases that receive compensation, settlements vary widely. Five percent of paid claims account for half of the dollars paid to plaintiffs and another 50 percent of paid claims account for only 4 percent of dollar outlays. Settlements and awards, however, do appear to reflect the severity of injuries.[6]

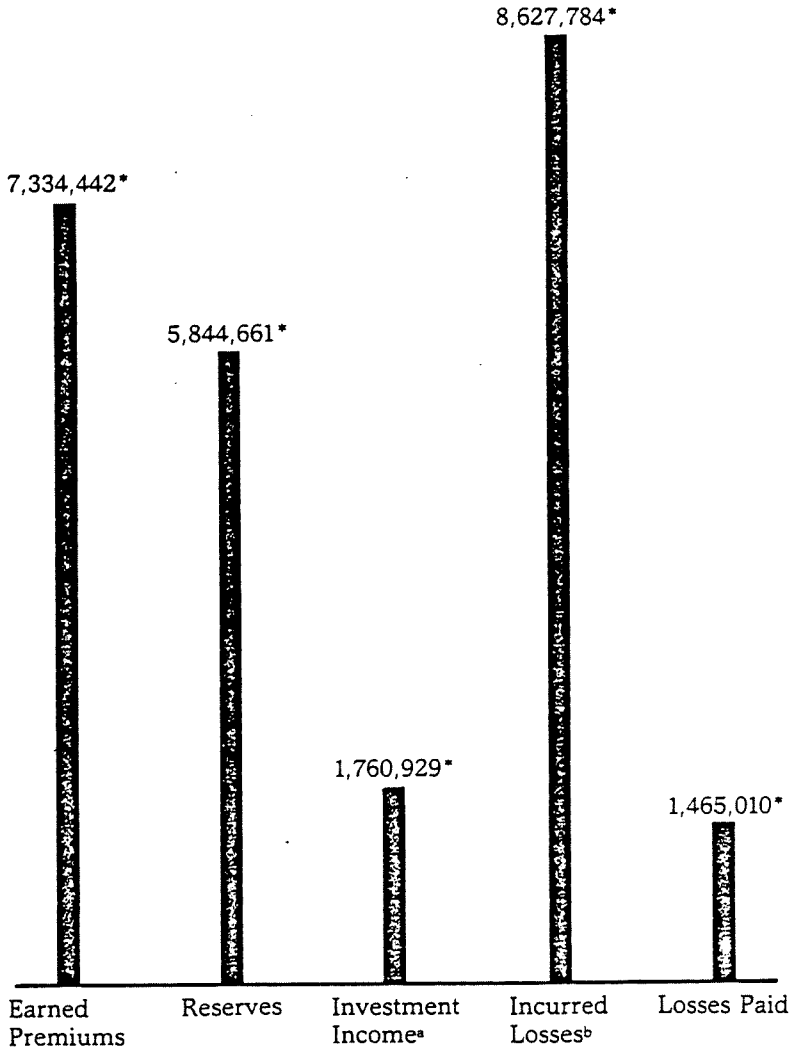
Until recently, most medical malpractice policies were written on an occurrence basis. Occurrence-based insurance holds the insurance company financially responsible for claims resulting from treatment rendered during the coverage period, regardless of when the claim was filed. This results in a "long tail" of exposure to unfiled malpractice claims. For example, the St. Paul Fire and Marine Insurance Company, the nation's largest malpractice insurer, found that 30 percent of claims are filed in the year of treatment, 30 percent in the year after treatment, 25 percent in the third year, 7 percent in the fourth year, and 8 percent in years five through 10. This long lag time makes it difficult to determine appropriate premiums and necessary reserve levels.

Because of these problems, the malpractice insurance market is moving to a claims-made system, under which insurers are contractually responsible for claims filed only during the coverage year. Thus, insurers can better set premium levels and reserves. Providers, however, bear the risk of suits filed late and must carry insurance even after retiring from practice. Claims-made policies now account for about half of the total premiums written.

The profitability of malpractice insurers can be measured either by using loss ratios or by comparing actual losses to premium income. In either case, a backlog of unresolved claims complicates the actuarial determination necessary to estimate profitability.

Loss ratios compare a company's actual and estimated future losses and expenses to its premium income. The industry-wide loss ratio over the last five years is estimated at 111.4, or a loss payment of $1.11 for each $1.00 of premium income. In 1982, major malpractice underwriters had a loss ratio of 122.

Figure 1: Medical Malpractice Insurance for 75 Selected Companies (94 Percent of Industry), 1978-1983



*000's omitted
[a] Estimate based on 10% return on investments.
[b] Paid losses and estimate of future payments and expenses.

Source: Association of Trial Lawyers of America, Washington, D.C. Based on figures in 1984 *Best's Casualty Loss Reserve Development.*

Some important considerations, however, are not reflected in loss ratios. First, these ratios are based on *estimated* future claims losses and often are revised up or down later. Second, this measure does not consider investment income from sizable reserves held against future losses.

Comparing actual losses paid to premium income is another way to measure the industry's economic performance, and critics of malpractice insurers prefer to cite these figures. From 1977 through 1982, major malpractice insurers earned net premiums of $7.2 billion. Since 1977, they have paid incurred losses of $1.7 billion. Insurers maintain that the reserves they have built up reflect appropriate actuarial estimates of future liabilities, while critics cite investment income earned from these large reserves.

Question Three: What Are the Trends in Medical Malpractice Premiums, Claims, and Awards?

The number of malpractice claims (frequency), the size of awards (severity), and the cost of insurance have increased steadily. Some data, some possible explanations, and some speculations on future trends are presented here.

Frequency of Claims

After the deluge of claims in the mid-1970s, their frequency declined briefly, from 24,240 in 1975 to 17,238 in 1978. In 1979, however, frequency once again began to rise rapidly. Physician-owned malpractice insurers experienced an increase in claim frequency from 12.17 cases per 100 physicians in 1979 to 20.3 cases per 100 physicians in 1983. The St. Paul Company saw hospital claims rise from 1.75 per 100 beds in 1979 to 3.0 per 100 beds in 1983. The figures vary greatly by provider specialty, from state to state, and even within a state. In 1978, for example, the state with the most claims activity had 12 times the claims frequency of the state with the least.

Size of Awards

Malpractice awards and settlements have been increasing even more dramatically in amount than in number. The St. Paul Company has seen its average loss per hospital claim, including allocated loss expense, grow from less than $5,000 in 1975 to more than $12,000 in 1983. Data compiled by the AMA from physician-owned insurers show the average paid loss going from $20,396 in 1979 to $72,243 in 1983.[7]

Although juries resolve only a small percentage of malpractice claims, jury awards influence the level of settlements and give patients and attorneys incentive to pursue claims. According to one reporting service, the average malpractice jury award grew more than fivefold, from $166,165 in 1974 to $888,285 in 1983.[8] Only four jury awards of $1 million or more were voluntarily reported to the service in 1974, compared with 70 in 1983. The size of malpractice claims also varies greatly between states, with a thirtyfold range between the most and least litigious states.

Insurance Costs

The growth in average malpractice premium costs has been much more moderate than the growth in frequency of claims or size of awards. In just the past year, however, indicators are that premiums have jumped suddenly.

Between 1976 and 1983, average physician premium expenses grew only 51 percent (from $4,700 to $7,100)—well below the nearly 100 percent increase in the Medical Care Price Index for this same period. According to the AMA, physicians' average malpractice premium expenses equaled 4.4 percent of gross income in 1976, and 3.7 percent in 1983. Recently, however, insurance rates have risen markedly. A New York insurer received approval to raise rates more than 50 percent. Many physician-owned malpractice insurers increased rates 10 to 39 percent in 1984, with more increases expected in 1985.

Malpractice insurance rates for the higher-risk specialties, such as surgery, obstetrics, and anesthesiology, have gone up more than for other specialties. The average rate for obstetricians went from $8,300 in 1978 to $14,100 in 1983, and surgeons saw their average rates increase from $7,187 to $10,900. Rates for internists and general practitioners rose from approximately $2,400 to $4,400.

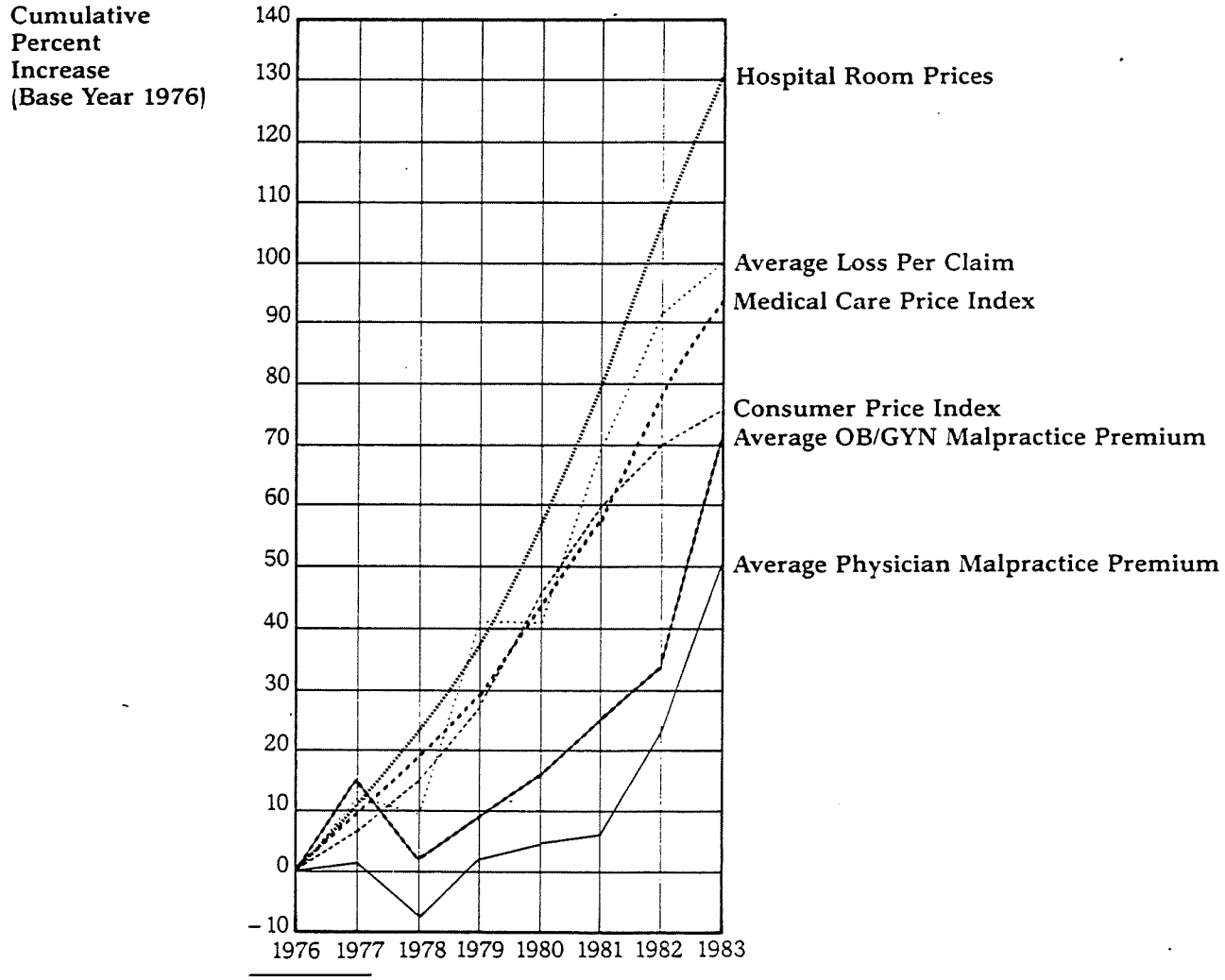
Insurance costs vary greatly by geographic region. Average physician premiums for physician-owned companies, for example, ranged from $1,200 in Indiana to $12,500 in New York, in 1984. Hospital premium rates also vary widely. The St. Paul Company's data showed that 1984 hospital premiums ranged from $378 per bed in South Carolina to $2,178 per occupied bed in Dade and Broward Counties of Florida. Individual hospital rates differ according to the institution's actual malpractice experience.

Explanations of the Trends

The growth in the number of claims, size of awards, and costs of malpractice insurance has been attributed to many factors, some of which are difficult to evaluate and control. They include:

- Rapid rises in health care costs, which are reflected in damage awards (between 1975 and 1983, the Medical Care Price Index nearly doubled);
- Rising expectations by patients and jurors of success in medical treatment;

Figure 2: Comparative Trends in Malpractice and Health Care Costs



Sources:

Consumer Price Index, Medical Care Price Index, Hospital Room Prices: *Statistical Abstract of the United States, 1985.*
Average physician malpractice premium, average OB/GYN malpractice premium: American Medical Association.
Average loss per claim: National Claims Frequency and Severity Indices for Physicians and Surgeons Coverage, 1975-84, The St. Paul Companies Inc.

- Changes in health care technology that have increased the use of dangerous and invasive treatments and diagnostic procedures;
- Increased incidence of malpractice claims for adverse birth-related outcomes, which may entail supporting a victim for an entire life;
- Impaired doctor/patient communication and trust resulting from the increasing depersonalization of health care;
- Increased willingness to sue in general and urbanization in particular, which explains much of the difference in the frequency of claims between areas;
- Liberalization of legal doctrine governing malpractice; and
- Increased sophistication of malpractice attorneys.

Future Prospects

Several factors may slow the rising costs of the malpractice system over the next few years. As the costs of malpractice continue to rise, hospitals and other health care organizations have a greater financial incentive to select their doctors carefully and scrutinize their actions to avoid liability. Risk management programs being introduced in hospitals may help improve the quality of care, prevent injuries, limit the extent of harm, settle claims on a realistic basis, and change patient expectations through education and disclosure.

Much of the difficulty in determining negligence results from wide variations in medical practice and lack of consensus on treatment standards. Current health care cost containment efforts, however, may bring more agreement on appropriate standards of care. The adoption of prospective payment systems, especially the Medicare diagnosis-related group (DRG) reimbursement system, has increased attention to cost-effectiveness. Utilization review systems, such as Medicare's Peer Review Organizations (PRO), also may effect greater agreement on medical standards.

Another factor that may help standardize care and improve quality is the expansion of health maintenance organizations (HMOs), primary care networks, and preferred provider organizations. These mechanisms often incorporate utilization review, quality controls, and incentives to avoid unnecessary care.

Although changes in organizational patterns and incentives may improve quality and better define the standard of care, many doctors and others are concerned that the DRG system and other cost containment measures may result in a two-tier system of care, exposing providers who economize to the risk that courts will penalize them for not adhering to higher standards.

As already noted, however, evidence exists that only a small percentage of negligent medical injuries result in malpractice claims. Thus, even if the incidence of injuries remains the same or declines, changes in patient attitudes and provider/patient relations, increased awareness of possibilities for legal action, and other factors could trigger more claims.

Question Four: What Are the Major Criticisms of the Existing Medical Malpractice System?

Critics of the system have a long list of complaints. These criticisms are reviewed here together with the responses of the system's defenders.

- *The system's administrative costs are excessive.* Estimates are that only 28 to 40 cents of each premium dollar ultimately goes to injured parties.[9] Administration, claims evaluation, and litigation costs, including plaintiff attorneys' contingent fees and defense attorneys' hourly fees, absorb more than half of each premium dollar. Defenders of the system believe that such costs are worth incurring because of the deterrence to malpractice that the system achieves. Dr. Patricia Danzon of Duke University argues, for example, that a 20 to 30 percent reduction in the incidence of negligent injury would justify the present cost of the fault-based system.
- *The resolution of medical malpractice claims is too slow.* One-third of all claims takes more than two years to resolve. The injured party often does not receive compensation when it would be most helpful in repairing his injuries. The present malpractice system sometimes discourages early settlement offers because that might be interpreted as a sign that one's case is weak. Defenders point out, however, that it is not clear that malpractice litigation is any more drawn out than other insurance and legal disputes and that defendants can avoid litigation costs through prompt, reasonable settlement offers.

- *Damage awards are often excessive.* A small percentage of cases account for the bulk of dollar payouts. Many of these and other awards are questioned as larger than necessary to compensate the patient. Damage awards sometimes duplicate amounts already reimbursed by other sources, such as health or disability insurance. Critics argue that awards for pain and suffering and other forms of noneconomic loss are highly subjective, and that emotional appeals result in awards that vary greatly in otherwise similar cases. Defenders argue that large awards for noneconomic loss, such as disfigurement or injuries that confine the victim to a wheelchair, are not inappropriate and that a patient's own insurance should not reduce the liability of a negligent provider. Finally, defenders believe that excluding or limiting these damages would weaken the system's deterrent effect.
- *The system encourages costly defensive medicine and inhibits responsible cost containment.* Defensive medicine consists of additional diagnostic tests, treatment procedures, and administrative costs, incurred primarily to improve the provider's defense to a possible future malpractice action. It also may include avoiding some high-risk or potentially litigious patients and forgoing desirable, but risky, procedures out of a fear of litigation if success is not achieved.

The most commonly quoted estimate of the cost of defensive medicine is $15.1 billion per year. The AMA derived this figure from its Socioeconomic Monitoring System. In the AMA's 1983 survey, 40.8 percent of responding physicians said they prescribed additional tests out of concern about possible lawsuits, 27.2 percent said they provided additional treatment procedures, 34.6 percent said they do not accept certain types of cases, and 31.4 percent said they increased their fees because of malpractice premium costs.[10]

Whatever the costs associated with defensive medicine, not everyone believes these costs are unwarranted. Dr. Danzon points out that "some defensive medicine is precisely the increased care which the malpractice system is intended to encourage."[11] She also notes that it is not possible to distinguish defensive medicine from the overutilization that results from the economic incentives inherent in fee-for-service medicine.

- *Malpractice insurance is overpriced.* Plaintiffs' attorneys in particular feel that the rising costs of malpractice coverage are more a problem with the insurance mechanism than with the legal system. They make three major points in arguing that premiums are too high: a) Premium income far exceeds paid losses. From 1977 through 1982, insurers received net premium income of $7.2 billion, and reported loss and loss expense payments of $1.7 billion. b) Premium rates fail to reflect income from investment of insurers' sizable reserves. c) Actuarial estimates of malpractice losses from claims not yet paid or filed are too high.

The insurers and others who disagree make the following points: a) Premium increases and large reserve amounts are necessary to meet expected losses from 186,000 pending claims.[12] b) Actuarial estimates are appropriate, although subject to change. Estimates of incurred losses since 1977 have been raised for some years, lowered for others. c) Malpractice insurers expect to pay claims that exceed premium income, and so they depend upon investment income. d) Physician-owned companies have experienced similar premium increases and have made similar actuarial estimates, although they have no incentive to earn large profits. e) Commerical insurance company rates are competitive with those of the bedpan mutuals.

Question Five: What Were the Effects of the Medical Malpractice Reform Measures?

The perceived crisis of the mid-1970s prompted state legislatures to enact many reforms. These reforms were meant to ensure the availability of insurance, to encourage settlements before trial, to limit recoveries, to improve the quality of care, and to alter the legal process.

State legislation was effective in solving malpractice insurance availability problems, but the effect of tort reforms on claims and recoveries is far less clear.

Research on the effects of reforms has been complicated by the difficulty of accurately characterizing reforms. Not every state reforming a specific element of malpractice law made precisely the same change. In addition, the complexity of reforms, typically mixing many different elements in one package, has hampered researchers' efforts to isolate the effect of any single element. Finally, studies may have been undertaken too early to assess reforms; not only might reforms take time to influence behavior, but also many pre-reform claims continued in the system.

Economist Frank Sloan of Vanderbilt University analyzed the reforms' impact on malpractice premiums. He concluded that "the empirical results of this study give no indication that individual state legislative actions, or actions taken collectively, have had their intended effects on premiums. The publicity resulting from considerable legislative activity may have made juries more aware of the cost consequences of malpractice suits."

Dr. Danzon analyzed malpractice claims closed by almost all insurers in the mid- to late 1970s. Her conclusions:

- Limits on the dollar amount of awards, including caps and provisions for periodic rather than lump-sum payments, appeared to cut average settlements by 25 percent, to raise the proportion of cases dropped from 43 to 48 percent, and to reduce slightly the share of cases going to verdict.
- Relaxation of the ban on introducing evidence of collateral sources of compensation available to the plaintiff appeared to reduce settlements, although the statistical significance of this finding was low.
- Limits on attorneys' contingent fees cut average settlements by 9 percent, somewhat raised the number of cases dropped without payment, and slightly reduced the percentage of cases going to verdict.

Question Six: What Issues Should Legislators Consider in Examining Medical Malpractice?

Provider groups and malpractice insurers are looking to state legislatures for additional changes in the malpractice system. Plaintiffs' attorneys and others dispute the need for change and seek different reforms. As legislators examine the malpractice system and the wide range of reform proposals, they will need to determine whether changes are needed, whether adjustments should be made in the tort system, or whether more fundamental changes are called for.

As noted earlier, legislators should be aware that the frequency and size of malpractice claims and the affordability of malpractice insurance vary greatly by state and by region. There are also shortcomings in malpractice data. Studies by the federal government and the National Association of Insurance Commissioners (NAIC) in the 1970s have not been continued or expanded in the 1980s. Much of the available data is proprietary and supplied by interested parties. Data for a specific state may be incomplete and inadequate as a basis for policymaking.

As legislators examine alternative approaches to the malpractice issue, they may want to consider the following objectives:

- *Assuring equitable patient redress for negligent injury.* The malpractice system should not discourage meritorious claims or encourage inadequate compensation. Patients have few other ways to effectively register their grievances about substandard care.
- *Deterring negligent practice and improving the quality of medical treatment.* This point is particularly important because current health care cost containment pressures may encourage providers to inappropriately cut corners.
- *Controlling health care costs.* Injuries resulting from medical malpractice are a significant cost of medical care. Awarding reparations for such injuries creates no new costs but merely shifts to providers and the public costs that otherwise would be borne privately. Making these costs explicit is not objectionable in itself. On the other hand, shifting costs through the tort system is itself expensive. Moreover, by inhibiting responsible economizing and encouraging wasteful defensive medicine, the tort system may add to the overall cost of health care.
- *Promoting reasonable expectations.* Medical malpractice suits are appropriate only in cases where negligence by providers results in patient injury. Medical care is an inherently risky activity and all undesirable treatment outcomes cannot be made compensable. The standard of care used in judging provider negligence should not curb reasonable economizing efforts, stifle innovation, or encourage inefficient treatment practices.

- *Assuring consumer access to needed care.* The increasing cost of malpractice insurance for providers undertaking high-risk activities has caused those in some geographic areas to leave certain activities or retire early. In a few places, patient access to services (e.g., obstetrics) is being curtailed.
- *Encouraging timely resolution of suits.* The length of time involved in settling malpractice cases fuels costs, inconveniences providers and patients, and saddles insurance companies with uncertainties about future claims.
- *Discouraging nonmeritorious lawsuits.* Competent doctors deserve to have their reputations protected from adverse publicity caused by nonmeritorious suits.
- *Developing legislation that can withstand legal challenges.* As noted later, state courts found a number of malpractice reforms passed in the 1970s unconstitutional. Great care needs to be taken in drafting new reforms.

Question Seven: How Can States Encourage Claims Resolution Without Trial?

Pretrial screening panels and arbitration are reforms that can speed resolution of disputes and limit litigation costs. Unlike pretrial screening panels, arbitration is an alternative designed to replace the judicial system altogether.

Pretrial Panels

Currently operating in 23 states, such panels encourage early settlements and weed out frivolous claims. In many states, the panel must review a claim before the action can be tried in court. Panels usually consist of physicians, lawyers, and public members. Decisions by pretrial screening panels are nonbinding. Panel decisions are admissible in court in some states and inadmissible in others.

In Florida, Illinois, Missouri, and Pennsylvania, state courts have invalidated pretrial panels on the grounds they unduly impeded access to courts and a jury trial, were arbitrary and capricious in their operation, or violated equal protection guarantees by treating medical malpractice differently from other negligence actions.

Proponents of panels argue that they not only will weed out less meritorious claims and encourage early out-of-court settlements but also will lessen the cost of litigation. Opponents believe that panels may increase costs by requiring an additional level of litigation (before the panel), that provider

representation on some state panels introduces a bias against claimants, and that panels whose decisions are admissible in court should not be conducted under different evidentiary and procedural rules.

Arbitration

Unlike screening panels, arbitration may provide a total substitute for a court proceeding—although substantive tort rules still govern. State law may permit patients and health care providers to agree in writing to submit a malpractice claim to binding arbitration and thus to have the issues of liability and damages resolved by mutually acceptable arbitrators rather than by a jury. Because some courts historically refused to enforce agreements to replace courts with arbitrators, most legislatures have passed arbitration acts.

Eleven states have statutes specifically allowing arbitration of medical liability cases. Such statutes generally provide that patients who do not sign an arbitration agreement may not be denied treatment or otherwise discriminated against. It is also common to allow a revocation period (usually 30 to 60 days after treatment) in which a patient may rescind the agreement.

In Michigan, institutional providers are required to offer all patients a voluntary agreement to arbitrate any future disputes. A booklet explaining the arbitration statute and process must be given to a patient along with the agreement. Arbitration panels include a public member, an attorney, and a health care provider of the same specialty as the defendant. Hearings are not open to the general public. Decisions are binding on all parties involved, and only in cases where there is alleged unfairness or bias of the arbitrators is an appeal available. The claimant is not responsible for the costs of the arbitration proceedings. The Michigan act has been upheld by the state supreme court.

Proponents of binding arbitration argue that expert arbitrators are better than juries at dealing with the complexities of medical treatment, law, and damages, and that results are therefore more predictable and equitable. They also believe that through this process claims may be resolved more promptly than in the court system and that lessened formality and reduced likelihood of appeals will reduce litigation costs. Finally, arbitration provides confidentiality for the parties.

Opponents of binding arbitration argue that individuals may be unaware of the meaning of the arbitration agreement they sign and the arbitration may be prejudiced against the plaintiff because the panel includes a provider. Critics also point out that the plaintiff forfeits his right to a jury trial and to appeal the panel's decision. Finally, they believe that plaintiffs may not be adequately compensated for their injuries, since panel awards tend to be lower than jury awards.

Table 1:
Tort Reform Provisions

	Alabama	Alaska	Arizona	Arkansas	California	Colorado	Connecticut	Delaware	Florida	Georgia	Hawaii	Idaho	Illinois	Indiana	Iowa	Kansas	Kentucky
Ad Damnum	1	1	1	1	1		1		1	1	1		1	2	1	1	1
Arbitration	1	1			1					1			1				
Attorney Fees			1		1	1		1	1		1			2	1	1	
Awarding Costs						1			1				1			1	
Collateral Source		1	2		1			1	2				1		2	1	
Expert Witness								1	1			2					
Limits on Liability					1								3	2			
Patient Compensation Fund									2		1			2		1	3
Periodic Payment	1	1		1	2			1	1							1	
Pre-Trial Screening Panel		1	2	1			1	1	3		1	1	3	2		1	
Res Ipsa Loquitur		1			1			1	1				1				
Statute of Limitations	2		1		1	2		1	1	1	1		2	2	1	2	1
Special Statute of Limitations for Minors	2		1		1	1		1						2		1	
Standards of Care	1	2	1	1				1	1			1					

Louisiana	Maine	Maryland	Massachusetts	Michigan	Minnesota	Mississippi	Missouri	Montana	Nebraska	Nevada	New Hampshire	New Jersey	New Mexico	New York	North Carolina	North Dakota	Ohio	Oklahoma	Oregon	Pennsylvania	Rhode Island	South Carolina	South Dakota	Tennessee	Texas	Utah	Vermont	Virginia	Washington	West Virginia	Wisconsin	Wyoming
2	1	1	1			1	1		1				1	1	1		1				1			1	1	1			1		1	
1				2													1						1				1	1				
		1		1					2		3	1		1				1	1					1					1		1	1
			2						1											1												
									2		3			1		3	1			3	1		1	1					1			
1				1						1	3						2	1						1				1				
1									2		3		1			3	1		1			1	1		1			1			1	
2									2				1		1				1	1		1									1	
		1		1							3		1							1		1								1	2	
2	1	1	2				3	2	2		1	2	1	1			2			3								1		2	
										1						3		1			1			1	1							
1	1	1	1	1	1	1	1	1	1	1	3		1	1	1	1	1	1	1		1	1	1	2	1	2			1		1	1
1		1	1			1	1				3		1	1	1		3						1		3	1					1	1
1		-		1			.		1	1					1			1	1					1			1	1	2			

Key:

1. Provision exists.
2. Provision found constitutional by highest state court.
3. Provision found unconstitutional by highest state court.

Notes:

This chart does not include all of the court rules that affect these provisions.
Chart reflects state actions through 1983.
Data source: AMA Division of Legislative Activities, Department of State Legislation. Chicago, November 1984.
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Question Eight: What Can States Do to Limit the Extent of Provider Liability?

