Approved January 27, 1986
Date

MINUTES OF THE House COMMITTEE ON Judiciary.

The meeting was called to order by Representative Joe Knopp, Chairman at
Chairperson

3:30 ~~a.m.~~/p.m. on January 13, 1986 in room 313-S of the Capitol.

All members were present except:

Representatives Douville and Solbach were excused

Committee staff present:
Jerry Donaldson, Legislative Research Department
Mike Heim, Legislative Research Department

Jan Sims, Committee Secretary

Conferees appearing before the committee:

Mike Heim of the Legislative Research Department briefed the committee on the activities of the interim committee concerning the medical malpractice issue. The activities of the interim committee as well as their conclusions, recommendations and the minority report were presented as a handout to the committee. (Attachment 1)

The Chairman announced that January 21, 22 and 23 would be devoted to an overview of liability insurance with a specific view of liability insurance in Kansas.

The meeting was adjourned at 4:45 P.M.

RE: PROPOSAL NO. 47-- MEDICAL MALPRACTICE*

Proposal No. 47 called for the Special Committee on Medical Malpractice to conduct a comprehensive study of the medical malpractice issue, including a review of the responsibilities of the Board of Healing Arts and the functions of the Insurance Department regarding malpractice insurance rate setting and administration of the Health Care Stabilization Fund, insurance company loss and experience records and rates, and health care providers' malpractice claims and insurance costs; also, to consider alternatives and suggested reforms of the tort system, the impact of 1985 Substitute for S.B. 110, and any other area relevant to the medical malpractice issue.

Background

The medical malpractice issue was suggested for study by the House Judiciary Committee Chairman and by the President of the Senate as a result of extensive legislative debate during the 1985 Session and the passage of Substitute for S.B. 110.

Past Legislative Studies and Enactments

Ten years ago an interim legislative committee was created to review what was referred to as a crisis affecting health care resulting from the soaring costs and declining availability of professional liability insurance for medical providers. After review of numerous materials and extensive hearings, the 1975 Special Committee on Medical Malpractice made a series of recommendations, all but one of which

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* H.B. 2661 and H.B. 2662 accompany this report.

Attachment 1
House Judiciary
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became law in 1976. The enactments had a twofold purpose of solving the insurance availability crisis and easing the affordability problem. These enactments and others passed subsequent to 1976 include the following.

Health Care Provider Insurance Availability Act. This law passed in 1976, mandates that all health care providers must carry professional liability insurance at a level of $200,000 per occurrence and $600,000 annual aggregate for all claims as a condition of practicing in Kansas. (The law initially required $100,000/$300,000 coverage until the limits were raised in 1984.) "Health care provider" is defined to include any person licensed by the Board of Healing Arts, persons engaged in postgraduate training, a medical care facility licensed by the Department of Health and Environment, health maintenance organizations, optometrists, podiatrists, pharmacists, nurse anesthetists, professional corporations of providers, dentists who administer anesthetics, physical therapists, and mental health centers and clinics.

This Act also created the Kansas Health Care Stabilization Fund as an excess insurance carrier for health care providers and provided unlimited excess coverage until a $3 million cap per claim and $6 million annual aggregate cap were placed on the Fund in 1984. The Fund is administered by the Kansas Insurance Commissioner and is funded by surcharges based on premiums paid by health care providers for their primary coverage. A $10 million limit on the amount that could be accumulated in the Fund was repealed in 1983, and the Fund was placed on an accrual funding scheme. A 13-member board of governors was established in 1984 to provide technical assistance for the administration of the Fund. The board may also terminate coverage of providers found to present a material risk of future liability to the Fund.

The Health Care Provider Insurance Availability Act also established an assigned risk or joint underwriting association (JUA) plan to provide coverage for those providers unable to secure primary insurance coverage on the open market. The JUA plan is under the supervision of the Insurance Commissioner and is governed by a nine-member board of governors. The provisions of the JUA are to be sunsetted on July 1, 1987,

but existing policies would be allowed to expire and payment of claims would be completed.

The mandatory insurance provisions of the Act were challenged in State ex rel. Schneider v. Liggett, 223 Kan. 610 (1978), and upheld by the Kansas Supreme Court. The Court said that the Act did not violate the due process rights nor the equal protection rights of the defendant doctor who had refused to obtain liability insurance.

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

Collateral Sources. A special statute (K.S.A. 60-471) regarding the admissibility of evidence in medical malpractice actions of certain collateral sources of reimbursement to injured parties also was enacted in 1976. The statute permitted evidence to be admitted of reimbursements or indemnifications to the injured plaintiffs except for insurance payments and health maintenance organization benefits where the plaintiff or his employer had paid for the premiums in whole or in part. The Kansas Supreme Court in Wentling v. Medical Anesthesia Services, 237 Kan. 503, (1985) found this statute, prior to its repeal in 1985, to be unconstitutional as a violation of equal protection. See the discussion of 1985 Substitute for S.B. 110 which follows for a description of the new collateral source rule regarding health care providers.

Damages Paid in Installments. K.S.A. 60-2609, enacted in 1976, allows the court to include a requirement that

damages awarded in a medical malpractice action be paid in whole or in part by installment or periodic payments. Any installment or periodic payment becoming due and payable under the terms of the judgment constitutes a separate judgment upon which execution may issue.

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

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

Screening Panels. A law (K.S.A. 65-4901 et seq.), enacted in 1976 and amended in 1979, permits screening panels in medical malpractice cases. A panel shall be convened if either party requests one or if the district judge orders a panel on his own motion. The findings of the panel shall not be admitted into evidence at a subsequent trial but screening panel members may be called as witnesses. Membership on a panel includes a health care provider chosen by each party, a third provider picked by the other two and a nonvoting chairman who must be an attorney chosen by the district judge.

Reporting of Malpractice Claims to Insurance Commissioner. K.S.A. 40-1126 and 40-1127 were amended in 1976, 1977, and 1978 to require insurers for health care providers, persons engaged in technical professions, attorneys, and certified public accountants to report to the Insurance Commissioner any claim for damages due to negligence based on

professional services, if the claim resulted in a final judgment or settlement in any amount, and, annually, the amount of premiums charged for the past year.

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

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

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

Malpractice Study Commission. 1976 S.B. 658 established an 11-member health care provider malpractice study commission to study malpractice problems and to report to the

Governor and Legislature. The statute sunsetted on December 31, 1978.

1985 Medical Malpractice Legislation

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

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

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

The bill alters the collateral source rule in the area of medical malpractice liability to permit the trier of fact

(either a judge or jury) to hear evidence regarding indemnification or replacement of any damages or expenses incurred by the injured party from any insurance, except life insurance, or from workers' compensation, social welfare benefit programs, military benefits, employment wage continuation plans, or other benefit plans provided by law. The injured party may present evidence of any payments made to secure the insurance or benefits and the extent to which these benefits are subject to any lien or subrogation right. The collateral source amendments apply to any action regardless of when the cause of action accrued. Finally, the provisions of the bill are sunsetted on July 1, 1989.

The new collateral source rule in Sub. for S.B. 110 has been upheld by one federal district court judge and found to be unconstitutional by two other federal district judge and one state district court judge as of mid-December.

Scope of the Committee's Activities and Study

The Committee held 14 days of meetings beginning in July and concluding in November. The Committee heard from over 50 conferees, including representatives of the Kansas Medical Society, Kansas Hospital Association, Kansas Association of Osteopathic Medicine, the Kansas Chiropractic Association, Kansas Association of Nurse Anesthetists, the Kansas Academy of Family Physicians, the Kansas Bar Association, the Kansas Trial Lawyers Association, the Kansas Insurance Department, the Legislative Division of Post Audit, the University of Kansas Medical Center, the State Board of Regents, the American Association of Retired Persons, the Medical Protective Insurance Company, the Providers Insurance Company, St. Paul Fire and Marine Insurance Company, the Western Insurance Companies, several state district court judges and a federal district court judge, parents of victims of medical malpractice, the Eureka Chamber of Commerce, Concerned Consumers of Wichita, and from an Indiana legislator sponsored by the Kansas Medical Society, an Indiana physician-attorney sponsored by the Kansas Trial Lawyers, a

staff attorney for the Indiana Insurance Department, and various other persons.