In the 1970s, several state legislatures acted to reduce awards and settlements in medical liability cases by limiting specific types of damages, placing caps on total recoveries, changing the rules on collateral sources, and providing for periodic payment of damages. A few states established state patient compensation funds to cover liability in excess of some specific dollar amount.

Limits on Specific Types of Damages
Some states, such as California, Louisiana, New Mexico, Ohio, South Dakota, and Texas, have enacted limits on the amounts recoverable for noneconomic losses such as pain and suffering, disfigurement, and impairment of the quality of life. The most common recovery limit is $500,000, although California has a $250,000 limit, and Ohio a $200,000 limit.

In 1980, the New Hampshire Supreme Court found unconstitutional a $250,000 limit on noneconomic loss, saying that "it is only the award above the out-of-pocket loss that is available to compensate in some way for the pain, suffering, physical impairment or disfigurement that the victim must endure until death." The court also felt that treating a malpractice tort differently from other torts violated equal protection under the law. The California Supreme Court, however, recently upheld that state's limit.

Proponents of limits on specific types of damages argue that noneconomic damages are subjective, resulting in widely differing awards in similar situations. Therefore, they argue, limits will provide more equity between awards as well as reduce malpractice premiums.

Opponents contend that it is inequitable to treat malpractice torts differently from other torts and that limits will prevent some victims from receiving fair compensation, especially for legitimate pain, suffering, and disfigurement.

Caps on Total Recoveries
Indiana, Nebraska, and Virginia have placed caps on the total recovery amount that malpractice victims may receive. Indiana's limit is $500,000, while Virginia's and Nebraska's is $1 million.

Illinois and North Dakota have ruled caps on total recoveries unconstitutional. The Illinois Supreme Court found this limit arbitrary and in violation of a state constitutional ban on "special laws" when a general law can be made applicable. The court said there was no societal "quid pro quo" whereby the loss of recovery potential for some victims was offset by lower insurance premiums and medical care costs for all citizens. The North Dakota Supreme Court held that the limit on recovery did not promote the legislative purposes of assuring the availability of medical services at reasonable costs and encouraging physicians to remain in practice, and that the limitation violated the state's equal protection clause.

Courts in Indiana and Nebraska have upheld the limits, ruling that they do serve a broad societal purpose, namely to ensure availability of liability insurance, and hence of all health care services, "to the benefit of the entire community including the badly injured plaintiff."

Proponents of caps believe that they would reduce costs to benefit all consumers and make insurance rating somewhat easier. Opponents argue that caps result in some consumers being unable to meet medical and living expenses and shift costs from the negligent party to the victim.

Changes in the Collateral Source Rule
The traditional collateral source rule in medical malpractice and other tort cases forbids evidence that the plaintiff has received compensation from other sources, such as health insurance. Thus, a patient may receive compensation from more than one source for a single element of loss, such as medical expenses. Twenty states have modified the rule either by allowing evidence of collateral payment to be considered in setting a malpractice award or by requiring that payments be deducted from awards. Such changes have met with judicial approval except in New Hampshire, North Dakota, and Pennsylvania, where courts accepted the argument that it is unreasonable to single out malpractice cases for special reduction of personal injury awards. A New Hampshire decision said this provision "arbitrarily and unreasonably discriminated in favor of the class of health care providers."

Those who agree that collateral source evidence should be permitted feel that this will prevent double compensation and free up insurance resources to cover other losses or to cut prices. Opponents of revealing collateral sources argue that victims of malpractice should not be penalized because they have purchased insurance, that collateral sources are not designed to compensate for negligence, and that insurance companies may have subrogation rights. Finally, they feel this change in the rule may weaken deterrence.

Periodic Payment of Damages
Traditionally, settlements in medical malpractice cases have been awarded in lump sums. Most states allow periodic payments only under court mandate or by arrangement of all parties; most plaintiffs (and their lawyers) want full payment immediately.

Sixteen states by statute allow structured awards—damages paid in installments throughout the plaintiff's period of disability, up to a lifetime. The frequency of installments varies and may be discretionary with a supervising court.

Courts in California and Wisconsin have upheld structured payments, saying that malpractice victims benefit from assured availability of funds to meet future medical and other needs. New Hampshire and North Dakota courts, to the contrary, saw these provisions as violations of equal protection guarantees.

Proponents of periodic payments argue that they eliminate speculation on future medical care and earnings while guaranteeing necessary funds. They also eliminate windfalls to the heirs of plaintiffs who die earlier than a judgment anticipated. Advocates also expect lower overall payouts.

Opponents argue that periodic payments involve higher administrative and court costs and that malpractice victims should get the use of and interest from settlements; the victim, not those liable or the court, should benefit from control of settlement amounts.

Patient Compensation Funds
These are state-sponsored excess liability funds, usually paid for by assessments on providers, liability insurers, and sometimes by state general revenues. Patient compensation funds generally require covered providers to carry malpractice insurance for losses up to $100,000; settlements above this amount are paid for out of the fund. Patient compensation funds in Indiana and Nebraska are coupled with caps on the total recovery amount malpractice victims may receive.

Proponents of patient compensation funds argue that they help ensure insurance availability by making it easier for insurers to estimate liability since the maximum cost per claim is capped. Opponents point out that if providers are assessed to pay for the fund, there is little or no reduction in malpractice insurance costs. They also cite the large deficits facing patient compensation funds in several states, where assessments have been inadequate to cover fund liabilities.

Question Nine: What Other Reforms of the Tort System Might States Consider?

Statutes of Limitations
Statutes of limitations define the time period within which medical liability actions must be commenced. A typical law might allow a lawsuit to be filed up to three years after the injury occurred or within one year after the injury's late discovery. Twenty-three states have adopted such statutes of repose specifically for malpractice actions, thus shortening the long tail of malpractice claims. Special provision usually is made for situations where the injury could not have been discovered, such as where a foreign object was left in the body or where the injury was fraudulently concealed.

A separate issue is the appropriate period of limitation applicable to minors. Some states provide that the limitation period does not begin to run until the minor reaches the age of majority, but others have enacted shorter

limits. Although court decisions usually have upheld statutes of limitations, special statutes for minors have been thrown out in three states as violations of minors' due process rights.

Proponents of shorter limitation periods argue that they will help ensure that pertinent evidence and witnesses are available, will allow insurers to better estimate awards and claims, and will protect providers against changes in legal doctrine and the risk of being judged on the basis of new medical knowledge. Opponents argue that very few claims are filed late and that injuries or the existence of negligence sometimes are not immediately discoverable.

The Legal Standard of Care

The legal standard of care is the law's measure of acceptable practice. In order to prove malpractice, this basic level of accountability must be established. Although the standard of care may be defined generally by statute or judicial decision, it must be established in more specific terms in each case. The applicable standard usually is drawn from observation of customary practice and that usually is established by expert testimony.

Eighteen states have statutes establishing a medical standard of care. Some of the issues involved in defining that standard include:

- Should physicians adhere to a local, state, or national standard of care? Should the standards of a similar locality be relevant?
- Should adherence to prevailing standards be absolutely required? Or should good faith deviations from customary standards be permitted?
- Should cost concerns enter into the definition of the appropriate standard of care?

Qualifications of Expert Witnesses

Ten states have established qualifications for the use of expert witnesses in medical malpractice actions. The following are some of the issues concerning expert witnesses:

- Should it be necessary that an expert witness practice in the defendant's medical specialty?
- Should states require that expert witnesses be familiar with the standard of care in the particular locality? (Concern frequently is expressed about the so-called "conspiracy of silence" that makes it difficult for some plaintiffs to find a physician willing to testify against a peer.)
- Should legislatures or the courts determine witnesses' qualifications?
- Should provision be made for calling impartial experts to supplement the testimony of the parties' possibly biased experts?

Informed Consent
The doctrine of informed consent requires physicians to inform patients of the risks of treatment procedures, alternative treatments and their risks, and to obtain the patient's consent to the agreed-upon treatment. If a physician does not do this, he may be liable for adverse results. A physician need not inform a patient of commonly known or unforeseeable risks, or medical emergency procedure risks.

Because of the amorphous nature of informed consent doctrine, it is subject to varying applications. Some states have attempted to clarify and limit this aspect of tort law by requiring evaluation based on the "same or similar community" rule or by using a test of reasonableness. Also, doctors sometimes require written proof of informed consent to protect themselves from lawsuits. Some states consider written proof of informed consent conclusive or presumptive, but subject to rebuttal.

Question Ten: What Other Actions Have Legislatures Taken That Affect the Malpractice System?

Attorney Fee Regulation
Some states regulate the contingent fee arrangements of attorneys representing patients in medical malpractice cases. Several approaches have been used. California, Delaware, and New York use a sliding fee scale. The maximum fee percentage decreases as the amount of the award increases. Delaware allows 35 percent of the first $100,000; 25 percent of the next $100,000; and 10 percent of the balance.

In nine states, the court must review all fees and may approve only "reasonable fees." In Tennessee, a reasonable fee may not exceed one-third of the award. Statutes in Indiana, Oregon, and Utah state that the plaintiff's attorney fees may not exceed a certain percentage of the amount awarded.

Florida's statute authorizes courts to award a "reasonable" attorney's fee in medical malpractice cases. To discourage weak cases and promote settlements, however, Florida makes the losing party liable for the winner's legal fees. This loser-pays-all rule is unique in U.S. tort law and resembles the British approach.

Courts in California, Indiana, and Nebraska have upheld limitations on attorney fees. The limitations were deemed to be reasonable and logically related to the state goal of holding down health care costs. The New Hampshire and Pennsylvania supreme courts, however, have declared such fee limits to be unconstitutional. The limits were found to violate equal protection guarantees and indirectly to interfere with the right to trial by jury.

Proponents of attorney fee regulation argue that it ensures that reasonable amounts go to the injured plaintiff without denying attorneys fair compensation. They believe that regulation will encourage earlier settlements by removing incentives to pursue jury verdicts with potentially larger awards and therefore larger fees. They also expect that fee limits will reduce lawyers' incentives to take cases that have doubtful merits but hold hope for a huge recovery.

Opponents of fee regulation argue that contingent fees are not meant solely as reasonable compensation for work on a particular case but also must cover the costs of unsuccessful cases. They also argue that, on average, plaintiffs' lawyers earn no more than defense lawyers. Moreover, they observe, if regulation actually lowers previous fees, it will discourage lawyers from taking smaller and harder-to-prove, but meritorious cases. Finally, an official contingent fee statute also could discourage price competition among lawyers as all adopt the official schedule of maximum fees as the minimum. In general, defenders of the contingent fee system argue that it facilitates access to the legal system and provides a strong incentive for lawyers not to pursue doubtful cases.

Malpractice Insurance Data Collection

Several states require insurance companies and self-insurers to submit basic information on their malpractice experience. This information can give a better understanding of the frequency and severity of claims and the adequacy of premiums as well as provide feedback on the effect of enacted legislation.

For example, a 1985 Washington law requires submission of insurance data for physicians, surgeons, hospitals, and other health care professions and facilities. Malpractice insurers must submit data concerning claims, settlements, premiums, investment income, reserves, and estimates of incurred claims.

Improved Discipline of Negligent Providers

Improved state discipline of physicians might reduce the incidence of malpractice and hence of claims and premiums. A few negligent providers may cause disproportionate problems. A 1977 study by the Washington State Medical Disciplinary Board found that physicians who had been subject to previous disciplinary review presented more than 10 times the risk of malpractice claims presented by a control group.

Because physicians with bad experiences tend to move their practices, a need exists for coordination across state lines. The AMA has recognized this need and is notifying state licensing boards of adverse actions against a physician licensed in several states.

State legislatures can affect medical discipline by:

- Expanding immunity from civil actions for members of medical review committees, witnesses, investigators, and proceeding reporters;

- Requiring reports of malpractice claims filed against a facility;
- Requiring medical facilities to report disciplinary actions against providers; and
- Expanding medical disciplinary boards' access to facility and patient records needed to investigate allegations of negligence.

Reviewing the Operation of State Malpractice Insurance Mechanisms
States established several mechanisms in the 1970s to help ensure the availability of malpractice insurance. Some examples are patient compensation funds, joint underwriting authorities, and reinsurance funds. Recently, many of these funds have had major problems. New Jersey, whose fund was disbanded, has an estimated deficit of $42 million. Florida's fund went bankrupt in 1984, largely as a result of a few large awards. And Wisconsin has a projected 1985 deficit of $48 million.

Legislators may want to review the operation of these insurance mechanisms to ensure that they are actuarially sound. Kansas, for example, has authorized its insurance commissioner to increase surcharges on insurance companies to ensure the soundness of the state's patient compensation fund.

Question Eleven: What New, Untried Proposals Have Been Made Regarding Medical Malpractice?

A number of innovative proposals to revise or revamp the existing malpractice system have been made. These proposals include corporate liability for malpractice, scheduled damage awards, experience rating of physician malpractice premiums, a no-fault approach, and patient/provider contracts. No state has enacted any of these proposals as yet, but some of them are under study.

Corporate Liability and Risk Management
Physicians were once considered wholly independent contractors, not subject to hospital control. Today, the trend of case law is to hold the hospital liable to injured patients for negligence in selecting physicians or in monitoring their performance.

Proposals for hospital liability differ. Some would have hospitals share liability with the physician, while others would assign liability solely to the hospital. Under sole hospital liability, patients

would bring suit against the hospital, and it would purchase insurance to cover malpractice actions against physicians with staff privileges. These approaches presumably would strengthen hospital review of physician actions and efforts to revoke or curtail staff privileges. This development would mesh with the new emphasis on hospital review of physician actions brought about by Medicare's DRG-based reimbursement system and hospital risk management programs.

Proponents of hospital liability argue that it is best to impose liability at the point where quality of health care can best be monitored. Eighty percent of all malpractice claims and almost all settlements over $100,000 arise out of events that occur in hospitals. Advocates argue that corporate liability would simplify malpractice actions and that concentrating insurance coverage at this level would produce economies of scale.

Opponents believe that hospitals do not have sufficient control of providers to assume this responsibility. In addition, critics fear that, if hospitals should assume such control, there would be a serious loss of professional independence and of the physician's direct accountability and responsibility to the individual patient. They also believe that a hospital might be better able to cover up negligence and "stonewall" patients if physicians were brought under hospital control.

Scheduled Damage Awards

Dr. Danzon recommends that malpractice damage awards be based on pre-established schedules, just as injuries are handled for some other coverages, including workmen's compensation. Benefits for economic loss would follow a schedule based on age and severity of injury rather than being determined on a case-by-case basis. Pain and suffering damages would be eliminated with the exception of modest, fixed payments for permanently disabling injuries.

Proponents of this approach insist that eliminating most disputes over the extent of loss would save litigation costs while improving overall patient compensation and eliminating disparities in outcomes. Opponents point out that administrative difficulties in determining severity of injury and compensation levels would remain. Moreover, such award schedules would tend to become outdated and thus undercompensate victims. Finally, settlement amounts under this system may be inadequate to allow patients to purchase new health care technologies that may better repair their injuries.

Experience Rating

Although most hospitals and HMOs pay premiums based on their malpractice experience, physicians—even groups of physicians—pay a rate based only on location, specialty, and operative procedures performed. Thus, a doctor with poorer than average malpractice experience does not pay more for liability insurance than, for example, a doctor with no malpractice suits brought against him.

Some experts believe that requiring such experience rating would improve quality incentives. Opponents of experience rating point out that insurers have not moved in this direction partly because of the difficulty of translating experience into an actual rating system. In addition, because insurers usually can settle a claim without a physician's permission, they could increase his premiums despite the lack of a legal finding of negligence.

No-Fault Proposals

Some reformers would replace today's malpractice system in whole or in part by introducing some type of "no-fault" approach. Like arbitration, no-fault might be tried on a voluntary basis rather than legislated as an across-the-board solution. Legislatures might consider how they could encourage private experimentation with these new ideas.

The more serious no-fault proposals stop short of making providers and their insurers pay for every adverse outcome of medical care. Rather, the idea is to limit the number of cases in which fault would be the dominant issue, requiring extensive claims evaluation and use of the legal process.

One proposal would provide automatic payment of prescribed amounts (presumably excluding noneconomic losses) for adverse outcomes appearing on a list of "designated compensable events." For outcomes not on this list, the patient would be free to bring an action under traditional tort principles. The list, however, would incorporate many of the injuries that are currently the subject of tort claims, and these would be paid without reference to provider fault in the particular circumstances. Providers' incentives to avoid injuries could be maintained through experience rating of premiums for no-fault insurance coverage. Such a system would pay many more claims than the prevailing system but might not cost appreciably more if administrative costs and compensation amounts were less.

A somewhat different no-fault approach has been proposed by Professor Jeffrey O'Connell, coauthor of early proposals for no-fault auto insurance. He suggests that providers get their insurers to make a pre-accident commitment to make prompt post-accident offers to pay victims' net economic losses. This offer, which would be made irrespective of fault, would be conditioned on the victim's release of his malpractice claims. This approach leaves the fault-based tort system in place but is designed to produce more prompt, fair settlements than are being reached today. O'Connell bets that few injured persons would sue if such an offer were made.

Proponents of no-fault approaches argue that they would provide fair and prompt compensation to more injured persons and would redirect to victims money that is now spent on lawyers' fees. They also believe that no-fault compensation could be designed to preserve deterrence of negligent practice and even to improve the quality of health care by giving providers direct feedback on how their experience

compares with that of others. They also see opportunities to improve trust between doctors and patients by reducing the necessity for assigning blame. The apparent high cost of compensating people for more injuries is deceptive, they say, because patients already bear these costs; the social costs would be less, advocates allege, because of the administrative cost savings and improved deterrence.

Opponents fear that a no-fault system would allow more awards because most injuries currently do not result in lawsuits; therefore, the no-fault system might be more costly than the tort system. They also doubt that litigation costs could be avoided in a no-fault system, observing that workers' compensation is a highly litigious area even though fault is not an issue. They also fear that a no-fault system would reduce deterrence by reducing payouts and the stigma associated with tort liability.

Reform Through Private Contract

An emerging idea is that medical malpractice reform might be undertaken, not through legislation, but by the private sector through contractual agreements under which patients accept limitations on their tort rights in exchange for compensating benefits. Most prominently advanced by Duke University law professor Clark Havighurst, this proposal envisions consumers agreeing to such changes as binding arbitration; various limits on potential recoveries; alterations in the applicable legal standard of care; surrender of their right to sue for any but gross negligence; and no-fault rather than tort-based compensation for designated compensable events.

The benefits to consumers who surrender some of their tort rights might include reduced costs for their medical care, which would reflect cutbacks in inappropriate defensive medicine and lower malpractice premiums and litigation costs. Under some arrangements, consumers might gain assurance of prompter, more certain payment for certain injuries.

Critics of malpractice reform by private contracts doubt that courts will enforce them and that consumers are able to make sound judgments on these issues.

In the past, court decisions have struck down contractual arrangements surrendering patients' malpractice rights in the following circumstances:

- Where consumer consent was deemed not to have been freely given—for example, where the patient was coerced or unaware of the restriction in question;
- Where public policy was violated—for example, where an exculpatory clause undercut a statutory requirement that a professional be liable for his torts; or
- Where the contract was unfair on its face—for example, where it amounted to a total surrender rather than a reasonable modification of the patient's right to sue.

It appears that, although courts can and do protect against provider overreaching in such contracts, there may be room for reasonable reforms to be adopted in this fashion.

Courts are most likely to uphold contracts limiting patients' tort rights in the following circumstances:

- Where the agreement is expressly authorized by statute—for example, where a state expressly allows arbitration of malpractice claims;
- Where the agreement was negotiated at arm's length by a sophisticated entity bargaining on behalf of consumers—as in the case of an employer's group health benefits plan; or
- Where the agreement appears fair on its face—for example, where the restriction seems reasonable and there is reason to believe that both sides made concessions.

Because courts still may be hostile to contracts that change tort rules, legislators should consider whether legislation is needed or desirable to facilitate private reforms. Such legislation might simply indicate that courts should not refuse to enforce agreements for this purpose (other than pure exculpatory clauses), or it might expressly authorize specific agreements.

Question Twelve: What Is the Federal Government Doing?

Two major proposals at the national level are of interest to state lawmakers. H.R. 5400, sponsored in 1984 by Congressmen Henson Moore (La.) and Richard Gephardt (Mo.), would preempt state malpractice laws in cases concerning services provided through Medicare, Medicaid, and other federally funded programs. States would have several years to establish an alternative medical liability system conforming to the bill's requirements to avoid preemption. This bill would give providers the right to foreclose a patient's right to sue in tort by promptly offering to pay his net economic loss. The Moore-Gephardt proposal is being revised for reintroduction in this session.

The AMA has called for a different federal initiative. This proposal would leave the fault system intact and would "provide monetary and other incentives for states to pass specified tort and judicial reform legislation." The specific reforms, not yet outlined in detail, would concern "refining the way in which damages are awarded" and "improving the liability resolution system."

Notes

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3. Insurance Information Institute, "California Superior Court Verdicts—Medical Malpractice Cases 1973-1983" (As cited in materials from The Urban Institute's national medical malpractice conference, "Can the Private Sector Find Relief?," Washington, D.C., February 21-22, 1985).
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7. American Medical Association Special Task Force on Professional Liability, *Professional Liability in the 80s, Report 1* (Chicago: American Medical Association, 1984), p. 17.
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9. Jeffrey O'Connell, "The Case Against the Current Malpractice System" (Presentation at The Urban Institute's national medical malpractice conference, "Can the Private Sector Find Relief?," February 21-22, 1985); and Patricia Danzon, "Evaluation of the Current Malpractice System" (Presentation at The Urban Institute's national medical malpractice conference, "Can the Private Sector Find Relief?," February 21-22, 1985).
10. Stephen Zuckerman, "The Costs of Medical Malpractice," *Health Affairs 3,* no. 3 (Fall 1984): Exhibit 3.
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National Conference of State Legislatures

The National Conference of State Legislatures is the official representative of the nation's 7,461 state legislators and their staffs. It is the only national legislative organization governed and funded directly by the states.

NCSL was created in January 1975 from the merger of three organizations that served or represented state legislatures. NCSL is a nonpartisan organization with three basic objectives:

- To improve the quality and effectiveness of state legislatures;
- To foster interstate communication and cooperation; and
- To assure state legislatures a strong, cohesive voice in the federal system.

The conference operates from its headquarters in Denver, Colorado, and an Office of State-Federal Relations in Washington, D.C.

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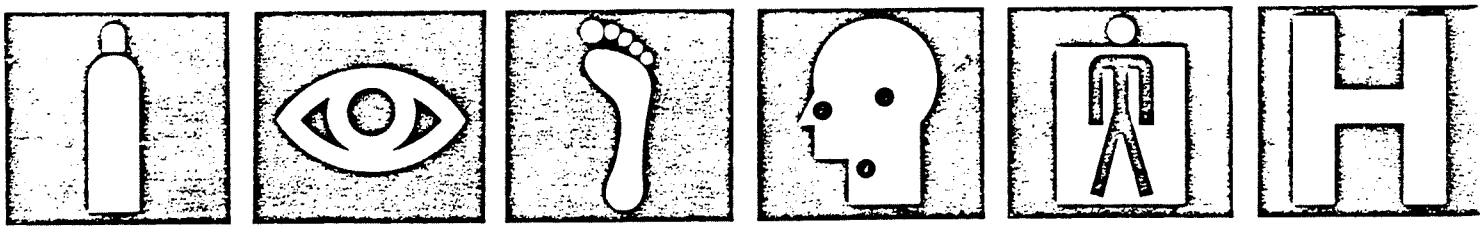

Kansas Practitioners by Specialty by County

County(Population)	Physicians No surgery/ Minor surg.	Family Prac./ GP	Emerg. Med.	Surg/ Urol.	Aneath.	Surg/ Plastic	Surg/ Cardio- vasc.	Surg/ Ob/Gyn	Surg/ Neur.	Other Surg. Spec.	Other Spec.	TOTAL
Allen (16,100)	1	9	0	0	0	0	0	0	0	1	0	11
Anderson (8,900)	0	7	0	0	0	0	0	0	0	0	0	7
Atchison (18,000)	3	11	0	0	0	0	0	1	0	3	0	18
Barber (7,200)	1	6	0	0	1	0	0	0	0	0	0	8
Barton (33,100)	11	17	2	0	1	0	0	2	0	5	2	40
Bourbon (15,900)	6	12	0	0	0	0	0	3	0	4	3	28
Brown (11,700)	0	6	0	0	0	0	0	0	0	0	0	6
Butler (47,100)	4	17	2	0	0	0	0	1	0	4	0	28
Chase (3,300)	0	2	0	0	0	0	0	0	0	0	0	2
Chautauqua (5,000)	0	4	0	0	0	0	0	0	0	0	0	4
Cherokee (22,300)	0	12	0	0	0	0	0	0	0	1	0	13
Cheyenne (3,700)	0	2	0	0	0	0	0	0	0	0	0	2
Clark (2,700)	0	2	0	0	0	0	0	0	0	0	0	2
Clay (9,600)	0	7	0	0	0	0	0	0	0	2	0	9
Cloud (12,100)	6	10	0	0	0	0	0	0	0	2	1	19
Coffey (10,000)	1	2	0	0	0	0	0	0	0	0	1	4
Comanche (2,600)	0	1	0	0	0	0	0	0	0	0	0	1
Cowley (37,300)	8	27	1	0	0	0	0	2	0	5	0	43
Crawford (38,000)	11	14	0	0	1	0	0	1	0	5	1	33
Decatur (4,600)	0	4	0	0	0	0	0	0	0	1	0	5
Dickinson (20,000)	1	9	0	0	0	0	0	0	0	2	0	12
Doniphan (9,100)	0	5	0	0	0	0	0	0	0	0	0	5
Douglas (69,800)	27	41	0	0	2	0	0	8	0	10	3	91
Edwards (4,100)	0	3	0	0	0	0	0	0	0	0	0	3
Elk (3,700)	0	1	0	0	0	0	0	0	0	0	0	1
Ellis (28,400)	20	11	1	0	3	0	0	2	0	9	3	49
Ellsworth (6,400)	0	4	0	0	0	0	0	0	0	0	0	4
Finney (28,800)	9	13	1	0	0	0	0	1	0	7	2	33
Ford (26,200)	10	13	2	0	0	0	0	2	0	6	1	34
Franklin (22,300)	0	11	0	0	0	0	0	0	0	1	0	12
Geary (29,400)	4	15	2	1	0	0	0	3	0	2	1	28
Gove (3,700)	0	1	0	0	0	0	0	0	0	0	0	1
Graham (4,200)	0	1	0	0	0	0	0	0	0	1	0	2
Grant (6,800)	0	3	0	0	0	0	0	1	0	0	0	4
Gray (5,300)	0	0	0	0	0	0	0	0	0	0	0	0
Greeley (1,900)	0	2	0	0	0	0	0	0	0	0	0	2
Greenwood (8,700)	0	5	0	0	0	0	0	0	0	1	0	6
Hamilton (2,500)	0	1	0	0	0	0	0	0	0	0	0	1
Harper (7,800)	1	8	0	0	0	0	0	0	0	0	0	9
Harvey (31,000)	32	19	0	0	1	0	1	5	0	13	1	72
Haskell (3,900)	0	3	0	0	0	0	0	0	0	0	0	3
Hodgeman (2,300)	0	2	0	0	0	0	0	0	0	0	0	2
Jackson (11,500)	0	3	0	0	0	0	0	0	0	0	0	3
Jefferson (15,900)	0	8	0	0	0	0	0	0	0	0	0	8
Jewell (5,000)	0	2	0	0	0	0	0	0	0	0	0	2
Johnson (296,400)	168	119	14	0	15	5	1	30	2	39	13	406
Kearny (3,800)	0	2	0	0	0	0	0	0	0	0	0	2
Kingman (9,100)	1	4	0	0	0	0	0	0	0	0	0	5
Kiowa (4,000)	0	3	0	0	0	0	0	0	0	0	0	3
Labette (25,700)	9	16	0	0	2	0	0	1	0	3	0	31
Lane (2,500)	0	3	0	0	0	0	0	0	0	0	0	3
Leavenworth (58,200)	24	29	2	0	2	0	0	2	0	10	1	70