The Committee reviewed numerous memoranda, studies and other materials prepared by staff and by the conferees noted above. Staff memoranda included a glossary of terms; a review of Kansas law related to medical malpractice actions; a review of the Health Care Provider Insurance Availability Act; a working paper on medical malpractice issues; a summary of recent legislative changes in Illinois, Florida, and New York; various articles about the insurance industry and its financial problems in recent years; materials dealing with the amount of insurance premiums paid by Kansas medical doctors; and physicians' income. Other studies reviewed included a performance audit of the Board of Healing Arts; a National Conference of State Legislatures' (NCSL) publication entitled "What Legislators Need to Know About Medical Malpractice," August, 1985; a 1985 study entitled "Medical Malpractice Insurance in Pennsylvania" by Alfred Hofflander, Ph.D. and Blaine Nye, Ph.D., which was jointly funded by lawyer and physician groups in that state; a series of short articles describing states' statutory and case law on various aspects of medical malpractice tort reform legislation prepared by the American Medical Association (AMA); "Professional Liability in the '80s" Reports 1-3, by the AMA Special Task Force on Professional Liability and Insurance, 1984; actuary reports regarding the Kansas Health Care Stabilization Fund dated February 22 and September 24, 1985; loss experience of certain Kansas providers with multiple claims; defense cost payouts and other data related to the Fund; and a number of other articles and materials on medical malpractice issues.

The Committee's study approach was geared toward gathering information to educate members on issues and determining the nature and extent of the problems that might exist in regard to the medical malpractice system. After eight days of hearings, review of materials, and deliberations, the Committee concluded that there is a problem with medical malpractice insurance costs which could affect the medical care delivery system in Kansas. The Committee emphasis then focused more on reforms of the tort and insurance systems and on means to permit closer scrutiny of health care

providers designed to prevent malpractice and improve the quality of care.

The Committee was made aware that a number of other state legislatures or executive branch study committees and commissions are reviewing problems relating to the medical malpractice system. In addition, the Committee was apprised of the activities of the 25-member Kansas Citizens Committee for Review of the Tort System in Kansas appointed by the Insurance Commissioner in January, 1985. The Citizens Committee's task was to study the medical malpractice liability situation and related issues in this state. Its recommendations were finalized in early November. Finally, the Committee made an effort to determine what effect one state's reforms might have on a problem that is national in scope.

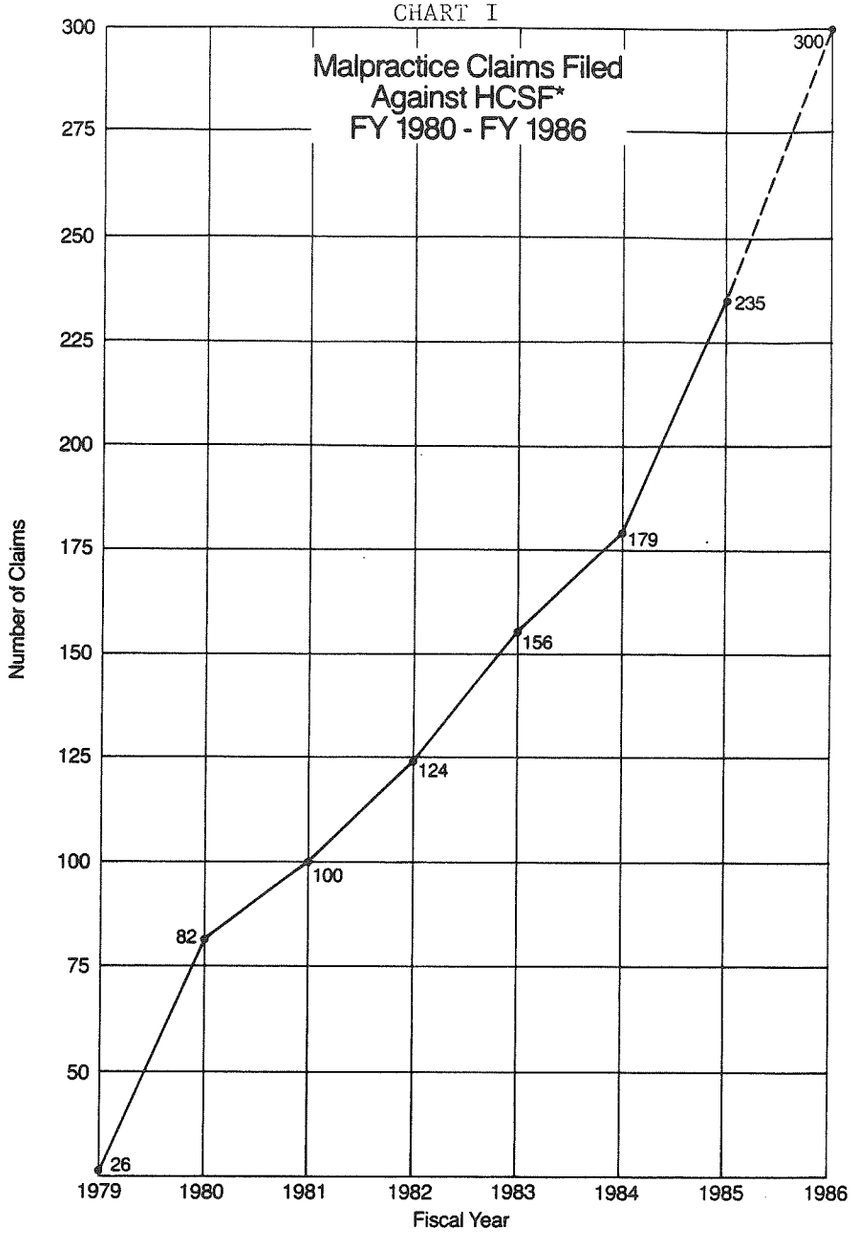
The Nature of the Problem

Medical Community, Insurers, and Others' Perspectives. Representatives of the Kansas Medical Society, other health care provider groups, the insurance industry, and various individuals testified that there is a crisis and that it is primarily one of affordability. They said 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 said that the problem may become especially acute in rural areas. The main culprits were said to be the increasing frequency of claims and the growing size of jury awards and settlements.

Data presented by the Kansas Medical Society included a chart showing the increasing frequency of claims from 26 in FY 1975 to 235 in FY 1985, and projected claims of 300 for FY 1986 against the Health Care Stabilization Fund (Chart I).

Also presented was information (Chart II) showing that medical malpractice awards and settlements have increased approximately tenfold from calendar year 1979 ($2.35 million) to calendar year 1985, when $22.25 million in estimated awards and settlements are expected to be paid out.

CHART I

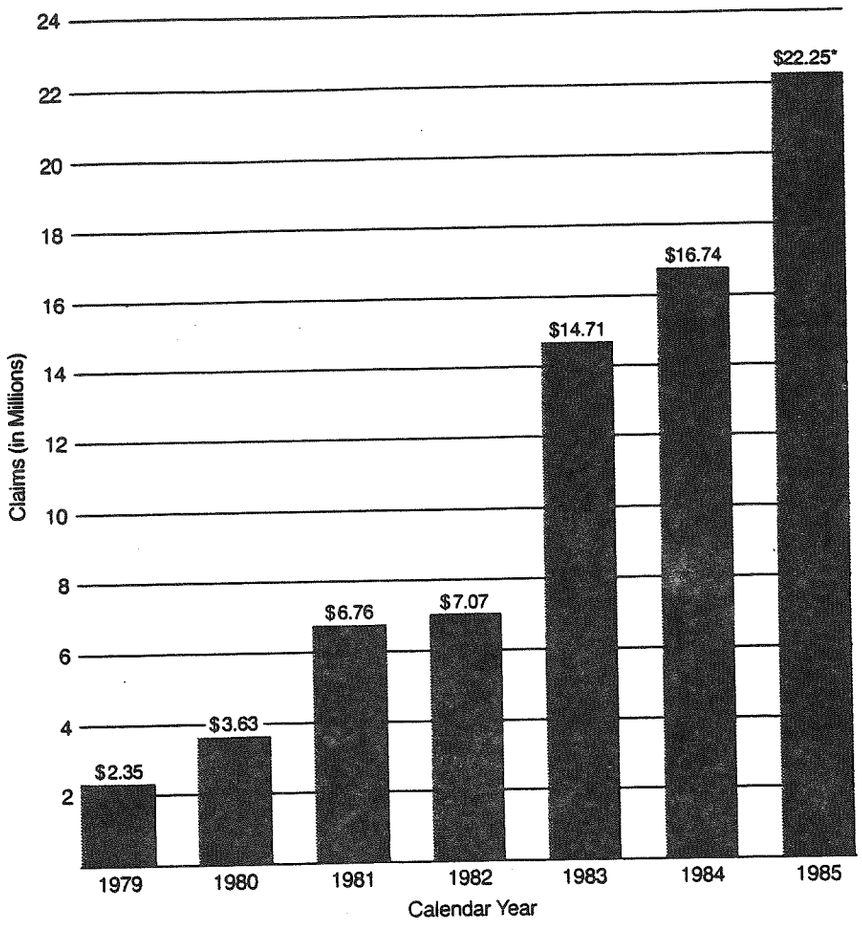


Source: Kansas Medical Society

*Health Care Stabilization Fund

CHART II

Total Awards and Settlements for Kansas Malpractice Claims (in millions)



*Estimated Based on Half Year Data

Source: *Report on the Health Care Provider Insurance Availability Act*, July 1, 1985

Additionally, a chart (Chart III) was presented showing that the average cost per claim in Kansas from 1980 to 1984 rose from $23,766 to $113,877. The chart also shows the total indemnity paid out for this time period and the number of closed claims with payments for 1980-1984. Finally, a chart was presented (Chart IV) showing that the average medical malpractice verdict nationwide rose from $166,165 in 1974 to $954,858 in 1984.