10/11/85 Attachment III

Kansas Practitioners by Specialty by County

County(Population)	Phyaicians No surgery/ Minor surg.	Family Prac./ GP	Emerg. Med.	Surg/ Urol.	Aneath.	Surg/ Plastic	Surg/ Cardio- vasc.	Surg/ Ob/Gyn	Surg/ Neur.	Other Surg. Spec.	Other Spec.	TOTAL
Lincoln (3,900)	0	2	0	0	0	0	0	0	0	0	0	2
Linn (8,300)	0	4	0	0	0	0	0	0	0	0	0	4
Logan (3,500)	0	3	0	0	0	0	0	0	0	0	0	3
Lyon (37,700)	9	17	1	0	0	0	0	4	0	8	3	42
Marion (13,400)	1	9	0	0	0	0	0	0	0	1	0	11
Marshall (13,100)	0	5	0	0	0	0	0	0	0	0	1	6
McPherson (27,600)	0	17	0	0	0	0	0	1	0	3	0	21
Meade (4,700)	1	1	0	0	0	0	0	0	0	0	0	2
Miami (22,200)	6	7	0	0	0	0	0	1	0	0	1	15
Mitchell (7,900)	1	4	0	0	0	0	0	0	0	1	0	6
Montgomery (42,300)	8	24	0	0	2	0	0	1	0	6	1	42
Morris (6,300)	0	4	0	0	0	0	0	0	0	0	0	4
Morton (3,500)	2	1	0	0	0	0	0	1	0	2	0	6
Nemaha (11,200)	0	7	0	0	0	0	0	0	0	0	0	7
Neosho (19,500)	1	11	0	0	1	0	0	0	0	1	0	14
Ness (4,700)	1	4	0	0	0	0	0	0	0	1	0	6
Norton (6,600)	0	6	0	0	0	0	0	0	0	1	0	7
Osage (16,100)	0	5	0	0	0	0	0	0	0	0	0	5
Osborne (5,700)	0	4	0	0	0	0	0	0	0	0	0	4
Ottawa (5,900)	0	4	0	0	0	0	0	0	0	0	0	4
Pawnee (8,300)	8	13	0	0	0	0	0	1	0	0	0	22
Phillips (7,300)	0	4	0	0	0	0	0	0	0	1	0	5
Pottawatomie (15,700)	2	7	0	0	0	0	0	2	0	0	1	12
Pratt (11,100)	4	6	0	0	0	0	0	1	0	2	0	13
Rawlins (4,000)	0	2	0	0	0	0	0	0	0	0	0	2
Reno (64,900)	27	25	1	0	5	0	0	6	0	10	3	77
Republic (7,200)	0	6	0	0	0	0	0	0	0	0	0	6
Rice (11,700)	1	5	0	0	0	0	0	0	0	0	0	6
Riley (63,300)	19	24	2	0	1	0	0	5	0	6	5	62
Rooks (7,000)	0	3	0	0	0	0	0	0	0	0	0	3
Rush (4,500)	0	2	0	0	0	0	0	0	0	0	0	2
Russell (9,300)	0	4	0	0	0	0	0	0	0	1	0	5
Saline (50,200)	32	25	1	0	3	0	0	6	0	15	4	86
Scott (5,900)	0	3	0	0	0	0	0	0	0	0	0	3
Sedgwick (381,500)	278	243	18	0	44	7	16	50	5	87	44	792
Seward (18,100)	5	7	2	0	0	0	0	2	0	3	1	20
Shawnee (159,000)	236	66	10	0	15	2	5	15	4	34	15	402
Sheridan (3,500)	0	2	0	0	0	0	0	0	0	0	0	2
Sherman (7,500)	1	4	0	0	0	0	0	0	0	2	0	7
Smith (5,700)	1	3	0	0	0	0	0	0	0	1	0	5
Stafford (5,900)	0	6	0	0	0	0	0	0	0	0	0	6
Stanton (2,400)	0	2	0	0	0	0	0	0	0	0	0	2
Stevens (4,800)	1	2	0	0	0	0	0	0	0	1	0	4
Sumner (25,400)	1	10	0	0	0	0	0	0	0	1	0	12
Thomas (9,000)	1	4	0	0	0	0	0	0	0	1	0	6
Trego (4,400)	0	2	0	0	0	0	0	0	0	0	0	2
Wabaunsee (6,800)	0	1	0	0	0	0	0	0	0	0	0	1
Wallace (2,100)	0	1	0	0	0	0	0	0	0	0	0	1
Washington (8,000)	1	3	0	0	0	0	0	0	0	0	0	4
Wichita (2,800)	0	1	0	0	0	0	0	0	0	0	0	1
Wilson (11,800)	1	6	0	0	0	0	0	0	0	1	0	8
Woodson (4,600)	0	1	0	0	0	0	0	0	0	0	0	1

Kansas Practitioners by Specialty by County

County(Population)	Physicians No surgery/ Minor surg.	Family Prac./ GP	Emerg. Med.	Surg/ Urol.	Anesth.	Surg/ Plastic	Surg/ Cardio- vasc.	Surg/ Ob/Gyn	Surg/ Neur.	Other Surg. Spec.	Other Spec.	TOTAL
Wyandotte (172,400)	221	145	17	1	29	7	5	30	2	57	30	544
Out-of-state	294	118	22	0	24	6	3	10	16	60	42	595
TOTAL	1,522	1,427	101	2	152	27	31	201	29	444	184	4,120

KANSAS PRACTITIONERS BY COUNTY (MDs AND DOs)

Physicians, No Surgery or Minor Surgery

County	Number of Doctors	County	Number of Doctors	County	Number of Doctors
Allen	1	Haskell	0	Riley	19
Anderson	0	Hodgeman	0	Rooks	0
Atchison	3	Jackson	0	Rush	0
Barber	1	Jefferson	0	Russell	0
Barton	11	Jewell	0	Saline	32
Bourbon	6	Johnson	168	Scott	0
Brown	0	Kearny	0	Sedgwick	278
Butler	4	Kingman	1	Seward	5
Chase	0	Kiowa	0	Shawnee	236
Chautauqua	0	Labette	9	Sheridan	0
Cherokee	0	Lane	0	Sherman	1
Cheyenne	0	Leavenworth	24	Smith	1
Clark	0	Lincoln	0	Stafford	0
Clay	0	Linn	0	Stanton	0
Cloud	6	Logan	0	Stevens	1
Coffey	1	Lyon	9	Sumner	1
Comanche	0	Marion	1	Thomas	1
Cowley	8	Marshall	0	Trego	0
Crawford	11	McPherson	0	Wabaunsee	0
Decatur	0	Meade	1	Wallace	0
Dickinson	1	Miami	6	Washington	1
Doniphan	0	Mitchell	1	Wichita	0
Douglas	27	Montgomery	8	Wilson	1
Edwards	0	Morris	0	Woodson	0
Elk	0	Morton	2	Wyandotte	221
Ellis	20	Nemaha	0		
Ellsworth	0	Neosho	1	Out-of-State	294
Finney	9	Ness	1		
Ford	10	Norton	0	TOTAL	1,522
Franklin	0	Osage	0		
Geary	4	Osborne	0		
Gove	0	Ottawa	0		
Graham	0	Pawnee	8		
Grant	0	Phillips	0		
Gray	0	Pottawatomie	2		
Greeley	0	Pratt	4		
Greenwood	0	Rawlins	0		
Hamilton	0	Reno	27		
Harper	1	Republic	0		
Harvey	32	Rice	1		

Kansas Annual Professional Liability Insurance Rates

Effective July 1, 1985

	With Surcharge (110%)
Kansas Joint Underwriting Authority ("Plan")* — $4,747 - $6,283	$ 9,969 - 13,194
Medical Defense Company — $2,461 - $3,325	5,168 - 13,913
Medical Protective Insurance Company — $3,408	7,157
Pennsylvania Casualty Company — $2,639 - $4,947	5,542 - 10,389
Providers Insurance Company — $4,585	9,629
St. Paul Fire and Marine Insurance Company — $3,956 - $5,236	8,308 - 10,996

* Rate is determined by adding 20 percent to the rate of St. Paul. Such practice is generally consistent with approved rate filings.

Kansas Legislative Research Department
October 7, 1985

F85-315a

10/10-11/85
Attachment IX

KANSAS PRACTITIONERS BY COUNTY (MDs AND DOs)

Family Practitioners and General Practitioners

County	Number of Doctors	County	Number of Doctors	County	Number of Doctors
Allen	9	Haskell	3	Riley	24
Anderson	7	Hodgeman	2	Rooks	3
Atchison	11	Jackson	3	Rush	2
Barber	6	Jefferson	8	Russell	4
Barton	17	Jewell	2	Saline	25
Bourbon	12	Johnson	119	Scott	3
Brown	6	Kearny	2	Sedgwick	243
Butler	17	Kingman	4	Seward	7
Chase	2	Kiowa	3	Shawnee	66
Chautauqua	4	Labette	16	Sheridan	2
Cherokee	12	Lane	3	Sherman	4
Cheyenne	2	Leavenworth	29	Smith	3
Clark	2	Lincoln	2	Stafford	6
Clay	7	Linn	4	Stanton	2
Cloud	10	Logan	3	Stevens	2
Coffey	2	Lyon	17	Sumner	10
Comanche	1	Marion	9	Thomas	4
Cowley	27	Marshall	5	Trego	2
Crawford	14	McPherson	17	Wabaunsee	1
Decatur	4	Meade	1	Wallace	1
Dickinson	9	Miami	7	Washington	3
Doniphan	5	Mitchell	4	Wichita	1
Douglas	41	Montgomery	24	Wilson	6
Edwards	3	Morris	4	Woodson	1
Elk	1	Morton	1	Wyandotte	145
Ellis	11	Nemaha	7		
Ellsworth	4	Neosho	11	Out-of-State	118
Finney	13	Ness	4		
Ford	13	Norton	6	TOTAL	1,427
Franklin	11	Osage	5		
Geary	15	Osborne	4		
Gove	1	Ottawa	4		
Graham	1	Pawnee	13		
Grant	3	Phillips	4		
Gray	0	Pottawatomie	7		
Greeley	2	Pratt	6		
Greenwood	5	Rawlins	2		
Hamilton	1	Reno	25		
Harper	8	Republic	6		
Harvey	19	Rice	5		

Kansas Annual Professional Liability Insurance Rates

Effective July 1, 1985

	With Surcharge (110%)
Kansas Joint Underwriting Authority ("Plan")* — $3,211	$ 6,743
Medical Defense Company — $1,330	2,793
Medical Protective Insurance Company — $1,363	2,862
Pennsylvania Casualty Company — $1,649	3,463
Providers Insurance Company — $1,507	3,165
St. Paul Fire and Marine Insurance Company — $2,676	5,620

* Rate is determined by adding 20 percent to the rate of St. Paul. Such practice is generally consistent with approved rate filings.

Kansas Legislative Research Department
October 7, 1985

F85-315b

KANSAS PRACTITIONERS BY COUNTY (MDs AND DOs)

Emergency Medicine

County	Number of Doctors	County	Number of Doctors	County	Number of Doctors
Allen	0	Haskell	0	Riley	2
Anderson	0	Hodgeman	0	Rooks	0
Atchison	0	Jackson	0	Rush	0
Barber	0	Jefferson	0	Russell	0
Barton	2	Jewell	0	Saline	1
Bourbon	0	Johnson	14	Scott	0
Brown	0	Kearny	0	Sedgwick	18
Butler	2	Kingman	0	Seward	2
Chase	0	Kiowa	0	Shawnee	10
Chautauqua	0	Labette	0	Sheridan	0
Cherokee	0	Lane	0	Sherman	0
Cheyenne	0	Leavenworth	2	Smith	0
Clark	0	Lincoln	0	Stafford	0
Clay	0	Linn	0	Stanton	0
Cloud	0	Logan	0	Stevens	0
Coffey	0	Lyon	1	Sumner	0
Comanche	0	Marion	0	Thomas	0
Cowley	1	Marshall	0	Trego	0
Crawford	0	McPherson	0	Wabaunsee	0
Decatur	0	Meade	0	Wallace	0
Dickinson	0	Miami	0	Washington	0
Doniphan	0	Mitchell	0	Wichita	0
Douglas	0	Montgomery	0	Wilson	0
Edwards	0	Morris	0	Woodson	0
Elk	0	Morton	0	Wyandotte	17
Ellis	1	Nemaha	0		
Ellsworth	0	Neosho	0	Out-of-State	22
Finney	1	Ness	0		
Ford	2	Norton	0	TOTAL	101
Franklin	0	Osage	0		
Geary	2	Osborne	0		
Gove	0	Ottawa	0		
Graham	0	Pawnee	0		
Grant	0	Phillips	0		
Gray	0	Pottawatomie	0		
Greeley	0	Pratt	0		
Greenwood	0	Rawlins	0		
Hamilton	0	Reno	1		
Harper	0	Republic	0		
Harvey	0	Rice	0		

Kansas Annual Professional Liability Insurance Rates

Effective July 1, 1985

	With Surcharge (110%)
Kansas Joint Underwriting Authority ("Plan")* — $8,434	17,711
Medical Defense Company — $3,325	6,983
Medical Protective Insurance Company — $3,408	7,157
Pennsylvania Casualty Company — $4,947	10,389
Providers Insurance Company — $4,585	9,629
St. Paul Fire and Marine Insurance Company — $7,028	14,759

* Rate is determined by adding 20 percent to the rate of St. Paul. Such practice is generally consistent with approved rate filings.

Kansas Legislative Research Department
October 7, 1985

F85-315c

KANSAS PRACTITIONERS BY COUNTY (MDs AND DOs)

Surgery — Urological

County	Number of Doctors	County	Number of Doctors	County	Number of Doctors
Allen	0	Haskell	0	Riley	0
Anderson	0	Hodgeman	0	Rooks	0
Atchison	0	Jackson	0	Rush	0
Barber	0	Jefferson	0	Russell	0
Barton	0	Jewell	0	Saline	0
Bourbon	0	Johnson	0	Scott	0
Brown	0	Kearny	0	Sedgwick	0
Butler	0	Kingman	0	Seward	0
Chase	0	Kiowa	0	Shawnee	0
Chautauqua	0	Labette	0	Sheridan	0
Cherokee	0	Lane	0	Sherman	0
Cheyenne	0	Leavenworth	0	Smith	0
Clark	0	Lincoln	0	Stafford	0
Clay	0	Linn	0	Stanton	0
Cloud	0	Logan	0	Stevens	0
Coffey	0	Lyon	0	Sumner	0
Comanche	0	Marion	0	Thomas	0
Cowley	0	Marshall	0	Trego	0
Crawford	0	McPherson	0	Wabaunsee	0
Decatur	0	Meade	0	Wallace	0
Dickinson	0	Miami	0	Washington	0
Doniphan	0	Mitchell	0	Wichita	0
Douglas	0	Montgomery	0	Wilson	0
Edwards	0	Morris	0	Woodson	0
Elk	0	Morton	0	Wyandotte	1
Ellis	0	Nemaha	0		
Ellsworth	0	Neosho	0	Out-of-State	0
Finney	0	Ness	0		
Ford	0	Norton	0	TOTAL	2
Franklin	0	Osage	0		
Geary	1	Osborne	0		
Gove	0	Ottawa	0		
Graham	0	Pawnee	0		
Grant	0	Phillips	0		
Gray	0	Pottawatomie	0		
Greeley	0	Pratt	0		
Greenwood	0	Rawlins	0		
Hamilton	0	Reno	0		
Harper	0	Republic	0		
Harvey	0	Rice	0		

Kansas Annual Professional Liability Insurance Rates

Effective July 1, 1985

	With Surcharge (110%)
Kansas Joint Underwriting Authority ("Plan")* — $6,283	$ 13,194
Medical Defense Company — $4,655	9,776
Medical Protective Insurance Company — $4,771	10,019
Pennsylvania Casualty Company — $6,184	12,986
Providers Insurance Company — $6,527	13,707
St. Paul Fire and Marine Insurance Company — $5,236	10,996

* Rate is determined by adding 20 percent to the rate of St. Paul. Such practice is generally consistent with approved rate filings.

Kansas Legislative Research Department
October 7, 1985

F85-315d

KANSAS PRACTITIONERS BY COUNTY (MDs AND DOs)

Anesthesiology

County	Number of Doctors	County	Number of Doctors	County	Number of Doctors
Allen	0	Haskell	0	Riley	1
Anderson	0	Hodgeman	0	Rooks	0
Atchison	0	Jackson	0	Rush	0
Barber	1	Jefferson	0	Russell	0
Barton	1	Jewell	0	Saline	3
Bourbon	0	Johnson	15	Scott	0
Brown	0	Kearny	0	Sedgwick	44
Butler	0	Kingman	0	Seward	0
Chase	0	Kiowa	0	Shawnee	15
Chautauqua	0	Labette	2	Sheridan	0
Cherokee	0	Lane	0	Sherman	0
Cheyenne	0	Leavenworth	2	Smith	0
Clark	0	Lincoln	0	Stafford	0
Clay	0	Linn	0	Stanton	0
Cloud	0	Logan	0	Stevens	0
Coffey	0	Lyon	0	Sumner	0
Comanche	0	Marion	0	Thomas	0
Cowley	0	Marshall	0	Trego	0
Crawford	1	McPherson	0	Wabaunsee	0
Decatur	0	Meade	0	Wallace	0
Dickinson	0	Miami	0	Washington	0
Doniphan	0	Mitchell	0	Wichita	0
Douglas	2	Montgomery	2	Wilson	0
Edwards	0	Morris	0	Woodson	0
Elk	0	Morton	0	Wyandotte	29
Ellis	3	Nemaha	0		
Ellsworth	0	Neosho	1	Out-of-State	24
Finney	0	Ness	0		
Ford	0	Norton	0	TOTAL	152
Franklin	0	Osage	0		
Geary	0	Osborne	0		
Gove	0	Ottawa	0		
Graham	0	Pawnee	0		
Grant	0	Phillips	0		
Gray	0	Pottawatomie	0		
Greeley	0	Pratt	0		
Greenwood	0	Rawlins	0		
Hamilton	0	Reno	5		
Harper	0	Republic	0		
Harvey	1	Rice	0		

Kansas Annual Professional Liability Insurance Rates

Effective July 1, 1985

	With Surcharge (110%)
Kansas Joint Underwriting Authority ("Plan")* — $12,900	$ 27,090
Medical Defense Company — $11,970	25,137
Medical Protective Insurance Company — $8,451	17,747
Pennsylvania Casualty Company — $8,430	17,703
Providers Insurance Company — $10,102	21,214
St. Paul Fire and Marine Insurance Company — $10,750	22,575

* Rate is determined by adding 20 percent to the rate of St. Paul. Such practice is generally consistent with approved rate filings.

Kansas Legislative Research Department
October 7, 1985

F85-315e

KANSAS PRACTITIONERS BY COUNTY (MDs AND DOs)

Surgery — Plastic

County	Number of Doctors	County	Number of Doctors	County	Number of Doctors
Allen	0	Haskell	0	Riley	0
Anderson	0	Hodgeman	0	Rooks	0
Atchison	0	Jackson	0	Rush	0
Barber	0	Jefferson	0	Russell	0
Barton	0	Jewell	0	Saline	0
Bourbon	0	Johnson	5	Scott	0
Brown	0	Kearny	0	Sedgwick	7
Butler	0	Kingman	0	Seward	0
Chase	0	Kiowa	0	Shawnee	2
Chautauqua	0	Labette	0	Sheridan	0
Cherokee	0	Lane	0	Sherman	0
Cheyenne	0	Leavenworth	0	Smith	0
Clark	0	Lincoln	0	Stafford	0
Clay	0	Linn	0	Stanton	0
Cloud	0	Logan	0	Stevens	0
Coffey	0	Lyon	0	Sumner	0
Comanche	0	Marion	0	Thomas	0
Cowley	0	Marshall	0	Trego	0
Crawford	0	McPherson	0	Wabaunsee	0
Decatur	0	Meade	0	Wallace	0
Dickinson	0	Miami	0	Washington	0
Doniphan	0	Mitchell	0	Wichita	0
Douglas	0	Montgomery	0	Wilson	0
Edwards	0	Morris	0	Woodson	0
Elk	0	Morton	0	Wyandotte	7
Ellis	0	Nemaha	0		
Ellsworth	0	Neosho	0	Out-of-State	6
Finney	0	Ness	0		
Ford	0	Norton	0	TOTAL	27
Franklin	0	Osage	0		
Geary	0	Osborne	0		
Gove	0	Ottawa	0		
Graham	0	Pawnee	0		
Grant	0	Phillips	0		
Gray	0	Pottawatomie	0		
Greeley	0	Pratt	0		
Greenwood	0	Rawlins	0		
Hamilton	0	Reno	0		
Harper	0	Republic	0		
Harvey	0	Rice	0		

Kansas Annual Professional Liability Insurance Rates

Effective July 1, 1985

	With Surcharge (110%)
Kansas Joint Underwriting Authority ("Plan")* — $14,495	$ 30,440
Medical Defense Company — $9,576	20,110
Medical Protective Insurance Company — $9,814	20,609
Pennsylvania Casualty Company — $10,116	21,244
Providers Insurance Company — $11,656	24,478
St. Paul Fire and Marine Insurance Company — $12,079	25,366

* Rate is determined by adding 20 percent to the rate of St. Paul. Such practice is generally consistent with approved rate filings.

Kansas Legislative Research Department
October 7, 1985

F85-315g

KANSAS PRACTITIONERS BY COUNTY (MDs AND DOs)

Surgery — Cardiovascular

County	Number of Doctors	County	Number of Doctors	County	Number of Doctors
Allen	0	Haskell	0	Riley	0
Anderson	0	Hodgeman	0	Rooks	0
Atchison	0	Jackson	0	Rush	0
Barber	0	Jefferson	0	Russell	0
Barton	0	Jewell	0	Saline	0
Bourbon	0	Johnson	1	Scott	0
Brown	0	Kearny	0	Sedgwick	16
Butler	0	Kingman	0	Seward	0
Chase	0	Kiowa	0	Shawnee	5
Chautauqua	0	Labette	0	Sheridan	0
Cherokee	0	Lane	0	Sherman	0
Cheyenne	0	Leavenworth	0	Smith	0
Clark	0	Lincoln	0	Stafford	0
Clay	0	Linn	0	Stanton	0
Cloud	0	Logan	0	Stevens	0
Coffey	0	Lyon	0	Sumner	0
Comanche	0	Marion	0	Thomas	0
Cowley	0	Marshall	0	Trego	0
Crawford	0	McPherson	0	Wabaunsee	0
Decatur	0	Meade	0	Wallace	0
Dickinson	0	Miami	0	Washington	0
Doniphan	0	Mitchell	0	Wichita	0
Douglas	0	Montgomery	0	Wilson	0
Edwards	0	Morris	0	Woodson	0
Elk	0	Morton	0	Wyandotte	5
Ellis	0	Nemaha	0		
Ellsworth	0	Neosho	0	Out-of-State	3
Finney	0	Ness	0		
Ford	0	Norton	0	TOTAL	31
Franklin	0	Osage	0		
Geary	0	Osborne	0		
Gove	0	Ottawa	0		
Graham	0	Pawnee	0		
Grant	0	Phillips	0		
Gray	0	Pottawatomie	0		
Greeley	0	Pratt	0		
Greenwood	0	Rawlins	0		
Hamilton	0	Reno	0		
Harper	0	Republic	0		
Harvey	1	Rice	0		

Kansas Annual Professional Liability Insurance Rates

Effective July 1, 1985

	With Surcharge (110%)
Kansas Joint Underwriting Authority ("Plan")* — $19,273	$ 40,473
Medical Defense Company — $11,305	23,741
Medical Protective Insurance Company — $11,586	24,331
Pennsylvania Casualty Company — $10,116	21,244
Providers Insurance Company — $13,210	27,741
St. Paul Fire and Marine Insurance Company — $16,065	33,737

* Rate is determined by adding 20 percent to the rate of St. Paul. Such practice is generally consistent with approved rate filings.

Kansas Legislative Research Department
October 7, 1985

F85-315h

KANSAS PRACTITIONERS BY COUNTY (MDs AND DOs)

Obstetrics/Gynecology

County	Number of Doctors	County	Number of Doctors	County	Number of Doctors
Allen	0	Haskell	0	Riley	5
Anderson	0	Hodgeman	0	Rooks	0
Atchison	1	Jackson	0	Rush	0
Barber	0	Jefferson	0	Russell	0
Barton	2	Jewell	0	Saline	6
Bourbon	3	Johnson	30	Scott	0
Brown	0	Kearny	0	Sedgwick	50
Butler	1	Kingman	0	Seward	2
Chase	0	Kiowa	0	Shawnee	15
Chautauqua	0	Labette	1	Sheridan	0
Cherokee	0	Lane	0	Sherman	0
Cheyenne	0	Leavenworth	2	Smith	0
Clark	0	Lincoln	0	Stafford	0
Clay	0	Linn	0	Stanton	0
Cloud	0	Logan	0	Stevens	0
Coffey	0	Lyon	4	Sumner	0
Comanche	0	Marion	0	Thomas	0
Cowley	2	Marshall	0	Trego	0
Crawford	1	McPherson	1	Wabaunsee	0
Decatur	0	Meade	0	Wallace	0
Dickinson	0	Miami	1	Washington	0
Doniphan	0	Mitchell	0	Wichita	0
Douglas	8	Montgomery	1	Wilson	0
Edwards	0	Morris	0	Woodson	0
Elk	0	Morton	1	Wyandotte	30
Ellis	2	Nemaha	0		
Ellsworth	0	Neosho	0	Out-of-State	10
Finney	1	Ness	0		
Ford	2	Norton	0	TOTAL	201
Franklin	0	Osage	0		
Geary	3	Osborne	0		
Gove	0	Ottawa	0		
Graham	0	Pawnee	1		
Grant	1	Phillips	0		
Gray	0	Pottawatomie	2		
Greeley	0	Pratt	1		
Greenwood	0	Rawlins	0		
Hamilton	0	Reno	6		
Harper	0	Republic	0		
Harvey	5	Rice	0		

Kansas Annual Professional Liability Insurance Rates

Effective July 1, 1985

	With Surcharge (110%)
Kansas Joint Underwriting Authority ("Plan")* — $24,062	$ 50,530
Medical Defense Company — $11,970	25,137
Medical Protective Insurance Company — $12,267	25,761
Pennsylvania Casualty Company — $11,802	24,784
Providers Insurance Company — $11,656	24,478
St. Paul Fire and Marine Insurance Company — $20,052	42,109

* Rate is determined by adding 20 percent to the rate of St. Paul. Such practice is generally consistent with approved rate filings.

Kansas Legislative Research Department
October 7, 1985

F85-315i

KANSAS PRACTITIONERS BY COUNTY (MDs AND DOs)

Surgery — Neurology

County	Number of Doctors	County	Number of Doctors	County	Number of Doctors
Allen	0	Haskell	0	Riley	0
Anderson	0	Hodgeman	0	Rooks	0
Atchison	0	Jackson	0	Rush	0
Barber	0	Jefferson	0	Russell	0
Barton	0	Jewell	0	Saline	0
Bourbon	0	Johnson	2	Scott	0
Brown	0	Kearny	0	Sedgwick	5
Butler	0	Kingman	0	Seward	0
Chase	0	Kiowa	0	Shawnee	4
Chautauqua	0	Labette	0	Sheridan	0
Cherokee	0	Lane	0	Sherman	0
Cheyenne	0	Leavenworth	0	Smith	0
Clark	0	Lincoln	0	Stafford	0
Clay	0	Linn	0	Stanton	0
Cloud	0	Logan	0	Stevens	0
Coffey	0	Lyon	0	Sumner	0
Comanche	0	Marion	0	Thomas	0
Cowley	0	Marshall	0	Trego	0
Crawford	0	McPherson	0	Wabaunsee	0
Decatur	0	Meade	0	Wallace	0
Dickinson	0	Miami	0	Washington	0
Doniphan	0	Mitchell	0	Wichita	0
Douglas	0	Montgomery	0	Wilson	0
Edwards	0	Morris	0	Woodson	0
Elk	0	Morton	0	Wyandotte	2
Ellis	0	Nemaha	0		
Ellsworth	0	Neosho	0	Out-of-State	16
Finney	0	Ness	0		
Ford	0	Norton	0	TOTAL	29
Franklin	0	Osage	0		
Geary	0	Osborne	0		
Gove	0	Ottawa	0		
Graham	0	Pawnee	0		
Grant	0	Phillips	0		
Gray	0	Pottawatomie	0		
Greeley	0	Pratt	0		
Greenwood	0	Rawlins	0		
Hamilton	0	Reno	0		
Harper	0	Republic	0		
Harvey	0	Rice	0		

Kansas Annual Professional Liability Insurance Rates

Effective July 1, 1985

	With Surcharge (110%)
Kansas Joint Underwriting Authority ("Plan")* — $30,442	$ 63,928
Medical Defense Company — $11,970	25,137
Medical Protective Insurance Company — $12,267	25,761
Pennsylvania Casualty Company — $13,488	28,325
Providers Insurance Company — $14,764	31,004
St. Paul Fire and Marine Insurance Company — $25,368	53,273

* Rate is determined by adding 20 percent to the rate of St. Paul. Such practice is generally consistent with approved rate filings.

Kansas Legislative Research Department
October 7, 1985

F85-315f

Merrill Lynch Settlement Services, Inc.