A representative of the Kansas Medical Society testified that a family practitioner in Kansas doing obstetrics is likely to pay $13,000 and an obstetrician, $45,000 for required coverage. The president of the Kansas Academy of Family Physicians testified that two doctors doing obstetrics in LaCrosse paid a total of $8,600 in 1983 for premiums and in 1984, paid a total of $26,000.

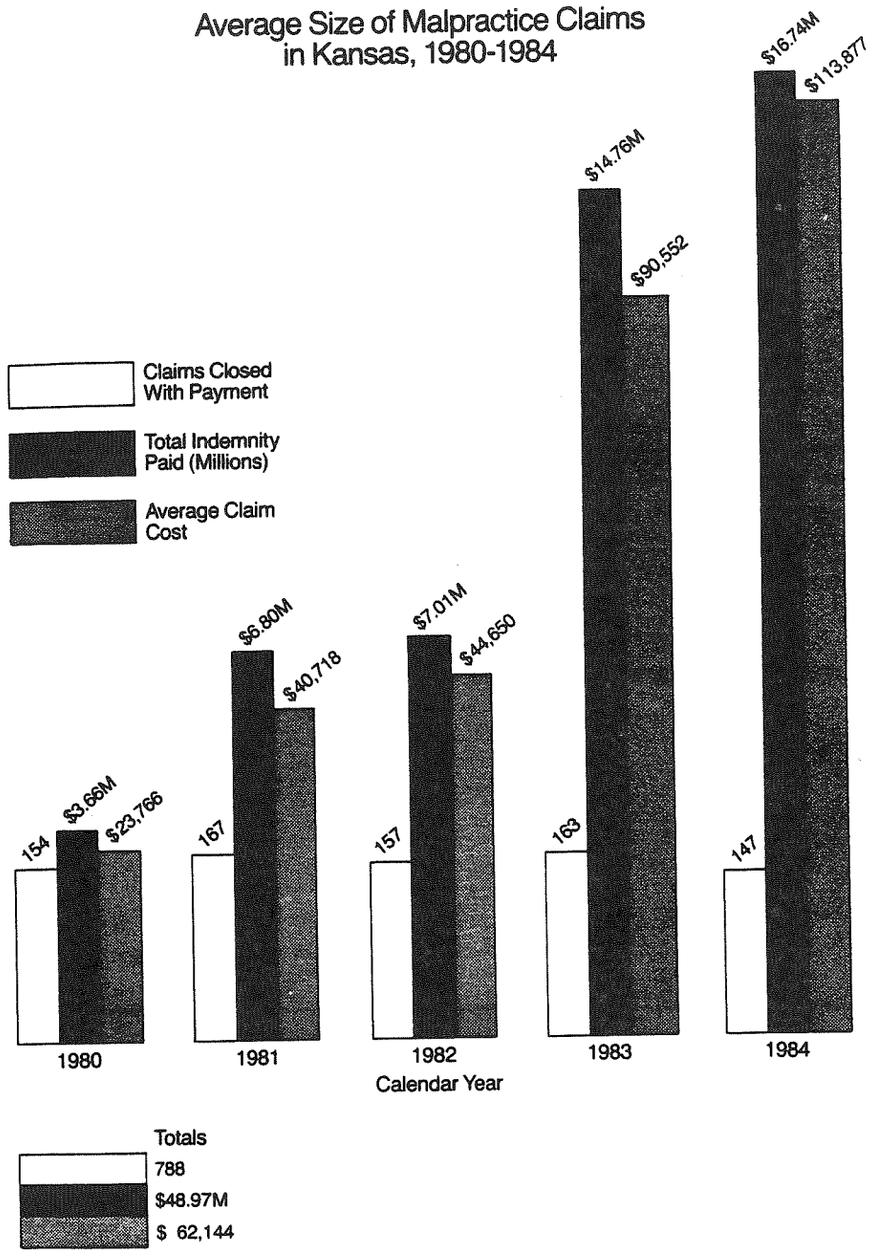
A Eureka osteopath testified that he and his partner in 1985 would be paying $24,580 a year for coverage, compared with $3,496 in 1981. A nurse practitioner testified that the two obstetrician/gynecologists she worked for in Wamego will pay $65,000 for coverage in 1985. A Wamego surgeon testified he quit his practice in August since his estimated premium for this year would be 40 percent of his income. A Eureka surgeon who quit his practice briefly because of his malpractice premium costs said his 1985 costs for insurance coverage were $17,976, which represented 25 percent of his income as a physician.

Conferees did not distinguish between insurance costs as individual providers and insurance costs related to professional corporations.

A representative of the Kansas Association of Nurse Anesthetists said next year's premium cost for nurse anesthetists is projected to be $6,000. She said that part-time nurse anesthetists usually have to pay this same amount themselves, which may force some to quit or work, instead, as staff registered nurses.

Viewpoint of Legal Profession and Parents of Victims. Representatives of the Kansas Bar Association and the Kansas

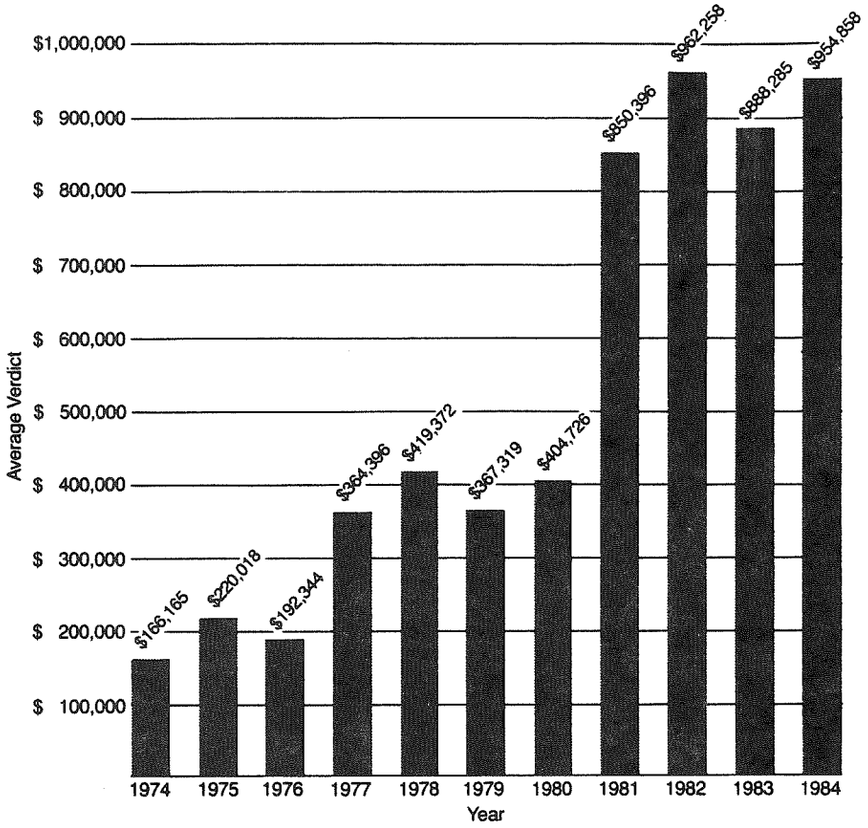
CHART III



Source: Kansas Medical Society

CHART IV

Average Medical Malpractice Verdict Nationwide



Source: Summary of Injury Valuation Reports from "Current Award Trends," 1985, Jury Verdict Research, Inc.

Trial Lawyers Association stated that the problem is that malpractice is being committed and the health care professions need to better police their members.

The Committee heard from the father of a brain damaged boy who was awarded nearly $15 million in actual ($6.2 million) and punitive ($8.8 million) damages due to the gross negligence of a hospital and staff involving a delivery room nurse who did not know how to read a fetal monitor. The father noted that a settlement offer on behalf of his son for $4 million was rejected by the various parties involved. He said the large jury verdict likely reflected outrage of jurors over the deliberate negligent practices of a hospital in its failure to properly train personnel.

Two mothers of children who were misdiagnosed as having Hirschsprungs disease requiring removal of large portions of the bowel testified. One of the children has had to undergo 23 reparatory surgeries.