The Financial Plaza
400 Town Center Drive
Suite 400
Dearborn, Michigan
48126

Telephone
313/336-4500

October 8,1985

Robert Peterson
Medical Protective Company
5814 Reed Road
Fort Wayne, Indiana 46815

Dear Bob,

As per our conversation and my interpretation of the hypothetical case file that you sent me, I've enclosed ratebook quotes from two (A+15) carriers. These are not firm quotes and are for illustrative purposes only, but should give you a fair idea of where the litigation annuity market is. In fact, both of these quotes are on the "high yield-low cost" end of the spectrum.

Bob, I hope this is what you needed and arrives in time to meet your deadline. It was difficult to know how to treat the burial expenses, so I just assumed that the child lived his normal life expectancy. This contingency might also be met through the use of a reversionary trust since no one but the Lord knows when this child is going to die. In any event, it looks like the cost could be held under $500,000 (excluding attorneys fees) even placed with a less competitive carrier.

I would encourage you to use Merrill Lynch Settlement Services on an actual file in the near future; you will recieve our packet shortly. Thank you for the opportunity to serve you.

Respectfully,

Barry Keeley

Barry M. Keeley
Settlement Consultant

10/10-11/85

Merrill Lynch Attachment X

ARRIER #1 A+ 15 *

* STRUCTURED SETTLEMENT *
* HYPOTHETICAL PROJECTION * DATE TODAY :10/07/85
****

DATE/LOSS :03/20/80
DATE/BIRTH :03/20/80
CLIENT :MALE BIRTH TRAUMA)
AGE : 0
ATTORNEY :

% ANNUAL ESCALATION : 2.00
BENEFIT : 4182883.77
(ANNU/CASH) TOTAL COST : 389569.00*
UP/FRONT CASH : 135000.00

AGE	YEAR	ANNUAL AMOUNT	LUMP/SUM PAYMENTS	AGE	YEAR	ANNUAL AMOUNT	LUMP/SUM PAYMENTS
0	1980	12893.00	0.00	45	2025	72564.15	0.00
1	1981	13150.86	0.00	46	2026	74015.43	0.00
2	1982	13413.88	0.00	47	2027	75495.74	0.00
3	1983	13682.15	0.00	48	2028	77005.65	0.00
4	1984	13955.80	0.00	49	2029	78545.77	0.00
5	1985	14234.91	0.00	50	2030	80116.68	0.00
6	1986	14519.61	0.00	51	2031	81719.02	0.00
7	1987	14810.00	0.00	52	2032	83353.40	0.00
8	1988	27792.00	24329.00	53	2033	85020.46	0.00
9	1989	28347.84	0.00	54	2034	86720.87	0.00
10	1990	28914.80	0.00	55	2035	88455.29	0.00
11	1991	29493.09	0.00	56	2036	90224.40	0.00
12	1992	30082.95	0.00	57	2037	92028.89	0.00
13	1993	30684.61	0.00	58	2038	93869.46	0.00
14	1994	31298.31	0.00	59	2039	95746.85	0.00
15	1995	31924.27	0.00	60	2040	97661.79	0.00
16	1996	32562.76	0.00	61	2041	99615.02	0.00
17	1997	41679.00	0.00	62	2042	101607.33	0.00
18	1998	42512.58	0.00	63	2043	103639.47	0.00
19	1999	43362.83	0.00	64	2044	105712.26	0.00
20	2000	44230.09	0.00	65	2045	107826.51	0.00
21	2001	45114.69	0.00	66	2046	109983.04	0.00
22	2002	46016.98	0.00	67	2047	112182.70	0.00
23	2003	46937.32	0.00	68	2048	114426.35	25000.00
24	2004	47876.07	0.00	69	2049	0.00	0.00
25	2005	48833.59	0.00	70	2050	0.00	0.00
26	2006	49810.26	0.00	71	2051	0.00	0.00
27	2007	50806.47	0.00	72	2052	0.00	0.00
28	2008	51822.60	0.00	73	2053	0.00	0.00
29	2009	52859.05	0.00	74	2054	0.00	0.00
30	2010	53916.23	0.00	75	2055	0.00	0.00
31	2011	54994.56	0.00	76	2056	0.00	0.00
32	2012	56094.45	0.00	77	2057	0.00	0.00
33	2013	57216.34	0.00	78	2058	0.00	0.00
34	2014	58360.66	0.00	79	2059	0.00	0.00
35	2015	59527.88	0.00	80	2060	0.00	0.00
36	2016	60718.43	0.00	81	2061	0.00	0.00
37	2017	61932.80	0.00	82	2062	0.00	0.00
38	2018	63171.46	0.00	83	2063	0.00	0.00
39	2019	64434.89	0.00	84	2064	0.00	0.00
40	2020	65723.58	0.00	85	2065	0.00	0.00
41	2021	67038.06	0.00	86	2066	0.00	0.00
42	2022	68378.82	0.00	87	2067	0.00	0.00
43	2023	69746.39	0.00	88	2068	0.00	0.00
44	2024	71141.32	0.00	89	2069	0.00	0.00

****

PORTANT..
THESE ARE NOT FIRM
QUOTES, BUT RATEBOOK
QUOTES..COULD CHANGE

STRUCTURE ELEMENT	COST	BENEFIT
1.ANNUAL MAINTENANCE	243777.00	4133554.77
2.LUMP/SUM PAYMENTS	10792.00	49329.00

ARRIER #2: A+ 15 *

* STRUCTURED SETTLEMENT *
* HYPOTHETICAL PROJECTION *

DATE TODAY :10/07/85

DATE/LOSS :03/20/80
DATE/BIRTH :03/20/80
CLIENT :MALE(BIRTH TRAUMA)
AGE : 0
ATTORNEY :

% ANNUAL ESCALATION : 2.00
BENEFIT : 4182883.77
(ANNU/CASH) TOTAL COST : 410148.00*
UP/FRONT CASH : 135000.00

AGE	YEAR	ANNUAL AMOUNT	LUMP/SUM PAYMENTS	AGE	YEAR	ANNUAL AMOUNT	LUMP/SUM PAYMENTS
0	1980	12893.00	0.00	45	2025	72564.15	0.00
1	1981	13150.86	0.00	46	2026	74015.43	0.00
2	1982	13413.88	0.00	47	2027	75495.74	0.00
3	1983	13682.15	0.00	48	2028	77005.65	0.00
4	1984	13955.80	0.00	49	2029	78545.77	0.00
5	1985	14234.91	0.00	50	2030	80116.68	0.00
6	1986	14519.61	0.00	51	2031	81719.02	0.00
7	1987	14810.00	0.00	52	2032	83353.40	0.00
8	1988	27792.00	24329.00	53	2033	85020.46	0.00
9	1989	28347.84	0.00	54	2034	86720.87	0.00
10	1990	28914.80	0.00	55	2035	88455.29	0.00
11	1991	29493.09	0.00	56	2036	90224.40	0.00
12	1992	30082.95	0.00	57	2037	92028.89	0.00
13	1993	30684.61	0.00	58	2038	93869.46	0.00
14	1994	31298.31	0.00	59	2039	95746.85	0.00
15	1995	31924.27	0.00	60	2040	97661.79	0.00
16	1996	32562.76	0.00	61	2041	99615.02	0.00
17	1997	41679.00	0.00	62	2042	101607.33	0.00
18	1998	42512.58	0.00	63	2043	103639.47	0.00
19	1999	43362.83	0.00	64	2044	105712.26	0.00
20	2000	44230.09	0.00	65	2045	107826.51	0.00
21	2001	45114.69	0.00	66	2046	109983.04	0.00
22	2002	46016.98	0.00	67	2047	112182.70	0.00
23	2003	46937.32	0.00	68	2048	114426.35	25000.00
24	2004	47876.07	0.00	69	2049	0.00	0.00
25	2005	48833.59	0.00	70	2050	0.00	0.00
26	2006	49810.26	0.00	71	2051	0.00	0.00
27	2007	50806.47	0.00	72	2052	0.00	0.00
28	2008	51822.60	0.00	73	2053	0.00	0.00
29	2009	52859.05	0.00	74	2054	0.00	0.00
30	2010	53916.23	0.00	75	2055	0.00	0.00
31	2011	54994.56	0.00	76	2056	0.00	0.00
32	2012	56094.45	0.00	77	2057	0.00	0.00
33	2013	57216.34	0.00	78	2058	0.00	0.00
34	2014	58360.66	0.00	79	2059	0.00	0.00
35	2015	59527.88	0.00	80	2060	0.00	0.00
36	2016	60718.43	0.00	81	2061	0.00	0.00
37	2017	61932.80	0.00	82	2062	0.00	0.00
38	2018	63171.46	0.00	83	2063	0.00	0.00
39	2019	64434.89	0.00	84	2064	0.00	0.00
40	2020	65723.58	0.00	85	2065	0.00	0.00
41	2021	67038.06	0.00	86	2066	0.00	0.00
42	2022	68378.82	0.00	87	2067	0.00	0.00
43	2023	69746.39	0.00	88	2068	0.00	0.00
44	2024	71141.32	0.00	89	2069	0.00	0.00

PORTANT..
THESE ARE NOT FIRM
QUOTES, BUT RATEBOOK
QUOTES..COULD CHANGE

STRUCTURE ELEMENT	COST	BENEFIT
1.ANNUAL MAINTENANCE	263969.00	4133554.77
2.LUMP/SUM PAYMENTS	11179.00	49329.00

Marsh & McLennan

Marsh & McLennan, Incorporated
Suite 620
1800 M Street, N.W.
Washington, D.C. 20036
Telephone 202 828-7906

OCT 8 1985

October 7, 1985

Robert S. Peterson, Esq.
Division Manager
Law Department
The Medical Protective Company
Fort Wayne, Indiana 46885

Re: Structured Settlements Scenario

Dear Bob:

John E. Scarbrough
Vice President

Pursuant to your request and our telephone conversation today, attached is a list of highlights from my critique of the damages report you sent me. Also provided is the approximate current cost of a set of annuities which would provide the stream of annual payments listed in the "Cash Flow Analysis" included with that damages report.

As I mentioned to you over the telephone, my conclusions from a quick review of the damages study is that the true damages are greatly overestimated. In addition, some caveats and cautions are listed with regard to the annuities. Essentially, the annuities whose total cost is quoted would provide the payments listed; however, the payments listed will not likely provide sufficient income to cover the future costs those payments represent. The reason is that, since they came from the damages study, they are net of inflation. Therefore, inflationary expectations should be factored in before one could conclude that payment stream provided by annuities would cover anticipated future needs.

Finally, structured payments in the subject scenario would be fully taxable, to the extent they are not offset by deductible medical expenses. However, payments made as part of a malpractice settlemnt are free of tax.

I hope these comments are helpful. If you have any questions, please do not hesitate to call.

Very truly yours,

Attachment
cc: C. Quilhot

STRUCTURED SETTLEMENTS SCENARIO

DAMAGES REPORT

The damages report provided in this scenario is seriously flawed. Several factors are included which inflate the damages stream to unreasonable levels. Some of the more important flaws are listed below.

1. Future growth rate (net of inflation) for earnings and medical costs is too high - The average annual rate of "real economic growth" from the period 1920-1970, taken as 3.586%, is used as the assumed future annual growth rate (over and above inflation) for earnings and medical expenses. This is inappropriate, as real economic growth does not mean that earnings, for example, grow at the same rate. For example, population increases will increase real GNP (i.e., real economic growth), even though per capita GNP might fall. What should be used is average changes in either average weekly earnings or productivity. Both these measures are on a per worker basis. The historical average increase in these indices for the past 37 years is 2.25% and 1.25% respectively. Moreover, projections, not historical averages, should be used. Long-term projections of worker productivity are available (for example, from the President's Counsel of Economic Advisors) and typically range from 1% to 2%.

2. The discount rate is too low - A discount rate of 1.6% was used to discount the future damages to present value. Remember, the purpose of a discount rate is essentially to convert future amounts into the lump sum that could be invested to generate those future amounts. According to the damages report, the discount rate used was derived by taking the difference between a historical interest rate and the historical inflation rate. (Strictly speaking, it is not really a simple subtraction of inflation rates from nominal interest rates, but is close enough.) The historical period used for this was not 1920-1970, as was used for economic growth, but was 1970-1978. The interest rate used was the average Federal Reserve Discount Rate for the period, 6.2774%. Note that this is the rate that the Federal Reserve charges its member banks. It is not the rate at which

individuals can invest or borrow money. Moreover, the average inflation rate for that period was 6.644%, according to the report. This yielded a negative discount rate, to which was added, somewhat arbitrarily, 2%. (Note that the average inflation rate for the period 1947-1984 has been only 4.25%. The period 1970-1978 was period of relatively high inflation and low interest rates.)

A much more direct way to develop an appropriate real rate of discount rate exists. It is a fact that one can go out today and purchase a Treasury bond that will pay 10.7% for the next 30 years. A 1.6% real discount assumes that inflation will average about 9% over that 30 year period. Most forecasts of long-term inflation are in the 4% range. The procedure used in the report would, therefore, yield a real discount rate of 6.7% (10.7% less 4%). I believe 3% is a reasonable rate to use for discounting future dollars that are net of inflation, such as those represented in the report. This is consistent with most projections of real interest rates and court decisions.

Note - The following puts the magnitude of the overestimate of lost damages caused by these inappropriate assumptions. Using 1980 U.S. Census data for earnings of high school graduates at various ages, adjusting these to 1983 dollars (those used in the report) using the Average Weekly Earnings index published by the Bureau of Labor Statistics, a 1% annual increase in addition to inflation to account for productivity increases, a 3% real discount rate and the probability of surviving to each successive year, taken from the Commissioners Standard 1980 mortality table, I projected lost earnings that have a discounted present value of $440,627. The report lists such a value as $1,203,826.38. Similar upward bias would exist in the other elements of damages as well.

3. Assuming a normal life expectancy inflates projected future costs - If the child is not expected to live a normal lifetime, the total expected costs will not be nearly as high as what is reflected in the damages report.

ANNUITIES REQUIRED

The request was to determine the cost of the annuity or annuities required to provide the payments listed in the "Cash Flow Analysis." Using current rates and assuming a normal life expectancy, the lowest cost is $239,843. Note that rates are subject to change. Note also that this rate is not necessarily from an annuity company which the purchaser would wish to use. Consequently, this quotation is for illustration purposes only.

While the above figure would provide the payments listed in the "Cash Flow Analysis," those payments would not likely correspond to the future needs of the child, if one assumes the accuracy of the damages report. The reasons for this are listed below.

1. The "Cash Flow Analysis" understates the payments which the damages report indicates would be required - The payments shown in the "Cash Flow Analysis" are net of inflation and are in discounted present value terms. This is because they were developed using a projected 2% annual increase, which was apparently derived by taking the difference between the real (net of inflation) growth rate used in the damages report of 3.586% and the real (net of inflation) discount rate used in that report of 1.6%. However, if inflation is 4% (or 6.644% as referenced in the report for 1970-1978), actual future needs (i.e., payments in current dollars) will be considerably greater. The payments which the annuities must make to provide for the needs of the child may have a present value equivalent to those payments shown in the "Cash Flow Analysis", the actual payment made must keep up with inflation as well as the 2% escalation factor.

2. Remember, the payments made in the scenario are taxable, while the payments made as a settlement to a medical malpractice claim are free of tax.

3. If the child has a reduced life expectancy, the annuities will be less expensive. For example, if the child is rated by the underwriters to have a life expectancy equivalent to a male of age 35, the cost of the annuities would be only $216,121.

OCT 8 1985

THE STRUCTURED SETTLEMENTS COMPANY

5757 West Century Blvd., Suite 620
Post Office Box 45023
Los Angeles, California 90045-0023
(213) 642-1999 • (800) 421-2022
Telex 653-446 • TSSC LSA

October 7, 1985

Mr. Robert S. Peterson
Division Manager
Law Department
THE MEDICAL PROTECTIVE COMPANY
Fort Wayne, Indiana 46885

Dear Mr. Peterson,

As you requested we have analyzed the documentation you provided that relates to a hypothetical structured settlement. In order to provide you with as accurate information as we could, we had to assume that the payments would commence in 1985 and not 1980 as outlined in the economic workup.

We described the birth defect to a few of our markets and on average, they suggested a child with these injuries would be rated with an age of about 45 years. The markets we spoke with are rated A+ Excellent and are recognized entities in providing structured settlement annuities.

Including $135,000 front cash to purchase a home, it would cost a total of $381,000 to provide all of the benefits described in the economic workup. If the youngster were considered to have a normal life expectancy for a female born March 20, 1985, the cost to provide the home and the benefits would be $500,000.

I hope that the information we provided is of value to you and I would be pleased to hear from you if you have any additional questions.

Sincerely,

THE STRUCTURED SETTLEMENTS COMPANY

Neil H. Small

NHS/mmm

STATE OF KANSAS

JOE KNOPP
REPRESENTATIVE SIXTY-SEVENTH DISTRICT
RILEY COUNTY
410 HUMBOLDT
MANHATTAN KANSAS 66502
913-776-4788

TOPEKA

COMMITTEE ASSIGNMENTS
CHAIRMAN JUDICIARY
MEMBER TRANSPORTATION
LEGISLATIVE JUDICIAL AND
CONGRESSIONAL APPORTIONMENT
ELECTIONS

HOUSE OF
REPRESENTATIVES

September 28, 1985

Dear Friends,

As I'm considering my position on limits for recovery, I want to put myself in the hypothetical position of a wealthy father who is concerned about the financial security of his child.

For this example assume the following:

A. My wife died in childbirth. No negligence... she just died.
B. My child lived, but with the injuries described in the attached letter. Again, no neglience caused it... it just happened.
C. My doctor informs me that I have 3 weeks to live.
D. I have unlimited resources. However I don't want any more than is necessary to be set aside for my child.
E. I also want to set aside enough so that the State of Kansas or Federal Government do not directly subsidize the care for my child.
F. My brother and sister in law (who I've generously assisted) wil provide the care in their home normally provided by my wife and myself.

Please assume the following assumptions are accurate (or please advise me as to the inaccuracies contained therein)

A. That the cost of care shown in the attached report is accurate.
B. That the duration of the care needed is accurate.
C. That the cost of those items will increase as shown.

My question is this: I want my insurance agent to quote me a price on a single premium policy that will pay the amounts shown on the attached schedule B.

I would also appreciate your thoughts on why I should provide my child with enough money to "pay" him for his "lost lifetime income"; and what will happen to that money if all of his medical needs are taken care of. (I will take care of his heirs independently so they shouldn't be a consideration)

Please do not hesitate to call if this request is not clear and to provide alternate schedules if more appropriate.

Sincerely yours,

Joe Knopp

I've sent this letter to Kathleen Sebelius, KTLA; Ron Smith, KBA; Jerry Slaughter, KMS: and directed that Mike Heim make additional copies available for other interested individuals. I will try to review this letter and your responses to arrive at a presentation for the committee that will facilitate discussion of this specific issue. I don't believe that I or members of the committee can intelligently understand "caps" until the costs are broken down for us on an annual basis.

SCHEDULE B

STATE OF KANSAS

JOE KNOPP
REPRESENTATIVE SIXTY SEVENTH DISTRICT
RILEY COUNTY
410 HUMBOLDT
MANHATTAN KANSAS 66502
913 776 4788

TOPEKA

COMMITTEE ASSIGNMENTS
CHAIRMAN JUDICIARY
MEMBER TRANSPORTATION
LEGISLATIVE JUDICIAL AND
CONGRESSIONAL APPORTIONMENT
ELECTIONS

HOUSE OF
REPRESENTATIVES

Mr Insurance Agent;

From the attached report it appears that I'll need to do the following:

Age 1-8

Orthopeadic	45/yr	Laundry	288/yr
Pediatrician	90/yr	Drugs	800/yr
Child Dev'p	90/yr	Nursing Care	10,920/yr
Opthamalogist	30/yr		
Audiologist	30/yr	Total	12,893.80 for 1980 and a 2%
Climate Control	600/yr		net growth for each year (3.5% -

Age 8-16

Total in group 1-8 is now 14,810 per year and in addition we need:

Transportation Depreciation	3,136/yr
Transportation Maintenance	1,696/yr
School Assistance	8,000/yr
Maintenance on Medical Equip't	150/yr

Total is 27,792.68 peryear commencing in 1988 and with a net growth of 2% per year

Age 17-67

SRS care at the rate of 110.60 per day for a total of 40,369.80
(This 110.69 is arrived at by increasing the 79.00 per day in 1980 at 2% per year to arrive at the cost in 1997)

Orthapedic	45/yr
Internist	90/yr
Drugs	800/yr
	935/yr in 1980 prices equals 1,309.23 in 1997 prices (2% grov

In addition, we need the following lump sum payments:

A. 1980 , 135,000 for new house with structural requirements
B. 1988 4,729 for medical equipment
C. 1988 19,600 for van
D. 1997 The house is sold,since it is no longer needed,for $75,000.

From these conclusions, it appears to me that I will need the cash flow as shown on the attached sheet.

Again please tell me what a single premium policy will cost to providethese benefi I don't want any of the annual payments guaranteed i.e. the benefits will terminate on death of the child. (Since I've independently given money to the heirs, they are not a concern.) Please guarantee the payments for the house, van, burial, etc.

By my calculations, the total amount over the next 65 years is $4.2 million approximately. The economist says that $4.8 million is needed now . (Total of $6.061 mi less the future income of $1.2 million.)

I believe that the present value of $4.2 to be paid over the next 65 years is less. To avoid any misunderstanding, I'd like to explain my methodology.

I started in 1980 with a total of 12,893.80 in medical expenses. I added 2% to that figure for 1981, and 2% of 1981 to arrive at the 1982 figure, etc until I had compounded it for each year until 1987.

In 1988, I used the basic medical expenses shown in 1980. I compounded them by 2% per year to arrive at their value in 1988. To that amount I added transportatio maintance and depreciation of 20% of the original value of the van. Likewise school expense was added. I note that I did not have school expense for a full 12 years and that medical equipment depreciation was not added in. This may partially explain the differance in the figures between me and the economist.

For the years of 1997 through 2048, I started with the SRS charge for institutional care. The 1979 charge of $79/day was recalculated at the 2% per year rate to arrive at the 1997 charge of 110.79/day. I added the medical expenses. I assumed that the transportation and medical equipment expenses were included in the charge for care by SRS. This totaled $41,679.

Again I took my simple calculator and multiplied $41,679 by 2%, added it to $41,679, and then compounded that process for the next 51 years.

With the recent disclosures about our state hospitals, you may wonder if we shouldn't try to set aside more for a better,private institution. I want to know what the basics cost. Perhaps you can talk me into buying more insurance.

Sincerely yours,

Concerned Father

P.S. If you would rather just start from the economist's report and base your calculations on his assumptions to arrive at your figure, that would be fine with me.

CASH FLOW ANALYSIS

Year	Amount needed:	
1980	12,893	+ 35,000 for house
1981	13,150	
1982	13,413	
1983	13,682	
1984	13,955	
1985	14,234	
1986	14,519	
1987	14,810	
1988	27,792	+ 24,329 for van, etc.
1989	28,348	
1990	28,915	
1991	29,493	
1992	30,083	
1993	30,685	
1994	31,299	
1995	31,925	
1996	32,563	
1997	41,679	(Sell house, net 75,000)
1998	42,512	
1999	43,362	
2000	44,230	
2001	45,114	
2002	46,017	
2003	46,937	
2004	47,879	
2005	48,883	
2006	49,810	
2007	50,806	
2008	51,822	
2009	52,859	
2010	53,916	
2011	54,944	
2012	56,094	
2013	57,216	
2104	58,360	
2015	59,527	
2016	60,718	
2017	61,932	
2018	63,171	
2019	64,343	
2020	65,723	
2021	67,038	
2022	68,379	
2023	69,746	
2034	71,141	
2025	72,564	
2026	74,015	
2027	75,495	
2028	77,005	
2029	78,545	
20302	80,116	
2031	81,719	
2032	83,353	
2033	85,020	
2034	86,720	
2035	88,455	
2036	90,224	
2037	92,028	
2038	93,869	
2039	95,746	
2040	97,771	
2041	99,615	
2042	101,607	
2043	103,639	
2045	105,712	
2045	107,826	
2046	109,983	
2047	112,182	
2048	115,000	

Burial Expenses $25,000

NORTHEASTERN UNIVERSITY

BOSTON, MASSACHUSETTS 02115

COLLEGE OF LIBERAL ARTS
DEPARTMENT OF ECONOMICS

August 1, 1983

Re:

Enclosed you will find my preliminary report on your client, . Explanation is as follows:

1. Life Expectancy

Source: Statistical Abstract of the United States, U.S. Department of Commerce, 1982-83, Table #107, "Expectation of Life and Expected Deaths, by Race, Age and Sex-1979," Source: U.S. National Center for Health Statistics, Vital Statistics of the United States, annual.

Born:	March 20, 1980
Date of Injury:	March 20, 1980
Age at Base:	3 years old (as of January 1983)
Life Expectancy:	68.6 years (from 1983)

2. Lost Earnings Capacity:

is suffering from encephalopathy which is nonprogressive, diffuse and manifested by developmental delay, impaired vision and hearing, and spastic quadriparesis. The prognosis is extremely poor with the patient requiring total care for life.

Calculations are made on the basis that enters the labor force at age 20 with a high school education only at a salary in 1979 of $9,800. Source: Statistical Abstract of the United States, 1979, U.S. Department of Commerce, Bureau of the Census. Table #755 "Median Money Income of Year-Round Full-Time Workers with Income, by Sex and Age." page 461. Source: U.S. Bureau of the Census, Current Population Reports, Series P-60, and earlier issues.

1979 = $ 9,800.00 >3.5% = 343.00 =
1980 = $10,143.00 >3.5% = 355.01 =
1981 = $10,498.01 >3.5% = 367.43 =
1982 = $10,865.44 >3.5% = 380.29 =
1983 = $11,245.73

Prospective calculations take the $11,245.73 and increase yearly by 3.5 percent to account for normal growth without inflation and decrease yearly by 1.6 percent to account for a discounting to current value. No earnings are calculated until Patrick reaches age 20.

Explanation of real economic growth rate without inflation of 3.5% and a discounting to present value without inflation of 1.6% is as follows:

> Based on the evidence and assumptions explicated below, we will use a predictive estimate of the annual rate of real economic growth of 3.586 percent, which is the average annual rate 1920-1970. For discounting a sum to present value, we will use a figure of 1.6334 percent, based on interest rates of 1970-78 (excluding inflation).
>
> Growth Rates:
>
> Real economic growth rates as given in various editions of the Statistical Abstract of the United States are, unfortunately, not expressed in the same constant dollars. The most comprehensive by far is the so-called Bicentennial edition,[1] which details growth rates from 1909 to 1970 in constant 1958 dollars. Annual issues giving figures after 1970 do not specify the base year (but do indicate "constant dollars"), and after 1978 the base changes to 1972 dollars.
>
> Given these constraints, we have two options: (a) use the 1970-78 figures (expressed in 1972 dollars) from the 1979 SAUS[2], or (b) use figures from the Bicentennial edition, which end in 1970. The average in option (a) is 3.25 percent, which seems a reasonable ballpark figure; but the standard deviation of these same eight years is 2.80, which only emphasizes the economically erratic nature of these data. I suggest instead a conservative sample of, say, 50 years from the Bicentennial edition -- or 1920 to 1970. This, naturally, includes the Great Depression and post-Second World War boom, but, the sample should be sufficiently large to control for this. I would caution against using figures before 1920, as the Commerce notes figures in general are "subject to only a small percentage of error.... but for the years prior to 1919 the margin of error widens noticeably."[3]

For the fifty-year period 1920-1970, the average annual rate of real economic growth is 3.586 percent.

Discount Rates:

Rates of discount, or real interest should consider a different set of arguments.

In order to exclude the effect of inflation from our estimate -- so much as may be practicable -- we must subtract that amount from our interest rates; and we must account for real growth in the same way. That is, a hypothetical interest (discount) rate of 10 percent per annum might represent four percent real economic growth, five percent inflation and only one percent net gain in principal. Our discount rate, then, should reflect this net gain -- and not simply gross increase in principal.

The most accurate measure of the combined rates of inflation and real growth in the Consumer Price Index, and our best estimate of gross interest rates comes from the Federal Reserve Bank. We can thus determine the net gain in principal to be realized or invested -- i.e., the discount rate. Using comparable figures for the period 1970-78 from the 1979 SAUS, we find an average Federal Reserve Bank (New York) "discount rate" of 6.2774 percent.[4] (This amount was figured by first calculating an average annual rate, a procedure which best accounts for seasonal fluctuations.) The average annual increase for the same period in the Consumer Price Index (all items) is 6.644 percent. Using the rationale developed above, our net discount rate (FRB% ΔCPI) is -.3866 percent. The FRB discount figures are typically conservative estimates of safe commercial investments, by a margin as large as two percent. With this adjustment, we arrive at a new net discount rate as follows:

$$(\text{FRB\%} + 2\%) - \Delta\text{CPI} = \text{DISCOUNT RATE}$$

$$6.2774 + 2 - 6.644 = \underline{1.6334}$$

References:

[1]U.S. Department of Commerce, Bureau of the Census. Historical Statistics of the United States: Colonial Times to 1970. Part I, Series F 31, "Average Annual Growth Rates of Gross National Product (Percent): 1909 to 1970", pages 226-227.