The Trial Lawyers' representative stated that a review of over 700 medical malpractice cases filed in Kansas has shown that 31 doctors or less than 1 percent of the medical population had multiple claims representing a total of 16 percent of the entire number of claims. It was estimated that between 30 and 40 percent of the payouts from the Fund were attributable to the negligence of these repeat offenders. The representative said the Insurance Department was either unable or unwillng to supply actual dollar amounts paid out by the Fund and by primary carriers against doctors with multiple claims.

The legal profession's representatives also pointed out that health care providers received unlimited excess insurance coverage from the Fund for three years (1981-1983) free of any surcharge. They said the "pay as you go" funding mechanism for the Fund utilized until 1983 is one of the major reasons surcharges are now so high.

Claims Against Providers Data. The Insurance Department presented the following information (Table I) regarding the number of claims, including multiple claims, against health

care providers from 1976 when the Fund was created to January 31, 1985.

TABLE I

NUMBER OF CLAIMS AGAINST PROVIDERS

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

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

Note: Professional Associations (P.A.s), Doctors of Osteopathic Medicine (D.O.s), Medical Doctors (M.D.s), and Doctor of Podiatry Medicine (D.P.M.).

Source: Kansas Insurance Department

The Insurance Department also presented a list of the dollar amounts paid out by primary carriers and the Fund for licensees of medicine and surgery with multiple claims filed against them. The data did not include payouts by professional associations on behalf of individual providers nor did they include cases on appeal or payments where a closed claim report had not yet been filed.

Health Care Stabilization Fund Surcharges. Table II shows the surcharge assessments for the Health Care Stabilization Fund since its inception.

TABLE II

SURCHARGE HISTORY

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

* No surcharge was levied between FYs 1981-83 since the Fund balance contained approximately $10 million. This $10 million cap was repealed in 1983 as noted earlier.

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

Information presented by the Insurance Department showed the estimated impact on the balances in the Fund if a

45 percent surcharge had been imposed from FY 1977 through FY 1984 and the impact of implementing the accrual funding immediately after the $10 million balance in the Fund was achieved. The information in Chart V shows $47.2 million in actuarial undiscounted losses for the Fund as of June 30, 1984, with the actual balance in the Fund of $7.9 million and a $31.5 million balance if the 45 percent model surcharge had been utilized. Total surcharge revenue from FY 1977 through FY 1984 was $17,262,011 in accordance with the statutory requirements, but would have been $41,737,529 if the 45 percent model had been used and $45,736,478 in total revenues if accrual funding had been implemented after the $10 million balance was achieved.

Premium and Surcharge Data — Kansas. According to the Kansas Insurance Department, 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. These two insurers write the majority of the medical malpractice insurance business for Kansas physicians and surgeons.

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, to be $5,743 for primary coverage and $6,317 for the $3 million excess coverage, for a total average premium cost of $12,060.

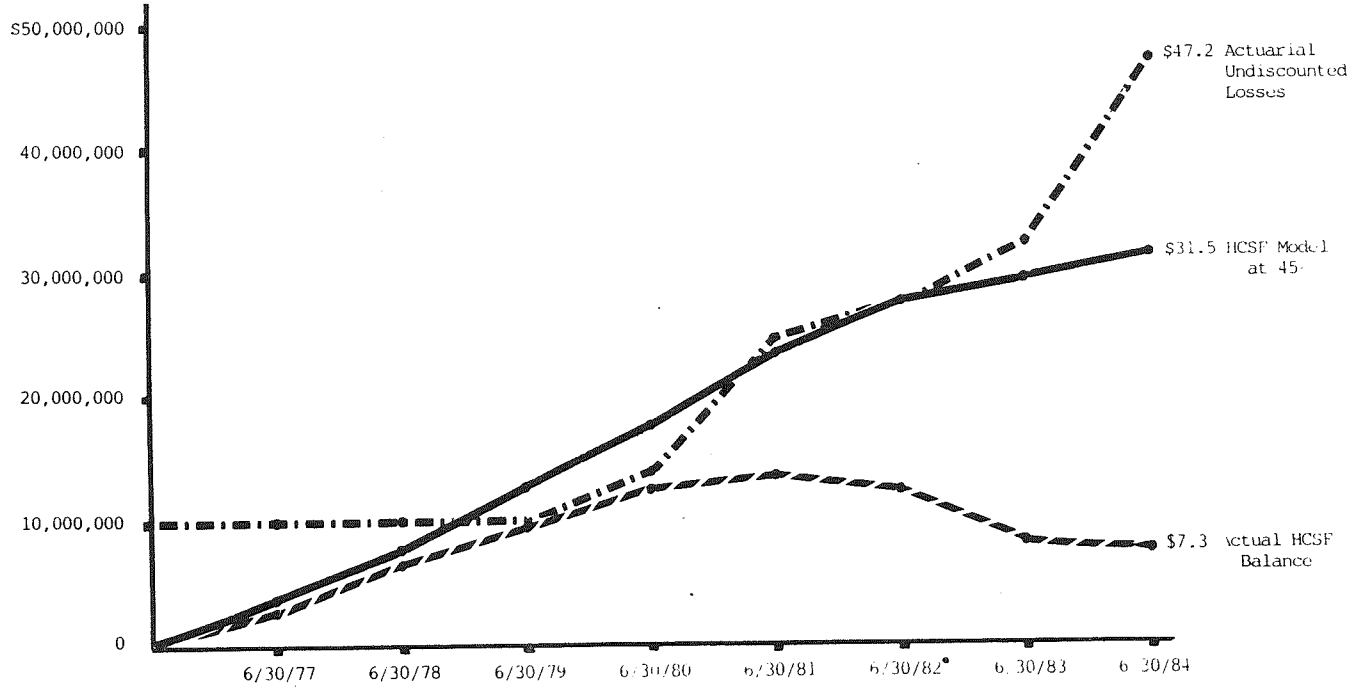
Committee staff presented information regarding the amount of premiums and surcharges paid by Kansas doctors of medicine and osteopathy based on individual policies in force on June 6, 1985, which represented the most current data the Insurance Department could provide (Table III).

CHART V

HCSF MODEL BALANCE AT 45% SURCHARGE

HCSF ACTUAL BALANCE

HCSF ACTUARIAL ACCRUED LOSSES



Source: Kansas Insurance Department

TABLE III

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

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

* This column does not reflect premiums and surcharges paid for professional corporations whose costs are approximately 20 percent of those of an individual provider.

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

Source: Based on data provided by the Kansas Insurance Department.

Staff also presented a list of Kansas doctors of medicine and surgery showing the number of practitioners by specialty in each county, based on 1984 data, provided by the Kansas Department of Health and Environment (Table IV). Selected specialty premium rates for six insurers and the currently applicable 110 percent surcharge rate are then displayed (Table V). In addition, staff noted data from the NCSL's publication "What Legislators Need to Know About Medical Malpractice" 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.

Malpractice Premium National Data. According to an AMA survey the average malpractice premium cost for physicians nationwide in 1984 was $8,400. The survey did not include any data regarding the amount of insurance coverage purchased by the premiums. The following table (Table VI) shows the 1984 nationwide average premium costs for ten specialties.

TABLE IV

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
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	16	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)	22	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	8	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

Source: Data provided by the Kansas Department of Health and Environment. 10/9/85

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
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 (15,100)	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	28	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 (26,400)	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	5	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
Wyandotte (172,400)	221	148	17	1	29	7	5	30	2	87	20	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

TABLE V

KANSAS ANNUAL PROFESSIONAL LIABILITY INSURANCE RATES
EFFECTIVE JULY 1, 1985

	Basic Premium	No. of Providers	Total (Basic Premium Plus 110% Surcharge)
Physicians, No Surgery or Minor Surgery		1,522	
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
Family Practitioners and General Practitioners		1,427	
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
Emergency Medicine		101	
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
Surgery — Urological		2	
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

	Basic Premium	No. of Providers	Total (Basic Premium Plus 110% Surcharge)
Anesthesiology		152	
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
Surgery — Plastic		27	
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
Surgery — Cardiovascular		31	
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
Obstetrics/Gynecology		201	
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
Surgery — Neurology		29	
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

Note: The table does not reflect premiums and surcharges paid by individual practitioners for their professional corporations. The charges are generally 20 percent of those paid for an individual practitioner.

* Rate is determined by adding 20 percent to the rate of St. Paul. Such practice is generally consistent with approved rate filings.

Source: Data for the table provided by the Kansas Insurance Department and the Kansas Department of Health and Environment.