[2]U.S. Department of Commerce, Bureau of the Census. Statistical Abstract of the United States, 1979. Table 717, "Rates of Economic Growth: 1950 to 1978, Page 438.

[3]Historical Statistics, op.cit., Notes to Series F 1-5, Page 216.

[4]Statistical Abstract of the United States, op.cit., Table 889, "Federal Reserve Bank of New York -- Discount Rates: 1970 to 1979," Page 541.

3. Retirement Income

Calculated beginning at age 67 until death in the year 2052, at 40 percent of the average income over the five last year of working life. In the first year of retirement, 2048, this amounts to $5,058.20. This amount appears to be considerably less than 40 percent average of the last five years of working life since the amount has been discounted to current value by 1.6 percent and does not reflect a growth rate of 3.5 percent.

4. Physician Expense - Orthopaedic:

Calculated for one visit per year to orthopaedic surgeon at $45.00 per year, (>3.5% <1.6%).

5. Physician Expense - Pediatrician:

Calculated for five visits per year to pediatrician, at $18.00 per visit, $90.00 per year, to terminate at age 16. (>3.5% <1.6%).

6. Physician Expense - Internist:

Calculated for five visits per year at $18.00 per visit, $90.00 per year, to begin at age 17, (>3.5% <1.6%).

7. Physician Expense - Child Development:

Calculated for two visits per year to Child Development specialist at $45.00 per visit, $90.00 per year, to terminate at age 16, (>3.5% <1.6%).

8. Physician Expense - Ophthalmologist:

Calculated for one visit per year to eye specialist at $30.00 per year, to terminate at age 16, (>3.5% <1.6%).

9. Physician Expense - Audiologist:

Calculated for one visit per year to hearing specialist at $30.00, to terminate at age 16, (>3.5% <1.6%).

10. Medical Equipment:

Calculated for the following:

1.	Manual wheel chair #1	$ 1,063.00
2.	Manual wheel chair #2	1,063.00
3.	Hospital Bed	1,240.00
4.	Over the bed table	148.00
5.	Hoyer Lift	750.00
6.	Shower and Bathroom Chair	465.00
	Total:	$ 4,729.00

First purchased in 1985, depreciated over five years and repurchased with no trade-in value.

11. Maintenance of Medical Equipment:

Calculated for maintenance of medical equipment to begin in 1985 at $150.00 per year, (>3.5% <1.6%).

12. Transportation:

Calculated for a van to accommodate wheel chair, with electric lift, at a cost of $19,600 to be purchased when Patrick is too heavy and old to be carried at age 8 (in the year 1988). The van is depreciated and replaced every five years, with 20% trade-in value, having a replacement cost of $15,680.00, (>3.5% <1.6%).

13. Transportation Maintenance:

Calculated for the following:

1.	Insurance	$ 450.00
2.	Maintenance	500.00
3.	Gasoline (8,000 miles per year, 15 miles to the gallon, $1.40 per gallon = 533 gallons x $1.40 =	746.68
	Total:	$1,696.68

- This variable to begin at age 8.

14. Home for Wheelchair Bound:

Calculated for a single level, two-bedroom, wheelchair-bound owner occupied house, with two car garage, at a total of 1,800 to 2,000 square feet, including the following specifications:

A. RAMPS

1. Home

Concrete poured to meet local building code at 4 feet in width. Length in feet should equal height of incline in inches at a slope of five degrees. Features include: rough troweled surface. wheel guiding bumpers, metal handrails, ramp platform at 4 foot deep with inward swinging door.

2. Portable

Portable metal ramp for environments not providing handicap access (Manufacturer: Nelson Medical Products, Sarasota, Florida).

B. DOORS AND DOORWAYS

1. Flush metal thresholds at all doorways (Manufacturer: Macklanburg-Duncan, Oklahoma City, Oklahoma).
2. All doorways at 3 feet in width.
3. Metal kickplates on all doors for protection against wheelchair scrapes.
4. Closed-end lever door handles installed at 3 feet above floor level.
5. Silent Swing radio - transmitter activated electromechanical operator unit to be installed above all doors (Manufacturer: Stanley Door Operating Equipment. Distributed by MacKenzie Co., Inc., New York, N.Y.).

C. WINDOWS

1. All windows to be Perma-Shield horizontal sliding or awning-type windows for accessibility and ease in operation (Manufacturer: Andersen Corporation, Bayport, Minnesota).
2. All window sills to be 3 feet above floor level.
3. Vertical louvered blinds at all windows with remote control operated pull cord.

D. POWER AND COMMUNICATIONS

1. ECU-2 Environmental Control System - voice or chin activated to operate the following household functions and appliances:

   a. Automatic Dialing Telephone. User can answer incoming calls or dial any number, even during a power failure.
   b. Household and exterior lighting system.
   c. Remote controlled garage, room, refrigerator and oven door opener units.
   d. AC powered appliances such as stereo, television, stove, burglar and fire alarm controls.

ECU-2 system has latching and momentary control receptacles for interfacing with optional electronic accessories and other functions requiring low voltage DC or a contact closure. Control receptacles are useful for controlling battery operated devices, tape recorders, nurse call, remote receptacles, etc. . . .

2. Electrical outlet strip consoles, with circuit breakers and heavy extension cords for the centralization of all electrically powered household functions (Manufacturer: Prentke Romich Company, Shreve, Ohio).

D. FURNITURE

1. Close approach tables in all rooms with shallow widths for accessibility.
2. High cushion reclining and arm chairs in bedroom and living room for owner, caretakers and guests.
3. Hoyer lift, transportable to bedroom & bath.
4. Wide base lamps in rooms.
5. Narrow Parsons table at bedside for ECU-2 unit, electronic devices and appliances.

E. BATHROOM

1. Outward swinging door in 3 feet wide doorway.
2. Medicine Cabinet with tilted mirror and remote control doors mounted with bottom at 3 feet 8 inches above floor level.
3. Soap dispenser and electric dryer mounted at 3 feet 8 inches above floor level.
4. Wall mounted lever-handled sink without legs or pedestal, with top of rim at 2 feet 3 inches above floor level. Depth should be 1 foot 10 inches from wall with a width of 2 feet 6 inches. Exposed drain and hot water pipes should be recessed, insulated or guarded.

The bottom of the adjacent counter should leave 2 feet 3 inches clear to the floor support brackets to be mounted on either side of sink. Sink must be capable of supporting 250 pounds for 5 minutes.

5. Toilet located 1 foot 6 inches from center line of fixture to nearest side wall, with 3 feet 6 inches clear space from center line of toilet to the farthest wall or other fixture. Toilet with narrow, receding understructure and seat at 1 foot 3 inches above floor level. Guardrails to be installed at either side for safety.
6. Wall mounted urinal with rim at 1'3" above floor level.
7. Shower stall with 3 feet door opening; non-slip surface, pitch-drain floor; and flexible metal hose shower head, adjustable from 3 feet, 6 inches to 6 feet above floor level.
8. Shower chair on wheels (Manufacturer: Nelson Medical Products, Sarasota, Florida).
9. Bathtub with rim at 1 foot 4 inches to 1 foot 8 inches above floor level. Adjacent built-in seat at 1 foot 6 inches deep. Single control level with pressure balanced mixing valve to be located 1 foot 3 inches from tub seat on longest wall and at 2 feet 4 inches above floor level. Adjustable wall mounted shower head.
10. 5 foot minimum turning diameter at center of bathroom.

F. KITCHEN

1. All work surfaces at 2 feet 6 inches above floor level with a depth of 1 foot 6 inches. Exposed pipes, drains, legs, pedestals and support structures should be recessed to allow 2 feet 3 inches knee room space from floor level. Countertops should be plastic laminate covered butcher block.
2. Frost free refrigerator/freezer with remote controlled side by side doors.
3. Custom built roll out pantries and permanent narrow storage shelves.
4. Sink with 1 foot 3 inches clear space on either side, and a depth of 4½ inches (Manufacturer: American Standard, New Brunswick, NJ).
5. Automatic, remote controlled dishwasher.
6. Self cleaning oven with side hinged, remote controlled door, the bottom of which is 1 foot, 6 inches above floor level.
7. 5 foot minimum turning diameter at center of kitchen.

This 1800 square foot home is to be located in the Baldwin City, Kansas area. Calculated at the local construction costs of $48.00 per square foot, a total of $86,400.00, plus $10,000 for the cost of the land, and $16,000 for enclosed small 12'x 24' swimming pool for physical therapy, plus $22,000.00 for all wheelchair and electronic accommodating features mentioned, for a total of $134,400.00.

15. Climate Control:

Calculated for heat and air conditioning at $50 per month, $600 per year, (>3.5% <1.6%). To terminate at age 16.

16. Laundry:

Calculated for laundry services at $24.00 per month, $288 per year, (>3.5% <1.6%). To terminate at age 16.

17. Schooling:

Calculated for a teaching aide to assist Patrick in public school, at eight hours per day, 200 days per year, 1600 hours, at $5.00 per hour, $8,000.00 per year to terminate at age 18, (>3.5% <1.6%).

18. Drugs and Pharmacy:

Calculated for the following: dietary supplements, diapers, and phenobarbital at $15.50 per week, $800 per year, (>3.5% <1.6%).

19. Home Care - Nursing Assistant:

Calculated for nursing assistant at home for six hours per day, 42 hours per week at $5.00 per hour, $210.00 per week, $10,920.00 per year, (>3.5% <1.6%). To terminate at age 16.

20. Retrospective Value of Medical Services of Mother:

Calculations made here for the value of medical services of mother to Patrick over and above the normal time and effort devoted to other children of family, at six hours per day, seven days per week, 42 hours per week, 2,184 hours per hear, for a three year period, 2,184 x 3 = 6,552 hours x $3.50 = $22,932.00.

21. Institutional Care:

Calculated for Institutional Care to begin when Patrick is age 17, according to the rates set by the State of Kansas, Department of Social and Rehabilitation Services, Administrative Services, Fiscal Section, State of Kansas, Topeka, Kansas at $79.00 per day, $28,835.00 per year (>3.5% <1.6%).

22. Summary:

Retrospective Totals:

Variable	Total
Lost Income	$ -0-
One-Time Costs Included:	
Home for Wheelchair Bound	134,400.00
Retrospective Value of Medical Services of Mother	22,932.00

Prospective Totals:

Variable	Total
Lost Income	$ 1,203,826.38
Physician - Orthopaedic	6,309.27
Physician - Pediatric	1,380.23
Physician - Internist	11,238.31
Physician - Child Development	1,380.23
Physician - Ophthalmologist	460.08
Physician - Audiologist	460.08
Medical Equipment	134,392.09
Maintenance of Medical Equipment	20,803.08
Transportation	413,715.19
Transportation Maintenance	229,926.28
Climate Control	9,201.52
Laundry	4,416.73
Schooling	143,619.09
Drugs and Pharmacy	112,164.75
Home Care-Nursing Assistant	167,467.63
Institutional Care	3,600,628.25
Subtotal (Retrospective):	$ 157,332.00
Subtotal (Prospective):	$ 6,061,389.50
Grand Total:	$ 6,218,721.50

I must emphasize the above calculations in no way deal with the issue of pain and suffering of as a direct result of his injury on March 20, 1980. Calculations made in this report represent real economic loss. Estimates for pain and suffering and loss of companionship of a normal son to mother and father must be added to the computations submitted herein.

Should you require additional information or clarification, please do not hesitate to call.

Sincerely,

Harold M. Goldstein
Professor and Director

HMG/ojs

Oklahoma

127584

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 _____

10/10-11/85
Attachment XI

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).

JOE KNOPP
MANHATTAN, KANSAS 66502

HOUSE OF
REPRESENTATIVES

September 17, 1985

Fletcher Bell
Commissioner of Insurance
420 S.W. 9th
BUILDING MAIL

Dear Commissioner Bell:

On behalf of the Special Committee on Medical Malpractice I am requesting the following information:

1. Please send a compilation of doctors, osteopaths, chiropractors, and hospitals that have had multiple claims made against them, with an indication of the claims amounts that were actually paid. The information should reflect payouts by both primary carriers and the Health Care Stabilization Fund. The format utilized by your Department in the information regarding primary carriers supplied to the Committee at its last meeting is fine, but we would ask that you add the name of the primary insurance carrier. In addition, please include the closed claims information for 1984 and 1985 that is available but has not been put onto your computer since this will provide a fuller picture and will be more helpful. In addition, please have your staff clarify why certain doctors have multiple specialty codes listed in the same year for different claims.

   Ted Fay of your Department indicated this information could be available within ten days or so which will be appreciated.

2. Please provide the total medical malpractice premiums collected by insurers in the years 1979 through 1984 and the actual losses paid for these same years, as well as incurred losses. Some of this information appears in the March 13, 1985 report by your Department entitled "Kansas Medical Professional Liability Insurance."

3. Please provide additional information regarding your Department's zip code list of doctors that currently notes their specialty and insurer, to include the actual dollar premium and surcharge now paid and whether the surcharge is at the 80 percent or 110 percent level.

10/10-11/85
Attachment XII

4. Please send a copy of the pretrial questionnaires and pretrial orders for the 12 jury award cases levied against the Kansas Health Care Stabilization Fund (HCSF).

5. Please provide a list of the names of cases involving the HCSF in which settlement figures were closed. Please include the case number and the district court where the settlement was approved.

6. Please send a copy of the actuarial report, which the Committee was told was now available, predicting the impact of certain tort reforms prepared for the Fund.

Thank you for your attention to this matter. The next meeting of the Committee is scheduled for October 10 and 11. I need this information as soon as possible to prepare for this next meeting. Please send a copy of the materials you supply me to our Committee staff representative, Mike Heim of the Kansas Legislative Research Department. Please inform me as soon as possible if there is a problem in obtaining any of this information.

Sincerely,

Representative Joe Knopp, Chairman
Special Committee on Medical Malpractice

JK/MH/aem

STATE OF KANSAS

KANSAS
INSURANCE DEPARTMENT

420 S.W. 9th
Topeka 66612 913-296-3071

1-800-432-2484
Consumer Assistance
Division calls only

FLETCHER BELL
Commissioner

September 26, 1985

Honorable Joe Knopp, Chairman
Special Committee on Medical Malpractice
Representative, Sixty-Seventh District
410 Humboldt
Manhattan, Kansas 66502

Dear Chairman Knopp:

Upon receipt of your letter of September 17, 1985, we began to attempt to compile the information you requested and have also been in contact with Mike Heim of the Legislative Research Department.

We will comment upon your requests in the order contained in your September 17, 1985 letter:

1. Attached is an updated and revised exhibit of doctors, osteopaths and chiropractors that have had multiple closed claims made against them. This exhibit shows payouts by both the primary carriers and the Health Care Stabilization Fund, as well as the name of the primary insurance carrier. Closed claims records received but not yet entered into the computer record keeping system have been individually reviewed and when appropriate, added to the exhibit. We also reviewed those doctors listed with multiple specialty codes and found that all situations could be reduced to only one specialty code per doctor. Closed claims data for Kansas hospitals has not been furnished. We anticipate that a similar exhibit for hospitals would require four to six weeks to compile reliable data on the basis requested in your letter. If it is absolutely essential, we will attempt to compile the hospital closed claims information on the basis you have requested. In discussing this with Mike Heim, we pointed out that hospitals will have multiple claims by their very nature and were not deemed necessary to include in our original exhibit.

With regard to the enclosed exhibit for doctors we are again pointing out that the closed claims records furnished by the insurance carriers was not intended to be utilized for this purpose. If the department were to be interested in obtaining prior loss data or a specific health care provider, such loss information would be requested from the individual provider's insurance carrier(s). This method is more reliable since it would include open claims files, as well as closed claims information.

2. Since the requested information is not contained in our files, it will have to be obtained from the various insurance companies as we had previously done for our March 13, 1985 report which you referenced. Mike Heim offered to write to the insurance companies and we have given him the necessary information to do so;

3. We are enclosing an exhibit that does contain the information requested;

4. We are enclosing copies of the pre-trial orders that are contained in our office files. The pre-trial questionnaires are not kept in our office files but we are in the process of obtaining a copy from our attorney in the respective cases. We will send such copies to you as soon as they are received;

5. The list of cases requested is enclosed;

6. There are two different reports that contain information relative to this subject and a copy of each is enclosed;

7. We are also enclosing a copy of some information that may be of interest that was furnished to Mr. Jerry Palmer.

If we can be of any further assistance, please let us know.

Sincerely,

Fletcher Bell
Commissioner of Insurance

By Ron Todd
Ron Todd
Assistant Commissioner

RT:sc

Enclosures

STATE OF KANSAS

KANSAS
INSURANCE DEPARTMENT

420 S.W. 9th
Topeka 66612 913-296-3071

1-800-432-2484
Consumer Assistance
Division calls only

FLETCHER BELL
Commissioner

COPY

September 30, 1985

The Honorable Joe Knopp
Chairman, Special Committee on Judiciary
Capitol, Room 175-W
Topeka, Kansas 66612

Dear Mr. Chairman:

Mike Heim has asked me to address two areas concerning the multiple claims report for physicians furnished to you last Friday.

You will note that total loss and expense figures are only included in the far right hand column for those providers who had some payment made from the Health Care Stabilization Fund. These totals had to be done by hand and we did not complete the totals for cases only involving the primary carriers. We will provide these figures for you or you may simply wish to have staff add the figures shown for the cases that did not involve a HCSF payment.

Secondly, the Health Care Stabilization Fund loss and cost figures include all readily identifiable closed HCSF cases involving multiple claims for physicians. Please note that in order to get the relevant information to you as quickly as possible, we did not in every case include closed HCSF cases that resulted in no indemnity. Also, please note that an adjustment was made in some cases where there were multiple defendants all of whom contributed to the loss.

You will recall from my earlier letter that we have not furnished data on multiple claims by hospitals. However, given sufficient time, this information on hospitals can be made available if you deem it necessary.

Finally, we wish to emphasize that some of the closed claims data shown for the primary carrier are for cases that predate the HCSF. In these instances, there is no further information available for us to provide.

Very truly yours,

Fletcher Bell
Commissioner of Insurance

Ron Todd

Ron Todd
Assistant Commissioner

RT:mmk

R	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
	115	Shawnee Mission	1983	$100,00	$56,578	0	Surgery	$115,000	0	JO	Western Casualty & Surety	$271,578
			1984	0	0	0	Improper Care				Penn. Cas. Co	
	115	Halstead	1981	2,500	124	4	Improper Care				Medical Protective	
			1981	0	6,204	1,676	Surgery				Medical Protective	
	113	Kansas City	1981	0	1,864	393	Birth Control				Med. Pro.	
			1982	100,000	7,763	3,894	Incorrect Diagnose	180,000	10,661		Medical Protective	302,318

)R	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
	111	Topeka	1984	100,000	6,378	1,865	Incorrect Diagnose	500,000	0	SN	Medical Protective	606)485
			1984	100,000	4,620	2,139	Incorrect Diagnose	100,000	3,766	SN	Medical Protective	210,525
			1984	100,000	1,651	6,126	Incorrect Diagnose	50,000	0	SN	Medical Protective	158,777
	114	Overland Park	1980	16,000	7,730	2,248	Surgery				U.S. Fidelity & Cas.	
			1980	0	0	0	Improper Consent				St. Paul F & M	
	111	Leavenworth	1979	2,000	2,700	446	Improper Care				Med. Pro.	
			1980	144,375	6,900	2,001	Incorrect Diagnose	0	0	LV	Medical Protective	153,276

DR	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
5	111	Wichita	1984	200,000	7,095	11,127	Incorrect Diagnose	0	0		Med. Pro.	218,222
			1980	0	0	0	Incorrect Diagnose				"	
			1982	0	0	0	Incorrect Diagnose				"	
1	130	Leawood	1982	0	0	0	Falls				St. Paul F & M	
			1983	45,963	7,631	943	Prescription Error				"	
	113	Shawnee Mission	1984	0	0	0	Improper Care				Prof. Mut.	
		Merrian	1984	0	168	0	Miscellaneous				"	
		Overland Park	1980	0	2,665	0	Birth Related				"	
			1981	0	4,943	0	Post-Op Infection				"	
			1982	0	6,520	0	Improper Care				"	
			1983	0	17,436	0	Reaction to Drugs				"	

SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
112	El Dorado	1982	5,000	5,699	755	Incorrect Diagnose				St. Paul F & M	
		1982	0	500	0	Reaction to Drugs				"	
115	Wichita	1981	0	0	791	Surgery				St. Paul F & M	
		1983	14,000	3,434	0	Surgery				"	
112	Topeka	1981	0	4,908	409	Post-Op Infection				Med. Pro.	
		1982	0	2,197	121	Surgery				"	
		1985.	20,000	6,145	0	Surgery				"	
		1980	12,500	2,310	524	Surgery				"	
		1980	0	6,820	933	Improper Care				"	
114	Wichita	1978	0	0	0	Birth Related				Med. Pro.	
		1979	100,000	4,500	724	Anesthesiology	0	0		"	105,224

is doctor was previously listed as doctor L, 4U, and 4Y. All claims for this doctor now listed under 4Y.
is doctor was previously listed as doctor M and 4Q. All claims for this doctor now listed under M.

SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
112	Wichita	1982	15,000	3,045	184	Surgery				Medical Protective	
		1983	0	1,076	24	Psychiatric					
114	Kansas City	1981	0	0	0	Incorrect Diagnose				Medical Protective	
		1982	2,000	444	18	Improper Care				"	
		1983	0	7,523	1,928	Incorrect Diagnose				"	
114	Topeka	1983	60,000	0	274	Birth Related				West. C & S	
		1983	0	3,027	0	Birth Related				"	
		1983	0	23,300	0	Anesthesiology				"	
		1980	100,000	25,069	0	Incorrect Diagnose	0	0		"	125,069
111	Wichita	1980	0	0	0	Incorrect Diagnose				Medical Protective	
		1982	0	0	0	Incorrect Diagnose				"	

DR	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
	114	Leavenworth	1984	0							St Paul F & M	
			1982	5,667	12,045	0	Birth Control				West. C&S	
			1983	4,000	50	0	Reaction to Drugs				St Paul F&M	
	112	Coldwater	1982	24,000	2,399	795	Doctor's Advice				Med. Pro.	
		Salina	1982	0	5,035	1,207	Improper Care				"	
			1983	10,000	629	129	Birth Control				"	
	114	Overland Park	1980	0	0	185	Reaction to Drugs				West. C&S	
			1981	0	731	0	Birth Control				"	
			1982	0	2,196	0	Birth Related				"	
			1983	0	0	0	Birth Related				"	

SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
114	Shawnee Mission	1984	100,000	4,528	2,271	Surgery	25,000	0	WY	Med. Pro.	231,799
		1983	45,000	2,139	152	Surgery				West. C & S	
		1984	7,500	0	698	Surgery					
		1984	100,000	19,987	11,447	Surgery	123,170	0	JO	Med. Pro.	243,158
		1985.	200,000	1,230	147	Surgery	93,750	560	JO	"	295,687
115	Kansas City	1984	16,635	6,970	479	Improper Care				Med. Pro.	
		1983	100,000	4,368	3,380	Surgery	0	0	JO	Med. Pro.	107,748
		1979	0	0	0	Vasectomy				"	
		1978	0	3,130	203	Miscellaneous				"	
112	Iola	1981	0	2,448	482	Improper Care				Med. Pro.	
		1983	0	6,542	608	Improper Care				"	

VR	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
	114	Topeka	1981	80,000	35,592	0	Post-Op Infection				St Paul F&M	
			1982	1,000	2,042	0	Incorrect Diagnose				"	
	114	Overland Park	1981	1,000	265	7	Improper Care				Medical Protective	
			1981	0	1,037	18	Post-Op Infection				"	
			1983	2,500	0	0	Improper Care				"	
	111	Wichita	1980	10,000	628	214	Incorrect Diagnose				Medical Protective	
			1982	0	0	0	Incorrect Diagnose				"	
			1984	83,300	4,349	1,469	Incorrect Diagnose				"	

R	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
	112	Wichita	1984	0	0	846	Birth Control				St Paul F&M	
			1982	13,500	593	0	Improper Care				"	
	112	Iola	1982	0	8,371	1,757	Doctor's Advice				Med. Pro.	
			1983	50,000	3,656	789	Doctor's Advice				"	
			1984	0	0	0	Improper Care				St Paul F&M	
	114	Overland Park	1982	20,000	646	8,044	Improper Care				St Paul F&M	
			1981	0	0	0	Personal Injury				"	

?R	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
E	114	Salina	1984	3,500	4,681	1,049	Birth Related				Med. Pro.	
			1983	0	0	0	Personal Injury				"	
	115	Leawood	1983	15,000	8,747	264	Surgery				West. C&S	
			1983	15,000	3,729	0	Surgery				"	
	111	Hays	1980	0	0	0	Incorrect Diagnose				Med. Pro.	
			1981	35,000	3,575	1,129	Incorrect Diagnose				"	
	114	Junction City	1979	18,750	1,560	244	Surgery				West. C&S	
			1980	20,000	7,829	2,226	Miscellaneous				"	
	112	Topeka	1982	0	947	363	Improper Care				Med. Pro.	
			1983	0	0	114	Improper Care				"	

DR	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
JJ	114	Emporia	1978	0	0	0	Surgery				Med. Pro.	
			1980	7,500	0	0	Surgery				"	
			1980	18,000	0	0	Hysterectomy				"	
			1983	0	2,727	1	Birth Related				"	
KK	114	Hutchinson	1979	0	1,823	264	Hysterectomy				Med. Pro.	
			1979	51,250	10,231	4,037	Birth Related				"	
			1979	0	3,684	1,270	Birth Control				"	
		Overland Park	1982	0	0	176	Birth Control				West. C&S	
L	115	Hays	1980	0	0	0	Incorrect Diagnose				Med. Pro.	
			1983	0	2,581	336	Incorrect Diagnose				"	
			1979	2,500	125	0	Improper Consent				"	

?	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
1	111	Wichita	1982	0	0	350	Reaction to Drugs				St Paul F&M	
			1982	0	0	0	Reaction to Drugs				"	
	122	Sabetha	1982	0	16,470	0	Reaction to Drugs				Pro. Mutual	
			1980	3,121	0	641	Personal Injury				St Paul F&M	
	124	Kansas City	1980	1,250	3,112	0	Birth Control				Gulf Ins. Co.	
			1981	0	0	1,000	Doctor's Advice				"	

)R	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
)P	115	Wichita	1982	5,000	0	0	Improper Care				St Paul F&M	
			1983	7,500	0	658	Surgery				"	
			1985.	1,455	0	392	Surgery				"	
Q	115	Wichita	1983	17,500	6,482	1,713	Surgery				Med. Pro.	
			1985.	0	5,378	2,327	Surgery					
			1983	0	29,700	8,018	Improper Care				Med. Pro.	
R	115	Mission	1982	0	6,605	0	Surgery				St Paul F&M	
			1982	6,000	1,451	1,897	Surgery				"	
			1981	4,250	0	75	Doctor's Advice				"	
			1981	1,667	0	2,500	Vasectomy				"	
			1981	2,500	0	0	Anesthesiology				"	
			1981	0	0	0	Surgery				"	
			1979	2,000	0	0	Improper Consent				"	
	114	Great Bend	1984	0	0	0	Birth Related				St Paul F&M	
			1984	0	55,595	13,861	Birth Related				"	

R	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
T	115	Topeka	1984	0	742	0	Improper Care				Med. Pro.	
			1983	0	368	481	Surgery				"	
			1983	18,000	6,266	2,778	Surgery				"	
	113	Arkansas City	1983	12,500	6,979	0	Incorrect Diagnose				St. Paul F & M	
			1983	5,000	3,667	300	Incorrect Diagnose				"	
	111	Overland Park	1980	0	0	93	Birth Control				West C & S	
			1980	250	0	111	Incorrect Diagnose				"	
	115	Shawnee Mission	1984	0	1,765	0	Improper Care				St. Paul F & M	
			1982	0	0	0	Improper Care				"	

SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
111	Hays	1983	37,500	14,125	0	Incorrect Diagnose				Med. Pro.	
		1982	0	0	0	Incorrect Diagnose				"	
114	Kansas City	1979	1,000	0	0	Improper Care				Med. Pro.	
		1977	0	2,052	409	Improper Care				"	
114	Overland Park	1980	0	0	0	Surgery				St. Paul F & M	
		1981	4,505	20,560	20,000	Post-Op Infection				"	
		1981	11,000	0	16,700	Dental				"	
112	Topeka	1979	750	778	121	Reaction to Drugs				Med. Pro.	
		1980	25,500	2,710	215	Birth Related				"	

R	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
*	114	Wichita	1979	0	1,400	211	Incorrect Diagnose				Med. Pro.	
			1979	6,000	0	156	Incorrect Diagnose				"	
			1982	25,000	4,591	1,885	Surgery				"	
			1982	7,500	990	37	Improper Care				"	
			1984	41,250	1,726	6,525	Surgery				"	
	114	Lawrence	1982	10,000	147	0	Surgery				St. Paul F & M	
			1983	0	3,000	0	Surgery				"	
	114	Lawrence	1979	0	1,463	48	Surgery				Med. Pro.	
			1980	55,000	9,707	2,974	Surgery				"	

is doctor was previously listed as doctor XX and 40. All claims for this doctor now listed under XX.