TABLE VI

NATIONWIDE PHYSICIAN AVERAGE ANNUAL PREMIUMS COSTS: 1984

Specialty	Premium Amount
Anesthesiology	$16,000
General and Family Practice	4,900
General Surgery	13,400
Internal Medicine	4,900
Obstetrics/Gynecology	18,800
Pathology	2,900
Pediatrics	3,500
Psychiatry	2,200
Radiology	6,300
Other	5,000

Source: American Medical Association

Physician Income and Expenditure — Regional and National Data. Staff reported that the physician's average net income, according to a recent AMA survey for the West North Central states (Kansas, Nebraska, Missouri, Iowa, North Dakota, South Dakota, and Minnesota), was $110,500 in 1984, compared to $108,400 annually nationwide. Income data for specialties are only compiled on a nationwide basis. The following table (Table VII) reflects the nationwide 1984 average net income of physicians in certain specialties as compiled by the AMA.

TABLE VII

NATIONWIDE PHYSICIAN AVERAGE NET INCOME DATA: 1984

Specialty	1984 Average Income
Anesthesiology	$145,400
General Family Practitioner	71,700
Internal Medicine	103,200
Obstetrics/Gynecology	116,200
Pathology	118,000
Pediatrics	74,500
Psychiatry	85,500
Radiology	139,800
Surgery	151,800

Source: American Medical Association

An article in the February 6, 1984, issue of Medical Economics made available to the Committee indicates the median expenditure for medical malpractice insurance, nationwide was 3.5 percent of the doctors' gross income for 1982.

Tort Reform

The following reflects the testimony and discussion regarding various tort reform issues the Committee considered.

Caps on Awards. Representatives of health care providers and insurers were in general agreement that a cap on damage awards will decrease the size of such awards, reduce medical malpractice premiums, and, possibly, discourage the filing of claims by reducing the so-called "lottery atmosphere" created, in part, by the mandatory insurance requirements for providers and the $3 million excess coverage provisions in Kansas. Caps combined with structured awards were said to be able adequately to compensate victims.

Not all groups agreed as to the type of cap that should be imposed. For example, a representative of the Medical Protective Insurance Company proposed an overall cap of $500,000 on all damages; whereas, a representative of the Western Insurance Companies advocated a $500,000 cap on nonpecuniary damages with no cap on actual damages. St. Paul Fire and Marine recommended a $100,000 cap on pain and suffering but no cap on pecuniary losses or future medical expenses. The Citizens Committee appointed by the Insurance Commissioner recommended a $500,000 cap on all damage awards except future medical costs and custodial care. The Kansas Medical Society proposed a $100,000 cap on pain and suffering and a $500,000 overall damages cap except for future medical care, for which the total award could not exceed $1 million.

The Kansas Bar Association, Kansas Trial Lawyers Association, 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 argued that large awards do not drive up malpractice insurance costs but that malpractice does. A representative of the American Association of Retired Persons (AARP) stated that those who are truly victims must be adequately compensated for their injuries.

The Trial Lawyers' representative noted that only 19 cases, representing 2 percent of the claims filed, have resulted in payments from the Fund of over $500,000. It was suggested this does not indicate runaway jury awards or frequent large judgments in Kansas. It was argued that caps do not keep pace with inflation and, if imposed, will force the addition of inadequately compensated victims to the welfare roles.

Indiana Plan. Much of the Committee's attention was focused on the so-called "Indiana Plan" which was advocated by a representative of the Medical Protective Insurance Company, the Kansas Medical Society and others. The major provisions of the Plan include a $500,000 cap on awards, screening panels whose decisions are admissible in court, and private insurance coverage of $100,000 per claim with a state administered patients' compensation fund liable for the remainder of up to $400,000.

The Kansas Medical Society and the Kansas Trial Lawyers Association each sponsored a conferee from Indiana to appear before the Committee. The Kansas Medical Society sponsored an Indiana legislator who chaired an interim study committee in 1984 dealing with medical malpractice issues. The Kansas Trial Lawyers sponsored a physician-attorney engaged in the practice of law in Indiana. In addition, the Committee invited the counsel for the Indiana Patients Compensation Fund to appear.

A key element in the Indiana system is that once a primary insurer tenders the full $100,000 to a claimant, the patients' compensation fund can no longer defend on the basis of lack of negligence but only on the issue of the extent of damages. Several conferees and some Committee members expressed concern that such a system, if adopted, would inhibit the defense of the Kansas Health Care Stabilization Fund. They feared also such a system might encourage primary insurance carriers to tender the full amount of their policy limits more readily and thus try and save legal and other defense costs. The legal counsel for the Indiana fund said a better defense of their fund could be provided if the fund were permitted to defend on the issue of negligence.

A representative of the Kansas Trial Lawyers Association noted that Indiana paid an average of $308,229 per claim from 1975 to 1985 while the average claim in Kansas for a similar period (1977-1985) was $294,869 or nearly $15,000 less per claim.

The Trial Lawyers' representative noted that under the Indiana Plan, there were 63 complaints filed per 100,000 population compared with 23 per 100,000 population in Kansas and that the number of lawsuits per doctor was higher in Indiana than in Kansas.

The Indiana legislator who chaired that state's interim medical malpractice committee in 1984, reported the Indiana Legislature recently has reviewed the $500,000 cap on damages and found this would provide adequate compensation for victims of medical malpractice. He noted no one appeared before his interim committee advocating the $500,000 be

raised and that there was no attempt to raise the cap on the floor of either house when the bill was debated.

The Indiana physician-attorney who appeared on behalf of the Kansas Trial Lawyers referred to the $500,000 cap as unconscionable.

Actuarial Effect of Caps on Fund. Two actuaries for the Kansas Health Care Stabilization Fund presented data on the estimated impact in the next two years of various caps on awards and on the Fund surcharge amounts if no changes are made. Data were updated to reflect projected actuarial impact on the Fund of a $500,000 cap on awards except for an additional $500,000 cap for future medical and custodial care expenses and a $500,000 cap on all damages, except for future medical costs which would be unlimited (Table VIII).

The actuaries estimated that, over time, the collateral source amendments adopted by the 1985 Legislature may reduce Fund surcharges by 5 percent. They said that they were unable to predict the effects of other tort reforms on future Fund surcharges.

Cap on Attorney Fees. Representatives of various health care provider groups and the Medical Protective Company advocated a cap on contingency fees for plaintiffs' attorneys. The Kansas Medical Society and Medical Protective Company proposed a 15 percent cap on contingency fees on awards above $200,000. A representative of Western Insurance Companies proposed plaintiffs' attorneys be paid at a "contract" price or an 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 is too high, but one-third is defensible. The Citizens Committee recommended a 25 percent cap on attorney fees on awards over $100,000.

Representatives of the legal profession opposed statutory limits on attorney fees and pointed to an existing statute which requires the judge to approve only reasonable fees in medical malpractice cases. All judges who appeared indicated no one had ever complained about a contingency fee in a

TABLE VIII

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	110.0%	100.0%	105.0%
2.	$500,000 cap			
	A. Effective July 1, 1986	—	91.0	79.0
	B. Retroactive	—	48.1	47.0
3.	$500,000 cap plus unlimited medical			
	A. Effective July 1, 1986	—	98.7	100.0
	B. Retroactive	—	85.8	90.1
4.	$750,000 cap			
	A. Effective July 1, 1986	—	93.4	85.0
5.	$1,000,000 cap			
	A. Effective July 1, 1986	—	94.7	88.0
	B. Retroactive		72.0	
6.	$500,000 cap plus $500,000 future medical cap			
	A. Effective July 1, 1986	—	94.1	87.6
	B. Retroactive	—	66.8	65.6
7.	$1,000,000 medical plus $500,000 nonmedical cap			
	A. Effective July 1, 1986	—	97.1	95.0
	B. Retroactive	—	79.6	81.0

Source: Based on testimony on October 11, 1985 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 and on data contained in a letter addressed to Mr. Bob Hayes of the Kansas Insurance Department dated November 19, 1985.

medical malpractice case and the fees had been routinely approved as required by statute. The Kansas Bar Association and Trial Lawyers pointed to the dual purpose of the tort system as one of compensation and deterrence and said the contingency fee is an integral part of this system. They noted that only one in four plaintiffs is successful at trial. The contingency fee system permits the spreading of costs of litigation over both successful and unsuccessful plaintiffs. They also argued that a limit would be an unfair advantage to the defense bar who would not be so limited.

Screening Panels. Representatives of health care provider groups, the Citizens Committee and the Medical Protective Company supported the appointment of mandatory screening panels with panel findings admissible at trial. The Medical Protective Company advocated the Indiana system where the panel consists of three health care providers and a nonvoting attorney who serves as chairman. Proponents said these panels will weed out questionable claims and encourage settlement in clear cases of malpractice.