R	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
E	111	Wichita	1980	0	0	0	Incorrect Diagnose				Med. Pro.	
			1982	0	0	0	Incorrect Diagnose				"	
	112	Lawrence	1980	0	8,661	1,113	Improper Care				"	
			1979	0	2,493	460	Doctor's Advice				"	
	122	Overland Park	1979	7,000	5,236	800	Birth Related				St. Paul F & M	
			1980	0	0	411					West C & S	
	112	Lawrence	1984	0	267	5	Incorrect Diagnose				Med. Pro.	
			1984	0	193	1,638	Incorrect Diagnose				"	

SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
116	Topeka	1978	1,500	342	0	Improper Care				St. Paul F & M	
		1979	1,750	2,140	404	Anesthesiology				"	
113	Topeka	1979	0	6,873	917					Med. Pro.	
		1980	0	0	0	Incorrect Diagnose				"	
113	Junction City	1981	100,000	67,145	0	Birth Related	300,000	47,902	Fed.Ct.	Western Casualty & Surety	515,047
		1982	10,150	2,186	616	Incorrect Diagnose					

DR	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
IL	113	Topeka	1979	0	6,874	916	Doctor's Advice				Med. Pro.	
			1979	2,500	1,455	234	Incorrect Diagnose				"	
			1980	250	457	42	Surgery				"	
			1980	20,000	385	47	Surgery				"	
1	114	Wichita	1980	1,100,000	22,719	0	Surgery	0	0	NO FILE		1,122,719
			1981	100,000	2,609	0	Surgery	225,000	1,102	SG	Medical Protective	328,711
			1981	34,000	2,038	0	Surgery	27,250	1,134			64,422
			1981	66,000	2,390	0	Surgery					
			1981	0	4,034	0	Surgery					
			1981	0	0	0	Surgery					
			1981	0	0	0	Incorrect Diagnose					
			1981	0	0	0	Incorrect Diagnose					
			1981	0	0	0	Incorrect Diagnose					
			1981	0	0	0	Incorrect Diagnose					
			1981	0	0	0	Incorrect Diagnose					
			1981	1,000,000	0	0	Incorrect Diagnose	0	0	NO FILE	West. C & S	1,000,000
			1983	25,000	18,049	0	Surgery				"	
			1984	75,000	24,272	666	Surgery				"	
			1984	100,000	21,395	0	Surgery	16,943	927	SG	Medical Protective	139,265

SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
112	Lenexa	1979	10,000	3,088	371	Reaction to Drugs				Med. Pro.	
		1979	50,000	68,000	0	Prescription Error				Gulf Ins. Co.	
		1979	25,000	17,873	4,608	Reaction to Drugs				Med. Pro.	
114	Topeka	1982	14,000	3,481	0	Birth Control				West. C & S	
		1982	15,000	0	972	Hysterectomy				"	
115	Prairie Village	1982	0	195	0	Miscellaneous				St. Paul F & M	
		1983	700	0	30	Surgery				"	
		1984	65,000	36,581	250	Surgery				West C & S	

SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
113	Topeka	1980	250	457	42	Surgery				Med. Pro.	
		1980	15,000	485	47	Surgery				"	
111	Topeka	1980	300	2,484	0	Incorrect Diagnose				Med. Pro.	
		1978	0	2,821	443	Post-Op Infection				West. C & S	
113	Arkansas City	1983	5,000	3,793	0	Incorrect Diagnose				West. C & S	
		1983	0	728	0	Surgery				"	
		1983	25,000	9,461	0	Incorrect Diagnose				"	
113	Shawnee Mission	1982	0	0	0	Improper Consent				St. Paul F & M	
		1984	0	0	0	Surgery				"	

SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
114	Pratt	1983	0	13,934	3,041	Incorrect Diagnose				Med. Pro.	
		1984	0	0	0	Incorrect Diagnose				St. Paul F & M	
		1984	0	0	0	Surgery				"	
		1984	11,000	2,515	8,397	Surgery				Med. Pro.	
		1985.	0	0	0	Miscellaneous				St. Paul F & M	
		1985.	0	0	0	Surgery				"	
125	Wichita	1983	100,000	7,975	0	Miscellaneous	32,500	0	SG	Professional Mutual	140,475
		1983	50,000	5,375	0	Improper Care				//	
		1984	100,000	4,118	0	Surgery	100,000	746	SG	Professional Mutual	204,864
		1980	0	0	0	Surgery					
115	Topeka	1980	0	3,536.47	0	Surgery				St. Paul F & M	
		1982	0	0	0	Incorrect Diagnose				"	

SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
115	Kansas City	1981	3,700	2,509	440	Doctor's Advice				Med. Pro.	
		1983	0	267	247	Surgery				"	
		1981	63,500	8,125	2,520	Surgery				"	
115	Topeka	1983	500	485	0	Incorrect Diagnose				St. Paul F & M	
		1981	0	6,983	88	Miscellaneous				West C & S	
114	Wichita	1979	0	1,076.70	105.60	Hysterectomy				St. Paul F & M	
		1979	11,700	1,602	507.11	Birth Related				"	
		1979	0	1,076	105.60	Hysterectomy				"	

R	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
	114	Fredonia	1980	0	12,827	0	Surgery				St. Paul F & M	
			1981	0	0	0	Birth Related				"	
	111	Kansas City	1982	42,500	23,846	0	Birth Related				"	
			1980	9,000	0	0	Surgery				"	
			1982	30,000	7,137	0	Surgery				"	
	112	Gardner	1980	0	0	0	Improper Care				"	
			1979	10,000	0	0	Surgery				"	
			1982	10,000	205	0	Birth Control				"	
			1983	50,000	10,723	205	Birth Related				"	
	111	Clay Center	1982	0	0	0	Improper Care				"	
			1982	10,000	1,000	0	Surgery				"	
			1984.	217.83	0	112,50	Birth Related				"	

)R	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
IE	115	Topeka	1984	0	100	163	Incorrect Diagnose				Med. Pro.	
			1981	0	1,084	81	Doctor's Advice				"	
			1983	0	3,202	611	Incorrect Advice				"	
			1983	0	1,228	511	Incorrect Adivce				"	
	115	Wichita	1981	0	0	93	Prescription Error				West C & S	
			1983	0	332	2	Surgery				Med. Pro.	
	112	Horton	1984	0	2,096	204	Improper Care				West. C & S	
			1981	0	2,716	216	Incorrect Diagnose				"	
			1981	2,500	0	34	X-Ray				"	
			1981	2,500	0	0	Improper Care				"	

IR	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
I	113	Hillsboro	1984	15,000	16,579	6,930	Miscellaneous				Med. Pro.	
			1984	0	1,569	6,000	Incorrect Diagnose				"	
	114	Overland Park	1984	0	14,521	4,682	Birth Related				Med. Pro.	
			1984	1,000	99	1,430	Birth Control				"	
	113	Topeka	1981	0	323	0	Improper Care				West C.& S	
			1982	2,200	2,076	0	Post-Op Infection				"	
	112	Hoisington	1981	45,000	500	0	Improper Care				St. Paul F & M	
			1981	0	487	0	Doctor's Advice				"	

DR	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
4L	114	Topeka	1981	1,000	2,039	337	Surgery				Med. Pro.	
			1983	7,500	1,776	273	Surgery				"	
4M	113	Kansas City	1980	0	0	185	Surgery				West C & S	
			1982	21,667	16,972	350	Surgery				"	
4N	113	Salina	1979	9	612.62	0	Surgery				St. Paul F & M	
			1980	0	13,894.01	0	Surgery				"	
40*												
4P	111	Prairie Village	1981	40,000	13,934	9,738	Surgery				Med. Pro.	
			1982	0	1,446	117	Incorrect Diagnose				"	
			1982	100,000	7,117	1,201	Improper Care	40,718	0	WY	"	149,036

*All claims for this doctor now listed under XX.

R	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
)*												
	113	Topeka	1981	0	1,512	0	Improper Care				St. Paul F & M	
			1981	0	0	0	Post-Op Infection				"	
			1981	15,000	0	0	Surgery				"	
			1982	343	0	0	Surgery				"	
			1983	0	0	100	Anesthesiology				"	
			1984.	0	0	0	Anesthesiology				"	
	111	Hutchinson	1979	0	641.62	68	Improper Care				West C & S	
			1979	0	120	68	Incorrect Diagnose				"	
	111	Ottawa	1982	0	0	75	Birth Related				St. Paul F & M	
			1984	500	1,484	68	Birth Related				"	

is doctor was previously listed under doctor M and 4Q. All claims for this doctor now listed under M.

?R	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
1U*												
1Y*	114	Kansas City	1982	0	2,595	348	Birth Related				Med. Pro.	
			1983	0	1,166	162	Birth Related				"	
			1979	0	6,576	855	Doctor's Advice				"	
			1979	1,000	444	39	Improper Care				"	
			1985.	25,000	5,954	559	Birth Related				"	
			1984	0	4,423	425?7	Birth Related				"	
7	114	Wichita	1978	25,000	4,132	1,541	Improper Care				Med. Pro.	
			1978	15,000	0	0	Surgery				"	
			1978	15,000	0	0	Surgery				"	
			1979	1,000	490	102	Hysterectomy				"	
1	111	Shawnee	1980	0	0	55	Personal Injury				Westc?C&S	
			1980	35,625	13,369	0	Doctor's Advice				St Paul F&M	
**	122	Eureka	1984	20,000		0	Incorrect Diagnose				Wes??C&S	
			1981	0	0	0	Birth Related				St Paul F&M	

This doctor was previously listed under 5B and 5D. All claims for this doctor now listed under 5B.
his doctor was previously listed under L, 4U, and 4Y. All claims for this doctor now listed under 4Y.

R	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
	115	Kansas City	1983	7,500	1,284	54	Surgery				Med. Pro.	
			1979	0	800	90	Incorrect Diagnose				"	
	115	Wichita	1978	0	15,231	3,345	Post-Op Infection				Med. Pro.	
			1979	35,000	4,801	1,924	Surgery				"	
			1979	0	90.75	0	Surgery				St. Paul F & M	
	111	Wichita	1980	200,000	11,932	4,067	Incorrect Diagnose	0	0	No File	Med. Pro.	215,999
			1982	99,000	2,525	437	Incorrect Diagnose				"	
			1982	100,000	1,313	213	Incorrect Diagnose	27,250	1,134	SG	"	129,910
			1982	100,000	1,262	219	Incorrect Diagnose	225,000	1,102	SG	"	327.583

)R	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
J	112	Kansas City	1979	0	0	0	Surgery				St Paul F&M	
			1979	0	0	0	Surgery				"	
K	114	Wichita	1982	0	672	50	Birth Related				Med. Pro.	
			1982	0	1,196	196	Birth Related				"	
L	113	Kansas City	1982	40,000	9,442	0	Surgery				St Paul F&M	
			1984	30,000	8,012	0	Surgery				"	

R	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
1	114	Wichita	1982	9,000	3,209	1,145	Improper Care				Medical Protective	
			1983	100,000	1,201	40	Surgery	750,000	5,074	SG	Medical Protective	856,315
			1984	90,000	8,367	18,653	Improper Care				Medical Protective	
			1984	100,000	9,822	3,449	Surgery	50,000	0	SG	Medical Protective	163,271
			1982	8,500	293	17	Surgery				Medical Protective	

ER	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
A	114	Kansas City	1982	9,500	2,515	469	Surgery				Med. Pro.	
			1983	200,000	12,373	8,207	Surgery				"	
B	111	Wichita	1981	0	1,288	0	Incorrect Diagnose				West. C & S	
			1982	0	0	0	Falls				St. Paul F & M	
	114	Topeka	1982	0	0	0	Hysterectomy				St. Paul F & M	
			1981	7,500	0	536	Hysterectomy				West. C & S	
			1983	145,000	18,000	0	Birth Related	0	0	SN	St. Paul F & M	163,000
			1984.	0	0	0	Surgery				"	
			1985.	202	0	0	Surgery				"	
			1985.	0	0	0	Birth Related				"	

)R	SPECIALTY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE	HCSF LOSS	HCSF COST	CNTY	INSURANCE CO	TOTAL LOSS AND EXPENSE
D	112	Ness City	1982	0	1,552	0	Improper Care				St. Paul F & M	
			1981	0	1,194	0	Miscellaneous				"	
			1981	0	0	0	Birth Control				"	
			1983	12,500	3,388	0	Birth Control				"	
	114	Kansas City	1984	0	0	0	Improper Care				Med. Pro.	
			1984	5,000	3,530	0	Improper Care				"	
	115	Shawnee Mission	1983	0	57	0	Surgery				St. Paul F & M	
		Overland Park	1984	0	4,525	0	Surgery				"	
		Merriam	1982	0	0	75	Falls				"	

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KANSAS HEALTH CARE STABILIZATION FUND

ACTUARIAL REVIEW OF

PROPOSED LEGISLATIVE CHANGES TO THE KANSAS

HEALTH CARE PROVIDERS INSURANCE AVAILABILITY ACT ON

FISCAL YEAR 1985/86 TO 1987/88 SURCHARGES

DRAFT REPORT

September 24, 1985

Prepared for: Kansas Insurance Department
Prepared by : DANI Associates, Inc.
Insurance Financial Services, Inc.

10/10-11/85
Attachment XIII

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BACKGROUND

The Kansas Health Care Stabilization Fund (hereafter referred to as "HCSF" or simply as the "Fund") began operation on July 1, 1976 pursuant to the Health Care Provider Insurance Availability Act ("HCPIAA" or "Act") -- Kansas statutes KSA Supp. 40-3401 to 40-3420 inclusive. The Act provides that each health care provider in the state must obtain a "basic coverage" professional liability insurance policy or must qualify as a self-insurer for basic coverage. Coverage may be on either a claims-made or an occurrence form.

A Health Care Provider Insurance Availability Plan ("HCPIAP" or "Plan") was also established by the HCPIAA and serves as a residual market mechanism for health care providers unable to obtain commercial insurance coverage. The HCPIAP operates, by mandate of law, on a no-profit/no-loss basis. At the end of each fiscal year, any surplus or deficit of the HCPIAP is transferred to/from the HCSF.

The HCPIAA established the HCSF as a segregated fund in the state treasury, to be administered by the Commissioner of Insurance, and held in trust to pay:

- losses in excess of basic coverage for active health care providers;
- basic and excess losses for inactive providers;
- attorney's fees in defending the HCSF against claims;
- reinsurance purchased by the HCSF;
- actuarial expenses;
- demands which might be made annually on the HCSF by the HCPIAP; and
- reasonable and necessary administrative expenses incurred by the HCSF.

The HCSF is funded by an annual surcharge levied on the active health care providers as a percentage of basic coverage premiums. In the case of health care providers self-insuring their medical liability exposure, the surcharge is based on the premium which would have been paid to the HCPIAP or in accordance with other statutory requirements.

For the period July 1, 1976 to June 30, 1984, basic coverage entailed limits of at least $100,000 per claim and $300,000 annual aggregate. The Fund operated on a modified "pay-as-you-go" basis in that surcharge dollars were collected as needed to meet annual disbursements subject to the maintenance of a $10,000,000 fiscal year-end cash balance. Surcharge rates applied during this period were capped at 65% annually and reflected, at various points in time, specific minimums for initial and total compliers with the Act. Coverage provided by the Fund was unlimited in excess of the commercially supplied or self-insured basic coverage.

Amendments to the HCPIAA effective July 1, 1984, introduced by Senate Bill 507, increased basic coverage to $200,000 per claim and $600,000 annual aggregate, and limited the Fund's liability to $3,000,000 per claim and $6,000,000 annual aggregate in excess of basic coverage. In addition, funding restrictions in the form of minimums or maximums previously applicable to HCSF cash balances and surcharge rates were removed. Premium surcharges under the amended Act are required to be deemed sufficient by the Commissioner to fund anticipated claims based upon reasonably prudent actuarial principles. Finally, provision was made to amortize any anticipated deficiencies in the Fund on this basis over a reasonable period of time.

Under the provisions of Kansas Senate Bill 110, effective July 1, 1985, 50% of punitive damage awards are to be credited to the HCSF and collateral sources of indemnification must be considered in determining damages sought on claims outstanding as of July 1, 1985.

Due to the continued increase in both the surcharge rate applied to primary coverage premiums and annual disbursements from the Fund, the Commissioner of Insurance has authorized the following study. Its purpose is to investigate the effects of implementing various legislative proposals in the attempt to stabilize and reduce the surcharge demands made on health care providers, as well as, the liabilities faced by the HCSF.

DANI Associates, Inc. and Insurance Financial Services, Inc. were engaged by the Commissioner to perform a study to:

1) Review and evaluate the HCSF surcharge needs, based on the implementation of legislative changes to revise the HCPIAA to incorporate certain provisions of the Indiana Medical Malpractice Laws as identified by spokesmen for the Commissioner. The implementation of these revisions was to be examined on both a prospective and retrospective basis. Coverage on a per incident basis in contrast to the current per policy basis was to be contemplated.

2) Provide actuarial projections of HCSF surcharge needs assuming prospective caps on awards of $750,000 and $1,000,000, rather than the $500,000 cap appearing in the Indiana law.

3) Provide actuarial projections of HCSF surcharge needs, assuming that a cap on awards would be supplemented by payments of future medical expenses subject to a separate limit. Due to time and budgetary constraints placed on this study, it was requested that we analyze only the effects of implementing a $1,000,000 cap on medical expenses along with a $500,000 cap on indemnity other than medical. These effects were to be examined on both a prospective and a retrospective basis.

Of the four coverage limit alternatives considered in this report, this option yielded the least reduction in the surcharge rate indications contained in the latest annual actuarial analysis of the HCSF's operations.

4) Review and evaluate the possible reduction of basic coverage premium rates derived from the implementation of specific provisions of the Indiana law in Kansas.

This report summarizes our findings to date and is presented initially in draft form for the Commissioner's review. We would be happy to undertake the additional analysis required to determine the effects of other coverage constraints. A final report will be prepared incorporating, to the extent possible, comments raised during the review of the draft report.

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SUMMARY OF RESULTS

The Commissioner of Insurance requested that the effect of implementation of the various coverage changes be analyzed on both a prospective and a retrospective basis. Four alternative means of implementing the changes are listed below in order of increasing initial surcharge reduction:

- o affecting all claims occurring on or after July 1, 1986
- o affecting all claims on policies issued on or after July 1, 1986
- o affecting all claims reported on or after July 1, 1986
- o affecting all claims outstanding as of July 1, 1986

It should be clear that the methods are also ranked in order of their increasing initial impact on the Fund's liability and differ only in their timing before the full benefits of the legislative changes are realized.

We have analyzed the effect of implementation on all claims occurring on or after July 1, 1986 (smallest initial reduction in surcharge) in satisfaction of the prospective requirement, and on all claims outstanding as of July 1, 1986 (largest initial reduction in surcharge) in satisfaction of the retrospective requirement.

We have estimated the effect of the following items on the Fund's required surcharge rates for fiscal years 1985/86 through 1987/88:

- o Provision of four alternative coverage limits:
  - $500,000 cap on indemnity awards
  - $750,000 cap on indemnity awards (prospective basis only)
  - $1,000,000 cap on indemnity awards (prospective basis only)
  - $1,000,000 cap on medical awards
    $500,000 cap on indemnity other than medical awards

- o Utilization of an arbitration system
- o Restriction of plaintiff attorneys' fees as they relate to the Fund's liabilities

The results of these analyses indicate that savings in the surcharge rate for fiscal year 1986/87, ranging from 5% to 10% based upon prospective implementation and from 20% to 50% based upon retrospective implementation, may be realizable over the surcharge rate set forth in our August 8, 1985, report. These indications are summarized in Exhibit 2 (prospective implementation) and Exhibit 3 (retrospective implementation). Exhibit 1 displays the surcharge indications presented in our August 8, 1985, report which were derived in accordance with the HCPIAA as it is currently constituted. We estimate that it would take 5 to 7 years longer to realize the full effects of the legislation if an occurrence as opposed to outstanding claim implementation is adopted.

The introduction of an arbitration system will impact the required surcharge both through its effect on the settlement process and through its effect on allocated loss adjustment expenses (ALAE) of primary carriers and the HCSF. Due to enforced arbitration for all claims, there may be a delay overall in the average time to settlement of claims. An examination of the State of Pennsylvania's experience with the encumbering effects of an arbitration system is warranted. The Commissioner may also wish to consult with State of Indiana authorities on characteristics of a successful arbitration system which they may have identified, such as the professional constitution of the panel and the number of individuals needed to avoid a claim backlog.

Depending on the features of the arbitration system Kansas chooses to implement, a significant reduction in allocated expenses may result. It should be noted however, that in consideration of the relative size of the ALAE component of the basic premium, a possible 20% - 30% reduction in ALAE would translate into a much smaller reduction in basic limits premium.

We have assumed in this report that the introduction of an arbitration system would reduce basic coverage premium by 6%. Since any reduction in basic limits premium based on an expense saving of the primary carriers leaves the Fund's loss liability unchanged, the presented surcharge rates are higher than those which would have been derived under an assumption of no savings in basic coverage premium.

We have considered the possible impact on the Fund's liabilities of capping plaintiff attorneys' contingent fees on awards made from the Fund's layer of coverage. No reductions in Fund surcharge rates based on capped fees have been introduced in this study due to the possibility that indemnity loss and contingent fees may be shifted between the primary carriers and the HCSF if the use of a two-tiered fee scale is permitted. Although the Fund provides both basic and excess coverage for inactive providers, we have assumed that this same two-tiered fee scale will be permitted in settling inactive provider claims.

The surcharges presented in this analysis contemplate Fund protection on a per incident basis. Previous analyses have contemplated protection on a per health care provider (per policy) basis. Determination of per incident surcharge rates required the simulation of the frequency with which provider limits adversely stack against the Fund. This process is analagous to the determination of the cost of clash cover purchased by the Fund. Legislation of statutory limitations on claimant awards on a per incident basis rather than a per policy basis affects three loss levels: basic losses, Fund losses, and losses in excess of statutory limits. First, a small reduction in basic losses results. In incidents involving multiple health care providers, the application of a per incident cap can prevent claimants from recovering the full basic coverage limit from each provider's policy. In such instances, it is assumed that the awarded statutory limit would be pro-rated among the policies involved. The resulting reduction in basic premium varies inversely with the difference between basic and statutory limits of liabilty.

Second, coverage in the Fund's layer is reduced in a similar manner but to a much greater extent. Third, it should be noted that implementation of the statutory limit on a per incident basis reduces the amount recoverable by claimants under a per policy system by approximately 10%.

On July 1, 1985, a 110% surcharge rate was adopted applicable to premiums on policies issued in fiscal year 1985/86. We have re-estimated required surcharges for fiscal year 1985/86 to reflect legislation effective July 1, 1986. The difference between collected surcharges and re-estimated required surcharges may be used either to reduce unfunded pre 7/1/84 liabilities (thereby spreading the effect of the savings over several years) or to effect a one time reduction in the otherwise indicated 1986/87 surcharge rate.

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DESCRIPTION OF ANALYSIS

The analytic methods used to arrive at the results contained in this report were patterned on those employed in our previous annual actuarial reviews of the HCSF in June, 1983, August, 1984, and most recently, August, 1985. Access to and familiarity with these reports would be helpful in providing additional background information for this analysis. For ease of review and understanding, we have presented only the surcharge and disbursement summaries of the various coverage scenarios. Supporting information can be provided upon request.

The attached exhibits summarize HCSF surcharge receipts and loss and loss adjustment expense disbursements under the various coverage scenarios. The surcharge receipts in the prospective funding of post 7/1/84 accrued loss and loss adjustment expense contemplate full discounted accrual funding of these liabilities (Part I of the exhibits). The retrospective funding of pre 7/1/84 accrued loss and loss adjustment expense contemplates the collection of surcharge dollars to offset the estimated payouts of these latter liabilities (Part II of the exhibits).

The current study makes use of the same information that underlies our August 8, 1985, indications which considered experience of the Fund through December 31, 1984.

ACCURACY OF RESULTS

While we believe our estimates are as accurate and reasonable as can presently be achieved, the prediction of present surcharge requirements based on future loss experience is necessarily an inexact science. The events which give rise to insurable losses are fortuitous and individually unpredictable. The ultimate settlement of these losses is further affected by inflation, social expectations, and other less predictable factors. The end result of these uncertainties is that the results as presented are our best estimates based upon mathematical expectations and the actual future experience of the Kansas Health Care Stabilization Fund may differ from the results we have calculated.

The computations leading to our projections of ultimate incurred losses and their payment over time involve many estimations. In our analysis, we have used those estimates we considered most accurate based upon the sources of information listed below. Our analysis included such reviews as we deemed necessary to ascertain the information's reasonableness and applicability; however, these reviews should not be construed to represent an independent audit or verification of the data contained in each of these sources. The sources used included:

- o magnetic tape files of HCSF claim information, supplied by the Kansas Insurance Department;*
- o HCSF financial reports supplied by the Kansas Insurance Department;*
- o magnetic tape file of HCSF premium and surcharge information, supplied by the Kansas Insurance Department;
- o recent malpractice basic and increased limits rate filings in the State of Kansas and countrywide of ISO and the major Kansas commercial carriers;

*DANI and IFS reconciled these two sources and found them to be consistent.

- the December 1980 Final Compilation of the Malpractice Closed Claim Study by the National Association of Insurance Commissioners (NAIC);
- Kansas Malpractice Closed Claim Summaries, supplied by the Kansas Insurance Department;
- Installment Payments Due in fiscal years 1985/86 through 1988/89 on claims arising prior to 7/1/84, supplied by the Kansas Insurance Department;
- reports to the Commissioner supplied by the Kansas Insurance Department;
- legislation pertinent to the HCPIAA; and
- Fiscal Year Annual Statements of the Kansas Health Care Provider Insurance Availability Plan.

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Exhibit 1

KANSAS HEALTH CARE STABILIZATION FUND

Projections Based on August 8, 1985 Report
Based on Current Provisions of the HCPIAA

Surcharge and Disbursement Summary ($000's)

	Fiscal Year 85/86	86/87	87/88
I. Based on the Prospective Funding of Post 7/1/84 Accrued Loss and LAE			
(1) Estimated $200,000/$600,000 Written Premium *	$22,230	$23,161	$24,010
(2) Indicated Required Surcharge Receipts	$16,620	$15,762	$18,733
(3) Indicated Surcharge Rate (2)/(1)	74.8%	68.1%	78.0%
(4) Projected Loss & LAE Disbursements	$ 440	$ 1,946	$ 4,356
II. Based on the Retrospective Funding of Pre 7/1/84 Accrued Loss and LAE			
(5) Indicated Required Surcharge Receipts	$ 7,626	$ 7,290	$ 6,063
(6) Indicated Surcharge Rate (5)/(1)	34.3%	31.5%	25.3%
(7) Projected Loss & LAE Disbursements	$ 7,626	$ 7,290	$ 6,063
(8) Estimated Ending Discounted Remaining Unfunded Liability	$26,415	$21,189	$16,530
III. Total			
(9) Indicated Surcharge Rate (3)+(6)	109.1%	99.6%	103.3%
(10) Projected Loss & LAE Disbursements (4)+(7)	$ 8,066	$ 9,236	$10,419

See Notes to Exhibits.

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KANSAS HEALTH CARE STABILIZATION FUND

Legislation Applicable To All Occurrences On or After July 1, 1986
Indemnity Capped At $500,000 Per Incident

Surcharge and Disbursement Summary ($000's)

	Fiscal Year 85/86	86/87	87/88
I. Based on the Prospective Funding of Post 7/1/84 Accrued Loss and LAE			
(1) Estimated $200,000/$600,000 Written Premium *	$22,230	$22,466	$22,689
(2) Indicated Required Surcharge Receipts	$16,620	$13,156	$11,835
(3) Indicated Surcharge Rate (2)/(1)	74.8%	58.6%	52.2%
(4) Projected Loss & LAE Disbursements	$ 440	$ 1,820	$ 3,959
II. Based on the Retrospective Funding of Pre 7/1/84 Accrued Loss and LAE			
(5) Indicated Required Surcharge Receipts	$ 7,626	$ 7,290	$ 6,063
(6) Indicated Surcharge Rate (5)/(1)	34.3%	32.4%	26.7%
(7) Projected Loss & LAE Disbursements	$ 7,626	$ 7,290	$ 6,063
(8) Estimated Ending Discounted Remaining Unfunded Liability	$26,415**	$21,189	$16,530
III. Total			
(9) Indicated Surcharge Rate (3)÷(6)	109.1%	91.0%	78.9%
(10) Projected Loss & LAE Disbursements (4)+(7)	$ 8,066	$ 9,110	$10,022

See Notes to Exhibits.

KANSAS HEALTH CARE STABILIZATION FUND

Legislation Applicable To All Occurrences On or After July 1, 1986
Indemnity Capped At $750,000 Per Incident

Surcharge and Disbursement Summary ($000's)

	Fiscal Year 85/86	86/87	87/88
I. Based on the Prospective Funding of Post 7/1/84 Accrued Loss and LAE			
(1) Estimated $200,000/$600,000 Written Premium *	$22,230	$22,536	$22,810
(2) Indicated Required Surcharge Receipts	$16,620	$13,780	$13,353
(3) Indicated Surcharge Rate (2)/(1)	74.8%	61.1%	58.5%
(4) Projected Loss & LAE Disbursements	$ 440	$ 1,821	$ 3,973
II. Based on the Retrospective Funding of Pre 7/1/84 Accrued Loss and LAE			
(5) Indicated Required Surcharge Receipts	$ 7,626	$ 7,290	$ 6,063
(6) Indicated Surcharge Rate (5)/(1)	34.3%	32.3%	26.6%
(7) Projected Loss & LAE Disbursements	$ 7,626	$ 7,290	$ 6,063
(8) Estimated Ending Discounted Remaining Unfunded Liability	$26,415**	$21,189	$16,530
III. Total			
(9) Indicated Surcharge Rate (3)+(6)	109.1%	93.4%	85.1%
(10) Projected Loss & LAE Disbursements (4)+(7)	$ 8,066	$ 9,111	$10,036

See Notes to Exhibits.

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KANSAS HEALTH CARE STABILIZATION FUND

Legislation Applicable To All Occurrences On or After July 1, 1986
Indemnity Capped At $1,000,000 Per Incident

Surcharge and Disbursement Summary ($000's)

	Fiscal Year 85/86	86/87	87/88
I. Based on the Prospective Funding of Post 7/1/84 Accrued Loss and LAE			
(1) Estimated $200,000/$600,000 Written Premium *	$22,230	$22,628	$22,930
(2) Indicated Required Surcharge Receipts	$16,620	$14,144	$14,226
(3) Indicated Surcharge Rate (2)/(1)	74.8%	62.5%	62.0%
(4) Projected Loss & LAE Disbursements	$ 440	$ 1,821	$ 3,969
II. Based on the Retrospective Funding of Pre 7/1/84 Accrued Loss and LAE			
(5) Indicated Required Surcharge Receipts	$ 7,626	$ 7,290	$ 6,063
(6) Indicated Surcharge Rate (5)/(1)	34.3%	32.2%	26.4%
(7) Projected Loss & LAE Disbursements	$ 7,626	$ 7,290	$ 6,063
(8) Estimated Ending Discounted Remaining Unfunded Liability	$26,415**	$21,189	$16,530
III. Total			
(9) Indicated Surcharge Rate (3)+(6)	109.1%	94.7%	88.4%
(10) Projected Loss & LAE Disbursements (4)+(7)	$ 8,066	$ 9,111	$10,032

See Notes to Exhibits.

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KANSAS HEALTH CARE STABILIZATION FUND

Legislation Applicable To All Occurrences On or After July 1, 1986
$1,000,000 Cap On Medical Expense
$500,000 Cap On Indemnity Other Than Medical Per Incident

Surcharge and Disbursement Summary ($000's)

	Fiscal Year 85/86	86/87	87/88
I. Based on the Prospective Funding of Post 7/1/84 Accrued Loss and LAE			
(1) Estimated $200,000/$600,000 Written Premium *	$22,230	$22,698	$23,050
(2) Indicated Required Surcharge Receipts	$16,620	$14,754	$15,887
(3) Indicated Surcharge Rate (2)/(1)	74.8%	65.0%	68.9%
(4) Projected Loss & LAE Disbursements	$ 440	$ 1,823	$ 4,021
II. Based on the Retrospective Funding of Pre 7/1/84 Accrued Loss and LAE			
(5) Indicated Required Surcharge Receipts	$ 7,626	$ 7,290	$ 6,063
(6) Indicated Surcharge Rate (5)/(1)	34.3%	32.1%	26.3%
(7) Projected Loss & LAE Disbursements	$ 7,626	$ 7,290	$ 6,063
(8) Estimated Ending Discounted Remaining Unfunded Liability	$26,415**	$21,189	$16,530
III. Total			
(9) Indicated Surcharge Rate (3)+(6)	109.1%	97.1%	95.2%
(10) Projected Loss & LAE Disbursements (4)+(7)	$ 8,066	$ 9,113	$10,084

See Notes to Exhibits.

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Exhibit 3
Page 1

KANSAS HEALTH CARE STABILIZATION FUND

Legislation Applicable To All Claims Outstanding At July 1, 1986
Indemnity Capped At $500,000 Per Incident

Surcharge and Disbursement Summary ($000's)

	Fiscal Year 85/86	86/87	87/88
I. Based on the Prospective Funding of Post 7/1/84 Accrued Loss and LAE			
(1) Estimated $200,000/$600,000 Written Premium *	$22,230	$21,308	$22,089
(2) Indicated Required Surcharge Receipts	$16,620	$ 6,930	$ 7,925
(3) Indicated Surcharge Rate (2)/(1)	74.8%	32.5%	35.9%
(4) Projected Loss & LAE Disbursements	$ 440	$ 1,013	$ 2,104
II. Based on the Retrospective Funding of Pre 7/1/84 Accrued Loss and LAE			
(5) Indicated Required Surcharge Receipts	$ 7,626	$ 3,332	$ 2,393
(6) Indicated Surcharge Rate (5)/(1)	34.3%	15.6%	10.8%
(7) Projected Loss & LAE Disbursements	$ 7,626	$ 3,332	$ 2,393
(8) Estimated Ending Discounted Remaining Unfunded Liability	$26,415**	$ 5,978	$ 4,146
III. Total			
(9) Indicated Surcharge Rate (3)+(6)	109.1%	48.1%	46.7%
(10) Projected Loss & LAE Disbursements (4)+(7)	$ 8,066	$ 4,345	$ 4,497

See Notes to Exhibits.

KANSAS HEALTH CARE STABILIZATION FUND

Legislation Applicable To All Claims Outstanding At July 1, 1986
$1,000,000 Cap On Medical Expense
$500,000 Cap On Indemnity Other Than Medical Per Incident

Surcharge and Disbursement Summary ($000's)

	Fiscal Year 85/86	86/87	87/88
I. Based on the Prospective Funding of Post 7/1/84 Accrued Loss and LAE			
(1) Estimated $200,000/$600,000 Written Premium *	$22,230	$21,771	$22,569
(2) Indicated Required Surcharge Receipts	$16,620	$12,317	$14,277
(3) Indicated Surcharge Rate (2)/(1)	74.8%	56.6%	63.3%
(4) Projected Loss & LAE Disbursements	$ 440	$ 1,870	$ 4,024
II. Based on the Retrospective Funding of Pre 7/1/84 Accrued Loss and LAE			
(5) Indicated Required Surcharge Receipts	$ 7,626	$ 5,010	$ 3,900
(6) Indicated Surcharge Rate (5)/(1)	34.3%	23.0%	17.3%
(7) Projected Loss & LAE Disbursements	$ 7,626	$ 5,010	$ 3,900
(8) Estimated Ending Discounted Remaining Unfunded Liability	$26,415**	$11,467	$ 8,289
III. Total			
(9) Indicated Surcharge Rate (3)+(6)	109.1%	79.6%	80.6%
(10) Projected Loss & LAE Disbursements (4)+(7)	$ 8,066	$ 6,880	$ 7,924

See Notes to Exhibits.

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KANSAS HEALTH CARE STABILIZATION FUND

Notes to Exhibits

* The modest growth in the basic written premium (Exhibit 1) reflects rate changes which can be reasonably anticipated based on primary carriers' past filing activities. Although the reflection of investment earnings and competitive pressures serve to contain basic premium costs, increases in both the frequency and severity of loss will continue to overshadow these cost containment forces.

Reductions in basic premiums attributable to ALAE savings and the exhausting of statutory coverage limits through the stacking of primary policies represent a one time savings (see Summary). Under a retrospective implementation (Exhibit 3), these savings will be sufficient to temporarily counteract the otherwise indicated growth in premiums. The full benefit of these savings are achieved more slowly under a prospective implementation (Exhbit 2), and hence the effect on basic premiums is less apparent.

** Because a portion of the fiscal year 85/86 liabilities, which varies by coverage and implementation method, will be affected by proposed legislation, we estimate that the following percentage savings of 85/86 basic written premium ($22.230 million) will be realized. As noted in the Summary, these savings can be used to reduce the estimated unfunded pre 7/1/84 liabilities.

Exhibit 2, Page 1	3.1%
Exhibit 2, Page 2	2.7%
Exhibit 2, Page 3	2.5%
Exhibit 2, Page 4	2.1%
Exhibit 3, Page 1	72.7%
Exhibit 3, Page 2	28.6%

NATIONAL DIVISION

REPORT TO THE COMMISSIONER OF INSURANCE
REGARDING THE
KANSAS HEALTH CARE STABILIZATION FUND

FINAL REPORT

February 22, 1985

10/10-11/85
Attachment XIV

NATIONAL DIVISION

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NATIONAL DIVISION

BACKGROUND

The Kansas Health Care Stabilization Fund (referred to hereafter as "HCSF" or simply as the "Fund") began operation on July 1, 1976 pursuant to the Health Care Provider Insurance Availability Act (the "Act"). The Act provides that each health care provider in the State must obtain a "basic coverage" professional liability policy or qualify as a self-insurer. The requisite basic coverage may be on either a claims-made or occurrence form and must carry the limits established by statute.

The Fund was established by the Act to be administered by the Commissioner of Insurance, and to provide for:

- losses in excess of the basic coverage limits for active health care providers;
- basic and excess losses for inactive providers;
- attorney's fees in defending the Fund against claims;
- reinsurance purchased by the Fund;
- actuarial and other administrative expenses; and
- demands which might be made annually on the Fund by the Insurance Availability Plan (the "IAP" or "Plan").

The Fund's revenues consist of income derived through an annual surcharge levied on active health care providers as a fixed percentage of their basic coverage premiums and income earned on the Fund's investments. In the case of health care providers self-insuring their basic coverage, the surcharge is based on the premiums which would have been paid to the IAP.

The basic coverage limits of liability from the Fund's inception through June 30, 1984 were $100,000 per claim and a $300,000 annual aggregate. The Fund provided unlimited coverage for any loss exceeding the basic coverage amounts and operated on a modified "pay-as-you-go" basis during these years. The surcharge determination provided for expected annual disbursements subject to the maintenance of a fiscal year cash balance of $10 million. Surcharge rates applied during this period were capped at 65% annually and reflected, at various points, specific minimums for initial and total compliers with the Act.

Amendments to the Act, effective July 1, 1984, increased the basic coverage to $200,000 per claim and $600,000 in the aggregate. The excess cover provided by the Fund above the basic coverage amount was limited to $3 million per claim with a $6 million aggregate. Minimum and maximum restrictions for surcharge percentages and the Fund's cash balances were removed. The surcharge determination was modified so that the amount collected each fiscal year would be sufficient to fund the HCSF's expected incurred losses and loss adjustment expenses for that year. In addition, amounts sufficient to fund the accrued liabilities on claims reported or occurring prior to 7/1/84 (but which remained unsettled as of June 30, 1983) were to be amortized over a ten year period. A condition imposed on this latter funding was that the portion of the Fund balance at the beginning of any fiscal year together with the portion of that year's surcharge attributable to pre 7/1/84 liabilities would be sufficient to meet disbursements due to these liabilities during the year.

The Act stipulates that an actuarial review be performed annually to assist the Commissioner of Insurance in fulfilling the statutory responsibilities. For the past two fiscal years, the National Actuarial Services Division of Fred. S. James & Co., Inc. was engaged to provide the necessary actuarial assistance to the Commissioner. Recent events, in the form of very large claim settlements, substantially increased premium costs for basic and Fund coverage, and heightened awareness of financial difficulties facing professional liability insurers in other states, have focused attention on the medical malpractice situation in the State of Kansas. This report, prepared in response to the Commissioner's request, presents an updated evaluation of the adequacy of the combined 80% surcharge for the current fiscal year, as well as, recommendations designed to assure the Fund's continued viability. Because of timeframe and cost constraints imposed by the Department, we have not included detailed exhibits which support our conclusions and recommendations. Additional detail underlying the enclosed summary exhibits may be provided at the Department's request. Our final report has been prepared, incorporating to the extent possible, comments raised by the Department in its review.

SUMMARY OF RESULTS

The scope of our review and the analytic methods used in this report are similar to those involved in our previous actuarial studies. Descriptions of these methods are not included within this report and access to our June, 1983, and August, 1984 reports would be helpful in providing additional background to the current analysis.

Our interpretation of the funding requirements for HCSF's liabilities was that they differed slightly from those imposed on commercial insurers. Commercial insurers' ratemaking techniques provide for the use of past experience but their rates are prospectively applied. If losses (or profits) were incurred during the past periods, insurers are not permitted to recoup these losses nor reimburse these profits to policyholders through adjustments in their prospective rates. Although the accrual funding for the HCSF in each fiscal year is intended to provide for all claims arising during the year, any inadequacies existing in reserves carried for past fiscal years, can be considered in the surcharge calculation for the upcoming year. Likewise, if a surplus appears to be present, then the surcharge again can be appropriately adjusted. This interpretation is important in reviewing the current financial condition of the Fund, in that, small variations in reserve adequacy are not unduly problematic because of their specific treatment each year.

The Fund's financial condition for the current fiscal year appears to be reasonably sound, if the interpretation of the surcharge computation given

above is accepted. A projection of the Fund's annual balance at June 30, 1985, is given within Exhibit 1 at the conclusion of this section. Note that although the current projected level of surcharge collections is somewhat less than the original projection contained in the most recent actuarial report, it is anticipated the Fund will have sufficient income to meet its claim payments and administrative expenses while still building a reserve position for the accrual of the 1984/85 fiscal year liabilities. Important items underlying these findings include:

- The loss projections for the Fund considering experience evaluated through November, 1984, appear to be in line with our indications in the most recent analysis. The reserves originally projected to be available as of June 30, 1985, anticipated full accrual funding of fiscal year 1984/85. Inadequacies in these reserve levels can be corrected in the calculation of the surcharge required for fiscal year 1985/86.

- A number of funding options were considered and carefully reviewed to bring the periods prior to July 1, 1984 to a full accrual basis. In order to reduce the magnitude of the surcharge burden to the lowest level consistent with the earliest possible achievement of accrual funding, the Department opted for a modified "pay-as-you-go" ten year funding strategy. The surcharge applicable for early years of this funding considers only paid losses. Accrual reserves were not contemplated for these periods as of the end of the current fiscal year.

- Any potential shortfall in the Fund's anticipated revenues may be primarily attributable to a shift in the market share of two commercial insurers -- St. Paul and Medical Protective Company -- during calendar years 1983 and 1984. A reversal of their respective market shares over the two calendar years could not have been reflected in analyses conducted prior to July 1984, due to time lags associated with the production of Annual Statement Page 14 data and rate filings from the Medical Protective Company. Information specifically provided by the Department for this review showed 50% and 35% market shares for Medical Protective and St. Paul, respectively. In sharp contrast, rate filings and 1982 Page 14 data, which were the latest available as of the July 1, 1984 surcharge calculation, suggested 30% and 55% market shares. The end result is that based on November 30, 1984 accounting information, our projection of basic coverage premium volume for fiscal year 1984/85 could prove to be overstated which would lead to an overstatement in surcharge collections. An unusual lag in the processing of surcharge collections affecting November 30th accounts which has recently come to light, however, serves to improve the comparison between original and recast estimates.

- Medical Protective's rates for physicians and surgeons are presently as much as 35% below St. Paul's rates. However due to differences in the companies' philosophies, operating

characteristics and distribution of writings, care must be exercised in drawing conclusions regarding either the relative or absolute adequacy of their rate structures. Rates are promulgated by insurers and are regulated by the Department in compliance with a standard of reasonableness which demands that they not be excessive, inadequate, or unfairly discriminatory. Notwithstanding this requirement, judgments and healthy competitive needs rightfully play a significant role in the practice of insurance pricing. A review of filings by these companies recently provided to us does not suggest any deviations from accepted standards and practice. Owing to a marked lack of consistency in the referencing, presentation and manipulation of information in the filings, however, it is not always possible to determine the relative degree of influence ascribable to their judgmental and competitive pricing elements. Unfortunately, the sporadic nature of formal independent company filings, the roles judgment and competition play in these filings, and the unsettling influence of current promulgated rates on future market composition make the forecasting of the size and adequacy (from the perspective of the Fund, not that of primary carriers) of the basic coverage premium base to which the Fund's surcharge rates are applied rather difficult.

The relationship of basic and excess coverage is treated in greater depth in the next section of our report.

KANSAS HEALTH CARE STABILIZATION FUND

Exhibit 1

Estimated 6/30/85 Ending Fund Balances As Evaluated at 11/30/84 (in $000's)

	Value as of 11/30/84	Extrapolated Value as of 6/30/85	Projected 6/30/85 Value Based on 12/31/83 Data*	Indicated Difference
(1) Basic Coverage Written Premium	$ 7,630	$ 14,534	$ 17,922	$ (3,388)
(2) Surcharge Collections at 80% of (1)	$ 6,104	$ 11,627	$ 14,338	$ (2,711)
(3) Other Income**	$ 440	$ 951	$ 959	$ (8)
(4) Subtotal Receipts	$ 6,544	$ 12,578	$ 15,297	$ (2,719)
(5) Loss and Loss Adjustment Expenses Paid	$ 3,193	$ 7,997	$ 8,658	$ (661)
(6) Other Disbursements***	$ 797	$ 2,349	$ 1,410	$ 939
(7) Subtotal Expenditures	$ 3,990	$ 10,346	$ 10,068	$ 278
(8) Addition to Fund Balance (4)-(7)	$ 2,554	$ 2,232	$ 5,229	$ (2,997)
(9) Fund Balance as of 7/1/84	$ 7,283	$ 7,283	$ 5,854	$ 1,429
(10) Fund Balance as of 7/1/85 (8)+(9)	$ 9,837	$ 9,515	$ 11,083	$ (1,568)

* Based on our 8/17/84 report to the HCSF "Actuarial Review of Fiscal Year 1984/85 -- 1986/87 Surcharges".
** Investment income and reimbursements.
*** HCIAP payments and HCSF administrative expenses.

NATIONAL DIVISION

RECOMMENDATIONS

Rating Base Considered in Determining the Fund's Surcharge

Since the Fund's inception, two major assumptions have been made in calculating annual surcharge rates.

The first assumption involves the projection of total premiums for basic coverage during an upcoming fiscal period. The method used in making the projection considers the number of active health care providers and their average premiums. The latter reflects a composite of the approved rate levels by insurer, weighted by their respective market shares as illustrated by the most recent information at our disposal -- provided rate filings and Page 14 data compiled from convention blanks. The assumption is made that marked departures from past rate levels and market shares will not occur in a relatively short timeframe; hence future average premiums can be reasonably computed in the described manner from past experience. If insurers' rate levels are comparable, then any market shift would have little effect on the Fund's revenues. In the case of widely different rate levels, since surcharges are prospectively applied as a fixed percentage of charged basic coverage premiums, the Fund is adversely affected by any dramatic and unforeseen increase in the market shares of lower rated companies.

The second major assumption is related to the first and involves the overall adequacy of commercial insurer's basic coverage rate levels. For lack

of detailed information (other than dated rate filings), an assumption is made that the underlying coverage is adequately rated. However, each primary insurer charges basic coverage rates which it deems appropriate and adequate given its unique data problems, classification mix, competitive position, expense needs, etc. To the extent that any particular insurer's basic coverage rate is not, or does not remain, fully adequate, it becomes more difficult to accurately forecast the Fund's excess liabilities since they are projected from the expected losses underlying basic coverage premiums. Obviously, any undetected inadequacies in the basic coverage premiums will result in the use of understated permissible loss ratios in the derivation of these expected basic coverage losses.

Furthermore, at current and foreseeable basic premium and surcharge levels, the Fund's layer of responsibility (viewed in terms of income) is nearly the size of the underlying basic coverage layer, but its liabilities are considerably more volatile than those of the primary layer. Thus any rate inadequacies in the basic coverage layer would not only be extended to the Fund's excess layer, but they would be magnified.

Lastly, with each movement in the basic coverage limit of liability (such as that effected on July 1, 1984) the overall adequacy of commercial insurers' rate levels becomes more difficult to ascertain due to the reduced credibility that must be attached to their independent assessments of their rate needs.

To be in the best position to project and fund its excess coverage liabilities, the Fund should ideally draw its own conclusions regarding the expected levels of basic coverage losses which underlie them. As a consequence, a unique set of actuarially determined basic coverage rates could be established which would be applicable: on a statewide basis; by type of provider and specialty; and to insureds and self-insureds alike. Surcharge collections would be based on these rates. It is important to note that we are not proposing that a single rate level be used by all insurers for primary coverage in the State, only that one rate level be used as a basis for projecting the Fund's liabilities and generating the Fund's revenues.

The primary advantage of this approach is that the the Fund will receive more predictable revenues which are not tied to either the competitive needs of commercial insurers or the adequacy of their independently determined rate levels. An additional advantage would be that the competitive postures of commercial insurers would not be enhanced or diminished by the magnitude of the Fund's surcharge. Each insured of a given specialty would be charged the same premium for the Fund's coverage regardless of the rates charged by their basic coverage insurer (the same holds true for self-insureds). Finally, the degree of control which the Department would be able to exercise in protecting the Fund's financial position would be greatly enhanced.

The determination of this one rate level for the Fund would require a significant change in the Fund's existing statutorily defined authority and

an analysis of statewide basic coverage exposure, premium, loss and expense statistics in provider type and classification detail. Reference to regional and countrywide information would be made only to the extent deemed appropriate and necessary. The choice of methods and assumptions to be employed in analyzing this basic coverage database would most properly fall within the scope of the Fund's annual review of its excess coverage layers.

Investigation into specific problem areas likely to be encountered in the specification, securing and implementation of a statewide basic coverage database does not fall within the scope of this report.

Limitation of the Fund's Losses

The Fund's coverage, prospectively and/or retrospectively, can be limited through the use of any or all of a number of options, including:

- legislative revision of the Fund's unlimited coverage prior to July 1, 1984, and/or the $3 million coverage after July 1, 1984;
- legislation limiting future awards to a fixed statutory figure (i.e., comparable to Nebraska's and Virginia's caps of $1 million per claim, including punitive damages); or
- reinsurance protection, whereby amounts in excess of the policy retention are borne by the reinsurers.

The objective of limiting large claims is to help maintain the short-term and long-term financial viability of the Fund by dampening the effect of fortuitous and catastrophic losses. Although each option helps achieve the objective, the political ramifications of transferring the responsibility for the portion of losses in excess of the selected limitation away from the Fund must be considered. The advantages of a legislative cap (either of the first two options) are administrative ease and cost. The burden, however, is placed on health care providers to obtain protection or remain uninsured for coverage previously provided by the Fund. This may be attractive to many health care providers who feel they do not need and should not have to bear the cost of the substantial limits provided by the Fund. Special attention to the needs of inactive providers would be required since they do not pay for the coverage afforded them by the Fund.

Although the purchase of reinsurance would ease the problem of transferring responsibility to health care providers, there is an additional cost involved in this option not present in the others. The following axiom of reinsurance pricing always holds true -- "the reinsured will, in the long run, pay its own losses plus the reinsurer's expenses and profit margin".

In reinsurance terms, this axiom refers to the direct loading for expenses and contingencies of the cedant's burning rate. The burning rate is determined as the ratio of the cedant's burning cost, or past actual losses

for the layer it wishes to cede, to its subject premium. The burning cost for the Fund would be that portion of its liabilities that it would desire to reinsure. The Fund's subject premium would be best related to the basic coverage premium underlying its surcharge. Because surcharge collections have been subject to various constraints and changes in purpose over time, they do not offer a desirable premium base. We consider an expense and contingency loading of 100/75 to be representative of that which the Fund would most likely encounter in reinsuring its medical professional liabilities. This fraction, when multiplied by the Fund's burning rate, implies a loading for expenses and contingencies of 33 1/3% on the losses ceded by the Fund. Note that as an agency representing the entire State, the Fund has some bargaining power to minimize, but not eliminate, the loading on its losses.

Exhibit 2, which follows, summarizes the expected losses eliminated by limiting the Fund's liabilities at various points. Due to the complexity of the manner in which reinsurance markets and rates are determined at any point in time, quotes of specific reinsurance costs and loadings cannot be included within this report. However, the discussion in the preceding paragraph is generally illustrative of the reinsurance pricing process. Once again, these recommendations are purely conceptual and can be given additional structure as more direction is provided by the Department over the next few months. For purposes of this report, it is sufficient to reiterate that the option to purchase reinsurance is more costly to the Fund than legislative actions.

KANSAS HEALTH CARE STABILIZATION FUND

Exhibit 2

Estimated Effects of Retroactive Caps
on the Fund's Liabilities
(in $000's)

Fiscal Years	Estimated Ultimate Undiscounted Loss and Loss Adjustment Expense Liabilities	Estimated Reduction In Expected Level Ultimate Liabilities Relative to Scenario A	Estimated Ultimate Discounted Loss and Loss Adjustment Expense Liabilities++	Estimated Reduction In Expected Level Funding Relative to Scenario A+++
		Scenario A*		
Prior to 7/1/84	$ 46,757	---	$ 35,569	---
7/1/84 - 6/30/85+	14,224	---	9,014	---
Total	$ 60,981	---	$ 44,583	---
		Scenario B**		
Prior to 7/1/84	$ 41,158	$ 5,599	$ 31,361	$ 4,208
7/1/84 - 6/30/85+	14,224	0	9,014	0
Total	$ 55,382	$ 5,599	$ 40,375	$ 4,208
		Scenario C***		
Prior to 7/1/84	$ 31,879	$ 14,878	$ 24,866	$ 10,703
7/1/84 - 6/30/85+	10,449	3,775	6,836	2,178
Total	$ 42,328	$ 18,653	$ 31,702	$ 12,881

* Current HCSF coverage which is unlimited relative to $100,000 basic coverage for pre 7/1/84 liabilities and provides for a $3 million layer of coverage relative to $200,000 basic coverage for post 7/1/84 liabilities.

** Alternative HCSF provision of a $3 million layer of coverage relative to $100,000 basic coverage for pre 7/1/84 liabilities and a $3 million layer of coverage relative to $200,000 basic coverage for post 7/1/84 liabilities.

*** Alternative HCSF provision of a $1 million layer of coverage relative to $100,000 basic coverage for pre 7/1/84 liabilities and a $1 million layer of coverage relative to $200,000 basic coverage for post 7/1/84 liabilities.

\+ Including the portion of fiscal year 7/1/83-6/30/84 which is unearned as of 7/1/84.

++ Discounted to 7/1/84 based upon an interest rate assumption of 8%.

+++ If the reduction in funding is accomplished through reinsurance, the indicated savings must be reduced to reflect the reinsurers' risk margins and expenses.

Additional Reinsurance Protection

The preceding discussion concentrated on a specific type of reinsurance -- excess of loss. This type of coverage is straightforward, in that, it reimburses the Fund for the portion of loss in excess of the selected retention. Legal and other expenses associated with the direct handling of the claim can be included as part of the loss or shared pro-rata based on the Fund's and the reinsurer's respective loss shares.

Other reinsurance protection may be available. These additional coverages may not be as directly involved with the Fund's claim process but provide for greater financial stability of the Fund and always at a cost.

- Multiple Insureds Involved in a Single Occurrence ("Clash Cover") -- It is our understanding that the Fund's coverage applies in excess of each health care provider's basic coverage policy, that is, separate limits are at stake for each and every provider in the State. If a number of providers are involved in a single occurrence, the Fund's limit of liability may be equal to the sum of each of the limits (i.e., with a $3 million limit and five providers, the Fund's liability may be as high as $15 million). Reinsurance can be structured so that the Fund's maximum liability per occurrence is capped at a selected retention, regardless of the number of providers involved. Excess of loss protection differs from clash cover because the former would apply generally to losses per health care provider.