St. Paul Fire and Marine Insurance Company and several judges questioned the use of mandatory screening panels saying they feared added costs and more lengthy litigation would result. The Kansas Bar and Trial Lawyers Associations advocated that screening panels, as presently constituted under Kansas law, be required if a case is filed without an accompanying affidavit by a medical expert stating that negligence occurred.

Settlement Conferences. Several Kansas district court judges thought mandatory settlement conferences would be beneficial. The Kansas Medical Society and the Kansas Trial Lawyers Association advocated mandatory settlement conferences. The Trial Lawyers suggested that a judge other than the trial judge conduct the conference. The Medical Society supported imposing sanctions against a party that refuses to settle and does not better its position by at least 25 percent at trial.

Judge Patrick Kelly, U.S. District Judge, supported the use of settlement conferences but did not support making

them mandatory in all courts, although, as part of a pilot project they are mandatory for all cases before his court. Two district court judges indicated mandatory settlement conferences were not needed since most cases (95 percent) were settled before trial anyway.

Structured Awards and Settlements. The Kansas Medical Society and some other health care provider groups and several insurers supported structured awards and settlements. A representative of the Kansas Bar Association supported a uniform method of calculating future damages. Providers Insurance Company said the details of structured settlements should be left to private industry. The Kansas Trial Lawyers Association favored structuring payments for future medical care only.

Expert Witness Limitations. The Kansas Medical Society, a representative of the Western Insurance Companies, and several others advocated limiting expert witnesses to those persons residing in Kansas or the surrounding states. The Medical Society also advocated imposing a qualification that experts must devote 75 percent of their time to clinical practice. The Medical Society arguments were 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 were said to make their livelihood from court testimony.

Representatives of the legal profession and several judges argued 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 that there is a national standard for physician providers who are board certified.

Itemized Jury Awards. There was a general consensus by conferees who addressed this issue that itemized awards were a good idea or, at least, would not create problems.

Post Judgment Interest. The Kansas Medical Society, the Kansas Bar Association, and the Citizens Committee

advocated tying the post judgment interest rate to the treasury bill rate.

Other Reforms Discussed. A representative of the Western Insurance Companies and several others supported legislation to "tighten up" jury instructions regarding the standard of care through statutory provisions. An argument made is that the current Pattern Instructions for Kansas (PIK) are too broad, lead to confusion, and facilitate a finding of negligence. Representatives of the Kansas Bar Association and several district judges pointed out that PIK instructions can be 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.

The Kansas Medical Society advocated the sunset provision of Sub. for S.B. 110 be repealed.

Various other reforms were also discussed before the Committee.

Insurance Issues

The following reflects the testimony and discussion of various insurance issues raised before the Committee.

Insurance Experience Rating by Primary Carriers. Representatives of the Kansas Bar and some Committee members 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. Currently, the Joint Underwriting Association (JUA) uses individual provider claim and loss experience as a factor in its determination of physician insurance costs. New York recently mandated insurance experience rating of physicians.

Advocates said that 1 percent of the physicians in Kansas account for a much larger percent of the paid claims and that without experience rating, health care providers with

good records unduly subsidize the rest. Advocates noted under the current system a type of experience rating occurs since rates of the Medical Protective Company, which writes insurance on a selective basis and is one of the major malpractice insurers, are significantly lower than rates of St. Paul Fire and Marine, another of the major insurers, and that the JUA Plan base rates are generally 20 percent higher than St. Paul's rates. The JUA does experience rate providers as noted above.

Several insurers 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 opposed merit rating because it was feared this would have a negative effect on the sense of unity and solidarity of the medical profession. It was also argued that number of claims may not correlate directly with competence since certain high risk specialties are more subject to lawsuits.

Experience Rating by the Health Care Stabilization Fund. Both the Kansas Trial Lawyers Association and the Citizens Committee recommended that level rate classifications for health care provider specialties be implemented and that an experience rating factor be added within classifications to reflect increased risk to the Fund. The level rate classification concept was proposed due to the fact that Fund surcharges now are based on a percent of the primary carrier's premium amount. Doctors of the same specialty, however, pay different insurance rates. For example, a doctor practicing obstetrics and gynecology under 1985 rates will pay $11,970 for base coverage if insured by Medical Protective but $20,052 if insured by St. Paul and $24,062 if insured by the JUA Plan. When the 110 percent premium surcharge is added, the total premium costs will vary from $25,137 for Medical Protective insureds to $50,530 for JUA Plan insureds. In this example, it is possible that none of the doctors have ever had a claim filed against them.

Reduction in Amount of Fund or Excess Coverage. Both the Kansas Bar Association and the Kansas Trial Lawyers Association advocated reducing the liability of the Health

Care Stabilization Fund from $3 million to $1 million per claim as an alternative to any type of overall cap on damage awards. They said physicians who desired higher limits of excess coverage could obtain this coverage in the private insurance market.

The Kansas Medical Society and the Medical Protective Company said insurance excess coverage markets are not readily available at this time.

Defense of the Health Care Stablization Fund. Several judges, a plaintiff's attorney, a doctor, and others complained about the Fund's legal representation. Some 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 currently is receiving good quality representation. Several conferees 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 the discovery period and be represented during any settlement negotiations.

The Insurance Department testified that independent counsel is now hired to review claims to determine potential Fund liability and to ascertain whether there may be a conflict of interest between defense of the Fund and of the private insurer. It was pointed out that a claims review position had been filled this fall to monitor the paperwork and oversee proper reserve maintenance. It was suggested that there is a need for additional clerical staff.

The Citizens Committee recommended additional secretarial and clerical staff for the Fund.

Periodic Payment of Surcharges. The Kansas Medical Society, several doctors, the Eureka Chamber of Commerce, and the Citizens Committee suggested health care providers be permitted to make monthly or other periodic payments of Fund surcharges.

Alternative Methods for Payment of Medical Malpractice Insurance Costs. Several conferees and some committee members proposed different methods for paying for medical malpractice insurance costs. One idea discussed was to give local units of government the option of levying taxes to pay or help pay medical malpractice insurance costs for health care providers. Another concept considered was a 1/4 percent increase in the premium tax on all insurance companies doing business in Kansas. An idea discussed in conjunction with the tax increase was the creation of a board of doctors whose task would be to oversee the use of the proceeds of the tax for needy doctors in rural areas who could not afford to pay their medical malpractice premiums.

A third alternative discussed was a surcharge on all hospital and surgical center admissions, with these moneys to be placed in the Health Care Stabilization Fund to lower costs. Finally, the idea of a surcharge on all health insurance policies was considered.

It was pointed out that nearly $141 million was collected for automobile liability bodily injury insurance premiums in 1984 compared to $14.8 million for medical malpractice liability insurance. This $141 million figure does not contain premium costs for personal injury protection (PIP) premiums which accounted for an added $29.1 million in 1984. Further, it was noted that Kansans paid an estimated $3.35 billion (preliminary estimate) for health care in 1984 or approximately $1,375 per capita. This preliminary estimate by the Kansas Department of Health and Environment includes personal expenditures for health care, government program expenditures, and administrative costs. Viewed from this perspective, medical malpractice insurance costs represent just over 10 percent of the insurance costs for automobile bodily injury and account for less than .5 percent of the total health care costs for 1984.

Some Committee members argued the proper approach to solving the problem of high medical malpractice insurance costs was to spread these costs over the general population rather than limiting the rights of medical malpractice victims. The Committee, however, rejected each of the alternatives noted above.

Other Insurance Issues Considered. Other issues advocated or commented upon by conferees or Committee members included the following: whether investment income should be considered in ratemaking by insurance companies; whether the Fund or the JUA Plan ought to be abolished; whether the mandatory insurance requirements for health care providers ought to be repealed; whether insurance company underwriting standards ought to be regulated to require coverage of broader groups of insureds; whether a risk management program ought to be implemented by the Fund; and whether the Insurance Department should be required to collect more specific data on providers and to monitor insurance rates more effectively.

In addition, the Committee heard from representatives of the University of Kansas Medical Center and the Kansas Board of Regents regarding problems with insuring medical residents who moonlight at other jobs while at the Medical Center. This issue also was brought before the Legislative Budget Committee, which agreed to deal with the problem.

Health Care Provider Issues

Board of Healing Arts Performance Audit. The Board of Healing Arts was the subject of a performance audit completed last summer by the Division of Legislative Post Audit. The auditors were directed to address two questions: whether current procedures for reporting cases of incompetent health care practitioners to the Board appear to be adequate, and how effective the Board is in protecting the public against the unprofessional, improper or unqualified practice of the healing arts. (A third question asked concerned the trend in the balances of the Health Care Stabilization Fund.) The audit recommendations are noted below.

Enhanced Reporting Requirements — Immunity. It was the consensus of all conferees who appeared before the Committee and who addressed the reporting issue that reporting requirements regarding incompetent health care providers should be upgraded. Various suggestions were made by different conferees and groups. The performance audit report, in

response to the question of whether reporting requirements regarding incompetent health care providers are adequate, recommended that hospital staffs and licensees be required to report to the Board information received that a licensee may have committed an act which "may" be grounds for disciplinary action. Also, hospitals should report whenever licensees voluntarily surrender or limit their hospital privileges while under formal or informal investigation.

The auditors recommended that state agencies, law enforcement agencies, and medical associations be required to report to the Board any licensees who are incompetent, impaired, or who otherwise violate the Kansas Healing Arts Act. Finally, the auditors recommended the Board be empowered to levy fines against organizations or licensees who fail to report as required.

The audit recommendations generally were endorsed by the Board of Healing Arts. In addition, the Board suggested that plaintiffs' attorneys be required to report to the Board the exact nature of a lawsuit against a licensee; that the Insurance Department be required to report licensees who may be incompetent; that peer review records of hospitals regarding licensees be submitted to the Board; and that hospitals in other states report licensees who voluntarily surrender privileges.

The Kansas Trial Lawyers Association suggested the repeal of the confidentiality of peer review records.

The Kansas Medical Society recommended reporting procedures to require licensees and others to report providers who may act beneath the appropriate standards of care to the appropriate local or state professional society or, in certain cases, to the chief administrative officer of a hospital. If a determination is made by the professional society or by the hospital official that the provider acted contrary to the standard of care, then this must be reported to the appropriate licensing agency. The recommendation provided that no person shall be liable for reporting unless the information is completely false. No civil liability would accrue for failure to report, but intentional failure to report would be a class C

misdemeanor. The Medical Society also supported a requirement that all insurers report claims filed against providers to the appropriate licensing agency and to the Commissioner of Insurance.

Representatives of Medical Protective and Western Insurance Companies supported insurers reporting incidents of medical malpractice if immunity for reporting was provided.

The Citizens Committee recommended that persons who report deficiencies to a hospital peer review committee or to the Kansas Board of Healing Arts be given a specific statutory cause of action to authorize courts to grant reinstatement of employees discharged for filing reports and to order back pay. The Citizens Committee also endorsed the other recommendations in the audit report regarding reporting.

Powers and Membership of the Board of Healing Arts. It was the general consensus of conferees who addressed this topic that the powers of the Kansas Board of Healing Arts should be expanded and that it should devote more attention to negligent providers.

The Legislative Post Audit report, in regard to the second audit question of how effective the Board was in dealing with unprofessional, improper or unqualified practitioners, concluded that a better system to track licensees' disciplinary problems was needed. Also, the auditors concluded that high priority should be given to investigating licensees with multiple claims filed against them or when gross negligence is alleged; that the Board should be empowered to levy fines against licensees in addition to other sanctions; that the Board membership should be expanded by adding one or more public members; and that methods should be implemented to insure all providers are carrying the required insurance.

These audit recommendations were also endorsed by the Kansas Board of Healing Arts and the Kansas Trial Lawyers, who supported expanded disciplinary powers. The Board asked for powers of censure, reprimand, and annulment of a license when obtained by fraud, and for authority to require public

service as a condition of continued licensure and to require remedial education. The Kansas Medical Society supported requiring a competency exam prior to reissuance of a suspended or revoked license. Remedial education was supported by the Citizens Committee. The Board also suggested that podiatrists be covered by any new law and recommended an increase in the amount of fines which now can be imposed.

The Citizens Committee suggested the Board be given authority to examine and copy documents, reports, and records relating to the practice of any licensee. Other recommendations of the Citizens Committee included that the present makeup of review committees appointed by the Board be altered; that relicensure be tied to proof that the licensee carries the required insurance; and that statutes include as a reason for disciplinary action the voluntary surrender or limitation of a license in another state or country if the surrender was in lieu of prosecution or revocation.

Impaired Physicians. The Board of Healing Arts, the Citizens Committee, and the Kansas Medical Society supported legislation to deal with impaired physicians. The Medical Society recommendation would authorize a state licensing agency to enter into agreements with a private association or society for provider treatment programs. Exemptions from reporting statutes would be provided.

The Kansas Trial Lawyers advocated criminal sanctions (class E felony) be imposed against providers, acting under the influence of alcohol or drugs, when treating patients.

Risk Management and Other Issues. A number of conferees supported improving or even mandating risk management procedures. The Chairman of the Obstetrics/Gynecology Department at Wesley Medical Center in Wichita explained that hospital's new risk management procedures. A representative of the Kansas Medical Society noted that a joint effort with the Kansas Hospital Association is underway to develop improved risk management procedures for Kansas hospitals. The Hospital Association reported that the Joint Commission on the Accreditation of Hospitals (JCAH) requires accredited hospitals to maintain an ongoing quality assurance program.

Various other issues regarding health care providers were raised by conferees.

Conclusions

The Committee concludes there is a problem with rising medical malpractice insurance premium costs which, if not addressed, will affect health care delivery and availability in Kansas. The Committee does not believe Kansas licensees in medicine and surgery will be willing to continue business as usual in their practices if costs of professional liability insurance are not stabilized. The Committee believes that ample evidence has been presented to show that a problem of affordability now exists which requires legislative action.

The Committee believes that there are various causes for this problem of affordability. It also recognizes that its recommendations may not reach some of these causes. Nonetheless, the Committee feels obligated to address as many of the factors contributing to increased costs as it can.

The Committee finds that two factors have impacted insurance: (1) jury awards in Kansas and other areas, and (2) increasing numbers of suits filed. It believes there is an increasing propensity to sue health care providers (and others). Some of the willingness to sue may be explained by depersonalized patient-provider relationships. The lack of time providers have to spend with patients, poor communication, higher patient expectations, and more of a consumer attitude on the part of patients have all contributed to the increased number of lawsuits in this area. Some attorneys who are willing to bring marginal cases when the possibility of medical negligence is slight also have added to the problem.

The Committee believes the affordability problem also has been caused by the insurance industry itself, due to ratemaking procedures which factor in national as well as state experience in order to arrive at Kansas medical malpractice insurance rates. The recent investment losses of

insurers nationally and internationally have had an impact on all types of liability insurance.

The Committee believes that the unwillingness of insurers to experience rate health care providers also may be a factor in the affordability problem. In addition, the current method of funding the Health Care Stabilization Fund on the basis of a percentage of the insured's primary coverage premium has had the effect of increasing costs to certain high risk specialties.

The Committee believes that medical negligence does exist and that the powers of the Board of Healing Arts are not adequate to insure timely removal or limitation of negligent practitioners of the healing arts. Additionally, the Committee believes that health care institutions should accept responsibility for reducing the risk of negligence in patient care through the development of risk management programs. The members believe that all health care provider regulatory agencies should receive information relating to actions filed against those providers whose practice they regulate.

The Committee believes that the current method of imposing surcharges for the Health Care Stabilization Fund is inequitable and should be changed to impose these surcharges at the same rate, with provision for a higher rate when loss experience justifies such treatment.

The Committee notes that licensees in medicine and surgery are now required to pay medical malpractice premiums and surcharges as individuals and, additionally, must pay these costs for professional associations they may belong to (albeit at a reduced rate). The Committee believes this dual coverage requirement is not necessary to protect the public welfare and is aggravating a problem that already exists with high insurance costs.

For these reasons the Committee is making a number of recommendations with the following broad objectives in mind: stabilize medical malpractice premium costs; deter negligent practice and improve the quality of health care; assure consumer access to needed care; control health care costs;

promote reasonable patient expectations; assure equitable and adequate patient redress for negligent injury; encourage timely resolution of malpractice suits; discourage frivolous, nuisance, or groundless claims; and develop legislation that can withstand constitutional challenge. The Committee's recommendations are aimed at tort reform, reform of insurance practices, and more effective regulation of the practices of health care providers.

Recommendations

The Committee recommends the following tort and insurance reforms and changes in the regulation of health care professionals which are incorporated in H.B. 2661.

Limitation on Awards. A $1 million overall cap on all damage awards against health care providers is imposed. A $250,000 cap on pain and suffering damages is included. All future damages other than for pain and suffering must be structured. In addition, juries are required to itemize awards to reflect noneconomic losses, and past and future economic losses.

Tort Procedures. The finding of screening panels appointed to review the question of whether a health care provider has been negligent is made admissible in trial. Payment for the panel is established. Costs of the panel shall be borne by the side in whose favor a decision is rendered. If the panel is unable to make a recommendation, the costs shall be split between the parties.