Pricing of clash cover requires information regarding provider claim frequencies and their joint distribution. This information could not be readily assembled from existing data sources available to us at this time, however it could be obtained in order to evaluate specific proposals made to the Department by reinsurers.

- Aggregate Stop Loss -- This protection would provide reimbursement for all payments in excess of an amount (i.e., the "stop") selected for a given fiscal year. For fiscal years 1984/85 and subsequent, this reinsurance could be structured so that the stop would apply at some dollar value in excess of accrued discounted liabilities. The larger dollar value would account for anticipated investment income to the Fund. Any payments made by the Fund in excess of the stop would be reimbursed on a dollar-for-dollar basis subject only to the policy limits of the reinsurance treaty. Specific aggregate proposals are susceptible to evaluation based on simulation and modelling of the Fund's liabilities.

- Cash Flow Protection -- A relative newcomer, this type of reinsurance could provide protection against an unusually large and unexpected fiscal year disbursement. If the retention is established at or near the Fund's anticipated revenues (surcharge premiums, investment income, etc.) for the fiscal year, then financial viability could be assured.

Layering of the Fund's Coverage

The utilization of optional layered coverage in excess of a reduced mandatory Fund coverage layer would be quite advantageous to both the Fund and Kansas health care providers.

Structuring of reinsurance to match offered optional layers would most equitably allocate costs to those providers desiring catastrophic coverage. In return, these same providers are benefited through the use of their collective bargaining power (in the form of the Fund) to secure and maintain a market for excess of loss protection. The Fund's liabilities are most clearly reduced and stabilized by any program which allows it to pass the cost of afforded high excess of loss protection on to the recipients of this protection. An additional benefit may however accrue to the Fund through the use of such programs because of its reduced profile in claim actions. The use of a relatively small mandatory layer (e.g. - $1 million) would simultaneously result in a reduced tendency to view the Fund as a "deep pocket" and would provide a smaller, well publicized target for plaintiffs.

The greatest disadvantage offered by such a program would involve the administrative burden placed on the Fund to account for the optional covers and reinsurance receivables. Marketing and negotiating efforts needed to assure the continued availability and affordability of the reinsurance-backed optional layers would likewise fall on the Fund.

Other Legislative Considerations

Redefinition of the Fund's liabilities through legislative action in the area of tort reform would be of some benefit. Specific scheduling of plaintiff attorneys' fees, recognition of collateral sources of recovery, or limitation of non-pecuniary losses are, in order, increasingly likely to reduce the Fund's liabilities but are decreasingly susceptible to precise quantification of their effects.

In light of the Fund's predominant involvement with liabilities in excess of those of basic coverage providers, it should also be observed that the Fund would be most benefited by any legislated changes which would serve to dampen the leveraged effect of inflation it faces. The periodic increase of the basic coverage limit, as has been discussed in our earlier reports, has exactly this effect.

ACCURACY OF RESULTS

While we believe our estimates are as accurate and reasonable as can presently be achieved, the prediction of present surcharge requirements based on future loss experience is necessarily an inexact science. The events which give rise to insurable losses are fortuitous and individually unpredictable. The ultimate settlement of these losses is further affected by inflation, social expectations, and other less predictable factors. The end result of these uncertainties is that the results as presented are our best estimates based upon mathematical expectations and the actual future experience of the Kansas Health Care Stabilization Fund may differ from the results we have calculated.

The computations leading to our projections of ultimate incurred losses and their payment over time involve many estimations. We have used those estimates in our analysis we considered most accurate based upon the following sources of information. Our analysis included such reviews as we deemed necessary to ascertain the information's reasonableness and applicability; however, these reviews should not be construed to represent an independent audit or verification of the data contained in each of these sources. The sources used included:

- magnetic tape files of HCSF claim information, supplied by the Kansas Insurance Department*;
- HCSF financial reports supplied by the Kansas Insurance Department*;

*James reconciled these two sources and found them to be consistent.

- magnetic tape file of HCSF premium and surcharge information, supplied by the Kansas Insurance Department;
- recent malpractice basic and increased limits rate filings in the State of Kansas and countrywide by ISO and the major Kansas commercial carriers;
- the December 1980 Final Compilation of the Malpractice Closed Claim Study by the National Association of Insurance Commissioners (NAIC);
- Kansas Malpractice Closed Claim Summaries, supplied by the Kansas Insurance Department;
- Installment Payments Due in fiscal years 1984/85 through 1988/89 on claims arising prior to 7/1/84, supplied by the Kansas Insurance Department;
- reports to the Commissioner, supplied by the Kansas Insurance Department;
- legislation pertinent to the HCPIAA; and
- Fiscal Year Annual Statements of the Kansas Health Care Provider Insurance Availability Plan.

ATTACHMENT XV

ACTUARY DATA*
HEALTH CARE STABILIZATION FUND SURCHARGE PROJECTIONS

		1985-86	1986-87 (Assumption of 3% Base Increase)	1987-88 (Assumption of 4% Base Increase)
1.	If Nothing Done	110%	100%	105%
2.	$500,000 cap			
	A. Effective July 1, 1986	—	91	79
	B. Retroactive	—	48	47
3.	$750,000 cap			
	A. Effective July 1, 1986	—	94	85
4.	$1,000,000 cap			
	A. Effective July 1, 1986	—	95	88
	B. Retroactive		72	
5.	$1,000,000 medical $500,000 nonmedical			
	A. Effective July 1, 1986	—	97	95
	B. Retroactive	—	80	81

* Based on testimony before the Special Committee on Medical Malpractice by Charles Lederman, Insurance Financial Services and Anthony Valenti, Dani Associates, Inc., actuaries for the Kansas Health Care Stabilization Fund.

Kansas Legislative Research Department
November 8, 1985

MH/aem

10/10-11/25
Attachment XV

ANALYSIS OF THE
INDIANA PATIENTS COMPENSATION FUND REPORT

DECEMBER 1984

10/10-11/85
Attachment XVI

The "Indiana Plan" which consists of a $500,000 total cap on awards and a mandatory 3-doctor screening panel in malpractice cases has been promoted in Kansas as a method of reducing the financial burden on doctors by lowering insurance premiums. While most observers acknowledge that the cap on awards creates a severe hardship for the catastrophic injuries, lawmakers in Kansas have been told that we cannot afford the tort system and must resort to an arbitrary restriction of victims' rights.

A key question for Kansas legislators is: does the Indiana Plan work? If we make dramatic changes in our Kansas laws and adopt the tort changes passed by Indiana in 1975, will Kansas doctors be helped? The answer is no and the questions below contain some detailed comparisons between the current system in Kansas and the Indiana Plan.

Will the Indiana Plan reduce the amount of money paid per claim? NO.

In Indiana, a total of $44,693,213.70 has been paid to malpractice victims in Indiana from 1975-1985. In that time, 145 payments have been made from the Fund, for an average payment of $308,229 per claim.[1]

The Kansas Fund paid 116 claims between 1977-1985. In that time a total of $34,204,765.80 was paid to Kansas victims for an average claim payment of $294,869.[2]

Have Indiana doctors experienced sharp increases in insurance rates? YES.

To finance $400,000 worth of insurance from the Fund, Indiana doctors paid a surcharge of primary coverage of 10% in

1975, 25% in 1980, 50% in 1982, 75% in September, 1985. Fund authorities have legislative permission to raise the surcharge to 100% in January, 1986.[3]

Has the Indiana Plan reduced the number of claim filings? NO.

In Indiana, complaints have increased from 1 claim in 1975 to 684 in 1984, for a total of 3,451 claims filed in 10 years.[4] In Kansas, 5 claims were filed against the Fund in 1977 and 179 claims were filed in 1984, for a total of 710 claims in 8 years.[5] In Indiana 63 complaints are filed per 100,000 population. In Kansas there are 28 complaints per hundred thousand citizens.

Does the Indiana Plan result in more prompt payment to injured victims? NO.

Comparing 1984 data from Kansas and Indiana, it took an average of 4.3 years[6] for an Indiana malpractice victim to be paid for an injury as opposed to 3.7 years for Kansas victims to receive compensation.[7]

Does Indiana have a problem with repeat offenders being responsible for a large number of the claims? YES.

According to statistics from the Indiana Fund report, 3% (296 doctors) of the doctors who pay a surcharge to the Fund are responsible for 33.4% of the total number of complaints filed in Indiana (3,451 complaints).[8]

Does the mandatory screening panel in Indiana help to process cases through the system? NO.

In Kansas, there were 835 complaints filed against the Fund between 1977 and 1985. As of January, 1985, 401 were

still in the system (48%), and 434 or 52% of the cases were closed.[9]

In Indiana, 3,451 cases were filed between 1975 and 1985. 2,375 cases or 68.8% of those cases were still active in January, 1985, and only 1,076 or 31.2% of the cases had been closed.[10]

How objective is the screening panel process in Indiana?

The data from the Indiana report indicates that the panel process is heavily weighted in favor of the health care providers. Between 1978 and 1984, screening panels issued 655 findings. In only 98 cases or 15% of the cases, the panel found that malpractice had occurred. 85% of the time, the panel ruled that no malpractice existed.[11]

Is the Fund solvent in Indiana? NO.

Although the surcharge for Indiana doctors has risen dramatically in the past few years (from 50% in 1984 to 75% in 1985; may be 100% in January, 1986), the judgments paid greatly exceed the surcharge collected. In 1984, $17,734, 930 was paid to victims and $9,545,058 was collected in surcharge. In 10 years, $32,975,188.41 has been collected from health care providers and $44,693,213.70 has been paid in judgments.[12]

CONCLUSION.

The data supplied by the Insurance Department in Indiana does not support the contention that the Indiana Plan will be helpful to Kansas doctors. In Indiana more dollars are paid per claim, it takes longer to process each complaint, and although the surcharge has risen sharply, the Fund paid $8,189,812 more than was collected in 1984.

FOOTNOTES

1. Report entitled "Patients Compensation Division, Department of Insurance, As of December 31, 1984". (Indiana).

2. Health Care Stabilization Fund Statistics - January 31, 1985; p. 1.

3. Op. Cit. Indiana Fund report. "Calendar Year Statistics for the Patients Compensation Fund."

4. Ibid. "Patients Compensation Division. Status of Complaints Filed Per Year."

5. Health Care Stabilization Fund Statistics - July 1, 1985; p. 2; #12.

6. 1984 Claims paid by Indiana Compensation Fund (57 case histories), addendum to Indiana Fund report.

7. July 1, 1985 summary from Kansas Insurance Department of 1984 claims settled (37 cases).

8. "Multiple Claims Reports", December 31, 1984; "Admitted Health Care Providers: 'Master File'", December, 1984.

9. Op. Cit. January 31, 1985 Health Care Stabilization Statistics; p. 1.

10. "Status of Medical Malpractice Complaints Filed with the Department of Insurance." Indiana Report.

11. "Malpractice Panel Opinions." Indiana Report.

12. "Calendar Year Statistics for the Patients Compensation Fund through December 31, 1984." Indiana Report.

PATIENTS COMPENSATION DIVISION

DEPARTMENT OF INSURANCE

AS OF

DECEMBER 31, 1984

10/10-11/85.

Attachment XVII

CONTENTS

PATIENTS COMPENSATION DIVISION
MONTHLY REPORT

MONTH REPORTING December 1984

ADMITTED HEALTH CARE PORVIDERS: "MASTER FILE"

	Beginning of Month		New This Month		Cancellations		End of Month	RENEWALS
Physicians	9,782		139		0		9,921	569
Dentists	2,507		65		0		2,572	374
Nurses	12,582		126		1		12,707	302
Hospitals	127		0		0		127	12
Miscellaneous	2,960		0		0		2,960	0
Sub-Total	27,958	+	330	-	1	=	28,287	1,257

Total admitted Health Care Providers as of Dec. 1984 28,287

CERTIFICATE ONLY

	Beginning of Month		New This Month		From "C.O." to Master File		End of Month
Physicians	71		2		5		68
Dentists	24		2		7		19
Nurses	294		46		15		325
Hospitals	3		0		0		3
Miscellaneous	30		0		0		30
Sub-Total	422	+	50	-	27	=	445

Total "CERTIFICATE ONLY's" as of December 1984 445

SURCHARGE ONLY

	Beginning of Month		New This Month		From "S.O." to Master File		End of Month
Physicians	27		0		0		27
Dentists	4		0		0		4
Nurses	18		0		0		18
Hospitals	1		0		0		1
Miscellaneous	9		0		0		9
Sub-Total	59	+	0	-	0	=	59

Total "SURCHARGE ONLY's" as of December, 1984 59

NUMBER OF COPIES MADE: 673

NUMBER OF VISITORS: 25

MAIL: OUTGOING
MIN. 20¢ 250

CERT:R/R 133

PATIENTS COMPENSATION DIVISION

STATUS OF COMPLAINTS FILED PER YEAR AS OF DECEMBER 31, 1984

YEAR	NUMBER OF COMPLAINTS FILED PER YEAR	COMPLAINTS PENDING(a)	COMPLAINTS PROGRESSING(b)	PROBLEM STATUS(c)	CLOSED (d)	PANEL OPINIONS(e)
1975	1	0	0	0	1	0
1976	18	0	2	0	8	8
1977	141	3	3	4	76	55
1978	272	10	11	2	154	95
1979	319	8	17	9	167	118
1980	401	26	43	19	191	122
1981	431	44	106	15	158	108
1982	556	75	184	14	179	104
1983	628	187	263	15	107	56
1984	684	463	182	1	35	3
CUMM. TOTAL	3451	816	811	79	1076	669

(a) (b) (c) - Current active cases filed with the Patients Compensation Division.

(a) PENDING - Complaint has been filed, but a request for a medical review panel has not yet been received.

(b) PROGRESSING - Complaint has been filed, and a request for a medical review panel has been received. The file will remain in this stage until all members of a panel have been selected.

(c) PROBLEMS - Complaint has been filed, but either a dollar amount has been referred to in the prayer, or the health care provide did not comply with the Malpractice Act, or a possible statute of limitations problem.

(d) CLOSED - Complaint was filed, but it was closed prior to the renderin of a panel opinion.

(e) PANEL OPINION - Complaint was filed and a medical review panel render an opinion.

STATUS OF MEDICAL MALPRACTICE COMPLAINTS FILED WITH THE DEPARTMENT OF INSURANCE

CUMMULATIVE TOTAL SINCE JULY 1, 1975 TO DECEMBER 31, 1984

1.	Total number of complaints filed with the Department of Insurance since July 1, 1975:			3,451
2.	Current number of active cases which have requested the formation of a medical review panel:		811	
3.	Current number of active cases which have not yet requested the formation of a medical review panel:		816	
4.	Current number of cases in which a panel opinion has been rendered:		669	
5.	Current number of cases which were settled prior to the rendering of a panel opinion:		1,076	
6.	Current number of cases which are presently defined as "Problem Status":		79	
* 7.	Current number of cases which have selected all 4 panel members:	260		
* 8.	Current number of cases which have requested a panel but all members have not yet been selected:	551		
	9. TOTALS:		811	3451 3451

* This figure is reflected in No. 2 above.

One hundred forty-five (145) payments have been made from the Patients Compensation Fund since its inception. Of this total figure, Seventy-four (74) cases have had panel opinions rendered, the remaining Seventy-one (71) cases were settled prior to the rendering of a panel opinion.

MEDICAL MALPRACTICE PANEL OPINIONS

Total Panel Opinions rendered since the inception of the Malpractice Act: 749

Panel Opinions rendered in 1984: 205
- Malpracitce: 20
- No Malpracitce: 144
- Material Issue of Fact: 11
- Variations: 30

Panel Opinions rendered in 1983: 173
- Malpractice: 21
- No Malpractice: 133
- Material Issue of Fact: 6
- Variations: 13

Panel Opinions rendered in 1982: 123
- Malpractice: 25
- No Malpracitce: 85
- Material Issue of Fact: 6
- Variations: 7

Panel Opinions rendered in 1981: 118
- Malpractice: 16
- No Malpracitce: 94
- Material Issue of Fact: 4
- Variations: 4

Panel Opinions rendered in 1980: 69
- Malpractice: 7
- No Malpractice: 55
- Material Issue of Fact: 1
- Variations: 6

Panel Opinions rendered in 1979: 40
- Malpractice: 6
- No Malpractice: 33
- Material Issue of Fact: 1

Panel Opinions rendered in 1978: 17
- Malpractice: 3
- No Malpractice: 13
- Material Issue of Fact: 1

Panel Opinions rendered in 1977: 3
- Malpractice: 1
- No Malpractice: 2

Panel Opinions rendered in 1976: 1
- Malpractice: 1

Panel Opinions rendered in 1975: 0

CALENDER YEAR STATISTICS FOR THE PATIENTS COMPENSATION FUND

THROUGH DECEMBER 31, 1984

	1975	1976	1977	1978
Surcharge Collected	$975,708.59	$2,294,261.00	$2,402,310.45	$2,306,934.32
Interest Earned	0	25,500.00	207,831.93	265,657.40
Sub-Total	975,708.59	2,319,761.00	2,610,142.38	2,572,591.72
Judgements Paid	0	0	0	425,000.00
TOTAL	$975,708.59	$2,319,761.00	$2,610,142.38	$2,147,591.72

	1979	1980	1981	1982
Surcharge Collected	$2,306,546.58	$2,426,958.83	$2,335,927.65	$2,754,188.56
Interest Earned	836,941.21	824,596.54	1,358,172.55	1,065,294.10
Sub-Total	3,143,487.79	3,251,555.37	3,694,100.20	3,819,482.66
Judgements Paid	2,894,500.00	3,900,000.00	1,972,500.00	7,194,713.70
TOTAL	$ 248,987.79	$ (648,444.63)	$1,721,600.20	$(3,375,231.04)

	1983	1984	TOTAL
Surcharge Collected	$5,627,314.35	$9,545,038.08	$32,975,188.41
Misc. Revenue I.R.M.I.A		7,209,467.00	7,209,467.00
Interest Earned	664,318.64	461,976.57	5,710,288.94
Sub-Total	6,291,632.99	17,216,481.65	45,894,944.35
Judgements Paid	10,571,570.00	17,734,930.00	44,693,213.70
TOTAL	$(4,279,937.01)	(518,448.35)	1,201,730.65

	$1,201,730.65
Office expenses July 1, 1975 through December 31, 1983 Including Salaries	361,988.26
Office expenses January 1, 1984 through December 31, 1984	20,387.33
Salaries for January 1, 1984 through December 31, 1984	81,870.95
Approximate Fund Balance As of December 31, 1984	737,484.11

* Judgements are paid from the Patients Compensation Fund once a year between January 1 through 15.

MULTIPLE CLAIMS REPORTS

DECEMBER 31, 1984

Total Number of Physicians with three or more complaints filed against them: 296

164 Physicians have 3 malpractice complaints filed against them.

64 Physicians have 4 malpractice complaints filed against them.

40 Physicians have 5 malpractice complaints filed against them.

14 Physicians have 6 malpractice complaints filed against them.

5 Physicians have 7 malpractice complaints filed against them.

4 Physicians have 8 malpractice complaints filed against them.

4 Physicians have 9 malpractice complaints filed against them.

1 Physician has 10 malpractice complaints filed against him.

1 Physician has 11 malpractice complaints filed against him.

1 Physician has 12 malpractice complaints filed against him.

Total Number of Dentists with three or more complaints filed against them: 13

6 Dentists have 3 malpractice complaints filed against them.

2 Dentists have 4 malpractice complaints filed against them.

5 Dentists have 5 malpractice complaints filed against them.

HOSPITAL MULTIPLE CLAIMS REPORT
DECEMBER 31, 1984

Total number of Hospitals with five or more complaints filed against them: 67

3 Hospitals have 5 malpractice complaints filed against them.

5 Hospitals have 6 malpractice complaints filed against them.

4 Hospitals have 7 malpractice complaints filed against them.

6 Hospitals have 8 malpractice complaints filed against them.

5 Hospitals have 9 malpractice complaints filed against them.

2 Hospitals have 10 malpractice complaints filed against them.

2 Hospitals have 11 malpractice complaints filed against them.

5 Hospitals have 12 malpractice complaints filed against them.

2 Hospital has 13 malpractice complaints filed against them.

1 Hospital has 14 malpractice complaints filed against them.

1 Hospital has 15 malpractice complaints filed against them.

1 Hospital has 16 malpractice complaints filed against them.

3 Hospitals have 17 malpractice complaints filed against them.

4 Hospitals have 18 malpractice complaints filed against them.

1 Hospital has 19 malpractice complaints filed against them.

2 Hospitals have 20 malpractice complaints filed against them.

1 Hospital has 21 malpractice complaints filed against them.

1 Hospital has 23 malpractice complaints filed against them.

2 Hospitals have 25 malpractice complaints filed against them.

2 Hospitals have 26 malpractice complaints filed against them.

3 Hospitals have 27 malpractice complaints filed against them.

1 Hospital has 30 malpractice complaints filed against them.

1 Hospital has 31 malpractice complaints filed against them.

3 Hospitals have 32 malpractice complaints filed against them.

1 Hospital has 34 malpractice complaints filed against them.

1 Hospital has 35 malpractice complaints filed against them.

1 Hospital has 39 malpractice complaints filed against them.

1 Hospital has 41 malpractice complaints filed against them.

1 Hospital has 55 malpractice complaints filed against them.

1 Hospital has 58 malpractice complaints filed against them.

1 Hospital has 81 malpractice complaints filed against them.

1 Hospital has 86 malpractice complaints filed against them.

1 Hospital has 128 malpractice complaints filed against them.

Federation of State Medical Boards
"Guide to the Essentials of a Modern Medical Practice Act"

SECTION IX:

DISCIPLINARY ACTION AGAINST LICENSEES

The medical practice act should provide for disciplinary action against licensees and the grounds on which such action may be taken. These provisions of the act should implement or be consistent with the following Federation recommendations.

A. A range of disciplinary actions should be made available to the Board. These should include, but not be limited to, the following:

1. revocation of the medical license;

2. suspension of the medical license;

3. probation;

4. stipulations, limitations, and conditions relating to practice;

5. fines (including costs);

6. reprimands;

7. letters of censure; and

8. letters of concern.

The Board should be authorized, at its discretion, to take such actions singly or in combination as the nature of the violation requires.

B. The Board should be authorized to require a licensee to be examined on his or her medical knowledge and skills should the Board have reason to believe the licensee may be deficient in such knowledge and skills. It should also be authorized to require a licensee to be physically or mentally examined should it have reason to believe the licensee's physical or mental condition may adversely affect his or her practice of medicine.

C. The Board should be authorized to take disciplinary action for unprofessional or dishonorable conduct, which should be defined to mean, but not be limited to, the following:

1. fraud or misrepresentation in applying for or procuring a medical license or in connection with applying for or procuring periodic reregistration of a medical license;

2. cheating on or attempting to subvert the medical licensing examination(s);

3. the commission or conviction of a gross misdemeanor or a felony, whether or not related to the practice of medicine, or the entry of a guilty or nolo contendere plea to a gross misdemeanor or a felony charge;

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4. conduct likely to deceive, defraud, or harm the public;

5. making a false or misleading statement regarding his or her skill or the efficacy or value of the medicine, treatment, or remedy prescribed by him or her or at his or her direction in the treatment of any disease or other condition of the body or mind;

6. representing to a patient that a manifestly incurable condition, sickness, disease, or injury can be cured;

7. willfully or negligently violating the confidentiality between physician and patient except as required by law;

8. gross negligence in the practice of medicine as determined by the Board;

9. being found mentally incompetent or insane by any court of competent jurisdiction;

10. a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine;

11. the use of any false, fraudulent, or deceptive statement in any document connected with the practice of medicine;

12. practicing medicine under a false or assumed name;

13. aiding or abetting the practice of medicine by an unlicensed, incompetent, or impaired person;

14. allowing another person or organization to use his or her license to practice medicine;

15. commission of any act of sexual abuse, misconduct, or exploitation related to the licensee's practice of medicine;

16. being addicted or habituated to a drug or intoxicant;

17. prescribing, selling, administering, distributing, or giving any drug legally classified as a controlled substance or as an addictive or dangerous drug for other than medically accepted therapeutic purposes;

18. except as otherwise permitted by law, prescribing, selling, administering, distributing, or giving to a habitue or addict any drug legally classified as a controlled substance or as an addictive or dangerous drug;

19. prescribing, selling, administering, distributing, or giving a drug legally classified as a controlled substance or as an addictive or dangerous drug to a family member or to himself or herself;

20. violating any state or federal law or regulation relating to controlled substances;

21. obtaining any fee by fraud, deceit, or misrepresentation;

22. directly or indirectly giving or receiving any fee, commission, rebate, or other

compensation for professional services not actually and personally rendered, though this prohibition should not preclude the legal functioning of lawful professional partnerships, corporations, or associations;

23. disciplinary action of another state or jurisdiction against a license or other authorization to practice medicine based upon acts or conduct by the licensee similar to acts or conduct which would constitute grounds for action as defined in this section, a certified copy of the record of the action taken by the other state or jurisdiction being conclusive evidence thereof;

24. sanctions or disciplinary actions taken by a peer review body, a hospital or other health care institution, or a medical or professional association or society for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;

25. failure to report to the Board any adverse action taken against him or her by another licensing jurisdiction (United States or foreign), by any peer review body, by any health care institution, by any professional or medical society or association, by any governmental agency, by any law enforcement agency, or by any court for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;

26. surrender of a license or authorization to practice medicine in another state or jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society while under disciplinary investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;

27. failure to report to the Board surrender of a license or authorization to practice medicine in another state or jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society while under disciplinary investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;

28. any adverse judgment, award, or settlement against the licensee resulting from a medical liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;

29. failure to report to the Board any adverse judgment, settlement, or award arising from a medical liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section;

30. failure to transfer medical records to another physician when requested to do so by the subject patient or by his or her legally designated representative;

31. failure to report to the Board the relocation of his or her office, in or out of the jurisdiction;

32. failure to furnish the Board, its investigators or representatives, information legally requested by the Board;

33. violation of any provision(s) of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board.

SECTION X:

PROCEDURES FOR ENFORCEMENT AND DISCIPLINARY ACTION

The medical practice act should provide for procedures which will permit the Board to take appropriate enforcement and disciplinary action when and as required, while assuring fairness and due process to licensees. These provisions of the act should implement or be consistent with the following Federation recommendations.

A. **Board Authority:** The Board should be empowered to commence legal action to enforce the provisions of the medical practice act and to exercise full discretion and authority with respect to disciplinary actions.

B. **Separation of Functions:** In the exercise of its power, the Board's investigative and judicial functions should be separated to assure fairness and the Board should be required to act in a consistent manner in the application of disciplinary sanctions.

C. **Administrative Procedures:** The existing administrative procedures act or similar statute, in whole or in part, should either be applicable to or serve as the basis of the procedural provisions of the medical practice act. The procedural provisions should provide for investigation of charges by the Board; notice of charges to the accused; an opportunity for a fair and impartial hearing for the accused before the Board or its examining committee; representation of the accused by counsel; the presentation of testimony, evidence, and argument; subpoena power and attendance of witnesses; a record of proceedings; and judicial review by the courts in accordance with the standards established by the jurisdiction for such review.

D. **Informal Conference:** Should there be an open meeting law, an exemption to it should be authorized to permit the Board, at its discretion, to meet in informal conference with an accused licensee who seeks or agrees to such a conference. Disciplinary action taken against a licensee as a result of such an informal conference and agreed to in writing by the Board and the accused licensee should be binding and a matter of public record. However, license revocation and suspension should be dealt with in open hearing. The holding of an informal conference should not preclude an open hearing if the Board determines such is necessary.

E. **Summary Suspension:** The Board should be authorized to summarily suspend a license prior to a formal hearing when it believes such action is required to protect the public health and safety. The Board should be permitted to summarily suspend a license by means of a vote conducted by telephone conference call if the Board president or executive believes such prompt action is required. Proceedings for a formal hearing should be instituted simultaneously with the summary suspension. The hearing should be set within a reasonable time (e.g., fifteen to thirty days) of the date of the summary suspension.

F. **Injunctions:** The Board should be authorized to obtain an injunction to restrain any person or any corporation or association and its officers and directors from violating the provisions

of the medical practice act. Violation of such an injunction should be punishable as contempt of court. No proof of actual damage to any person should be required for issuance of such an injunction, nor should its issuance relieve those enjoined from criminal prosecution for violation of the medical practice act.

G. **Board Action Reports:** All final disciplinary actions taken by the Board, including license denials, should be matters of public record and should be promptly reported by the Board to the central disciplinary data bank of the Federation of State Medical Boards of the United States. Voluntary surrender of and voluntary limitation(s) on the medical license of any person should also be a matter of public record and should also be reported to the Federation of State Medical Boards of the United States.