Mandatory settlement conferences are required to be conducted by the trial judge or his designee not more than 30 days after the close of discovery. Any party who rejects a settlement offer and does not better his position by at least 25 percent by going to trial shall be liable for the reasonable attorney fees of the other party after the date of the offer.

Expert witnesses are required to have devoted at least 50 percent of their professional time to clinical practice in the past two years in order to qualify as expert witnesses.

Attorney fees for either party must be approved at an evidentiary hearing at which the judge must determine the reasonableness of the fees based upon eight factors, which now appear in the lawyer canon of ethics regarding fees.

Health Care Stabilization Fund. The excess coverage exposure for the Fund would be reduced to $1 million per claim with an annual aggregate of $3 million per health care provider.

The method for computing Fund surcharges is amended to require health care providers within the same rate classification to pay the same surcharge; however, health care providers with poor loss experience will be required to pay higher rates.

The Fund coverage for inactive health care providers is amended. After July 1, 1986, inactive health care providers must have paid surcharges for at least three consecutive years in order to qualify for continued coverage. If they do not qualify for coverage they must show proof of equivalent insurance.

Other Insurance Changes. The bill requires partnerships of persons who are health care providers to obtain the mandatory insurance coverages so that vicarious liability of one health care provider for another may be abolished if both are covered by the Fund. Further, insurers may exclude from coverage liability for those health care providers already required to maintain professional liability insurance.

Health Care Providers — Reporting. Insurers providing professional liability insurance would be required to report within 30 days any written or oral claims for medical malpractice to the appropriate state licensing agency and the State Department of Insurance. The reports shall be confidential and not admissible in civil or criminal trials nor in administrative proceedings, except in administrative licensure

proceedings. Insurers shall be subject to civil fines of not to exceed $1,000 for each day after the 30-day period for failure to report. Insurers who make these reports in good faith shall not be liable in any civil action for reporting.

Medical care facilities licensed by the Department of Health and Environment must report and other persons may report to the State Board of Healing Arts any actions of a licensee which may be grounds for revocation, suspension, or limitation of the person's license. Medical care facilities would be required to report any recommendation for the termination, suspension, or restriction of practice privileges of licensees or the voluntary surrender or limitation of privileges which are related to a person's competence. Reporting penalties, procedures, and immunities are similar to those noted above. Failure to report is made a grounds for revocation, denial, or suspension of the facilities' license to operate.

Licensees of the State Board of Healing Arts would be required to report knowledge of another licensee that "may be" grounds for license limitations or revocation.

Risk Management — Impaired Providers. The bill mandates that all medical care facilities establish internal risk programs and, in 1987, submit for approval such plans to the Secretary of the Department of Health and Environment. Failure to maintain a risk management program shall be grounds for the denial or revocation of a facility's license. Reporting procedures are established for medical care providers and facility agents and employees for the reporting of actions of providers that may be below the applicable standard of care. Procedures are established for dealing with providers who are impaired due to abuse of alcohol, drugs, or deterioration through aging.

State licensing agencies may enter into agreements with impaired provider committees of private associations, societies, or organizations of the healing arts for treatment programs. Participation in these programs may not be the sole grounds for excluding a health care provider from a medical facility staff.

Immunity from civil suits is established for persons reporting or investigating reports of providers acting beneath the appropriate standard of care. In addition, state antitrust immunity is granted to health care providers and review, executive, and impaired provider committees when carrying out their duties.

State Board of Healing Arts. The number of public members on the Board is expanded from one to three. In addition, the grounds for revocation, limitation, or suspension of a licensee's license (including failure to maintain insurance or pay surcharges as required), and the definition of professional incompetence are expanded. The powers of the Board are expanded to include the powers of annulment or public or private censure, and imposition of civil fines of not to exceed $15,000 (third offense) against licensees who violate provisions of the Kansas Healing Arts Act.

Post Judgment Interest. The Committee is recommending a second bill, H.B. 2662, to tie the post judgment interest rate in all civil cases to the treasury bill rate. Currently the post judgment interest rate is set by statute at 15 percent.

The Committee also endorses S.B. 382, which amends the Kansas Insurance Premium Finance Act to permit the installment payment of Fund surcharges.

The Committee delegated to the Chairman the decision regarding the number of bills that should be introduced incorporating the various changes recommended. Staff advised that the safest way to avoid a constitutional challenge that a bill contain two subjects was to introduce several bills. Article 2, section 16 of the Kansas Constitution requires that a bill contain only one subject.

The Chairman, after a review of relevant case law (State v. Reves, 233 Kan 972 (1983), and State ex rel Stephan v. Board of Lyon County Commissioners, 234 Kan. 732 (1984)) which appears to permit comprehensive legislation to be encompassed in one bill, decided that all the Committee's recommendations should be incorporated in one bill. An

exception was made for the post judgment interest amendment which applies to all civil cases and the recommendation regarding installment payment of Fund surcharges which is already incorporated in holdover S.B. 382. The Chairman's rationale was that the Committee's work should be considered as a comprehensive package. Further, the Chairman was aware that the wisdom of such a decision can be further reviewed by the full Legislature and the Governor before being examined by the Kansas Supreme Court.

Respectfully submitted,

December 6, 1985

Rep. Joe Knopp, Chairperson
Special Committee on Medical Malpractice

Sen. Jack Walker,
Vice-Chairman
Sen. Roy M. Ehrlich
Sen. Paul Feleciano, Jr.
Sen. Frank D. Gaines
Sen. Jeanne Hoferer
Sen. Nancy Parrish
Sen. Jack Steineger
Sen. Robert Talkington
Sen. Wint Winter, Jr.
Sen. Eric Yost

Rep. Marvin Barkis
Rep. William Brady
Rep. J. Frank Buehler
Rep. Rex Hoy
Rep. Ruth Luzzati
Rep. Michael O'Neal
Rep. Vincent Snowbarger
Rep. John Solbach
Rep. Dale Sprague
Rep. Thomas Walker

MINORITY REPORT

The Committee chair was quoted at the time of his appointment to this Committee saying that to fulfill our charge was an ambitious undertaking for the time period the Committee had to grapple with this very complex and esoteric issue. Time was well utilized but ran out before the Committee could adequately study some major areas of the charge. We recommend that more time and care be taken to dig further into this issue and to develop questions, particularly with regard to rate setting within the insurance industry. The 1975 interim committee recommended laws that were enacted in the 1976 session. Further study was recommended, and two years of additional study was completed before enactment of the final legislative package in 1978. This Committee should be so deliberative in order to render a more comprehensive report on this issue.

We concur with the majority report on 17 of the recommended proposals which were incorporated into the recommended legislation. These proposals largely result from serious bipartisan Committee work aimed at improving a system of health care delivery and fair and equitable redress for loss in a strengthened judicial system better sensitized to deal with the issue of medical negligence. These proposals include:

1. Limit post judgment interest rate to current market rates in an effort to be fair to both parties and to reduce the cost on the health care stabilization fund when good faith appeals are prosecuted.

2. Incorporate into the attorney's fees approval statute the ethical considerations that must be considered in determining whether or not attorney's fees are reasonable, and also to require an evidentiary hearing on the reasonableness of fees.

3. Average premium surcharges within classes to eliminate the current penalty physicians pay for being insured by the wrong insurance carrier and experience rate physicians for the purpose of levying surcharges to prevent excessive rates from being charged against physicians with good loss records.

4. Qualify expert witnesses based upon a certain percentage of clinical practice to assure the setting of a fair and reasonable standard of care.

5. Itemize jury verdicts to prevent unconscionably large awards and facilitate remittitur when appropriate.

6. Require reporting of certain events by medical care facilities and others to the board of healing arts.

7. Require insurers to report certain information to the board of healing arts.

8. Require reporting to the board of healing arts of licensees in certain cases where medical negligence occurs and setting forth additional and reasonable grounds for license revocation or modification.

9. Require more efficient and appropriate risk management/peer review to reduce the incidence of potentially compensable events.

10. Eliminate the need for health care providers to provide double liability, both individually and through their corporation, when one individual coverage is sufficient.

11. Reduce the limits of liability on the health care stabilization fund to $1 million.

12. Add three public members to the board of healing arts to facilitate greater layman input.

13. Allow civil penalties to be imposed for violation of the Healing Arts Act. Also, expand the range of disciplinary actions that can be taken against a licensee by the board of healing arts.

14. Require settlement conferences in medical malpractice cases together with penalties for failing to reasonably settle.

15. Allow health care providers to pay premium surcharges in installments.

16. Require the structuring of future damages by the purchasing of an annuity.

We are greatly concerned, however, about arbitrary caps on awards and mandatory screening panels in all cases.

Caps on Awards

Arbitrary caps provide insurance companies with a greater degree of certainty in rate setting and reduce premiums accordingly; but, this provides no trade-off benefit to already seriously injured victims who would be further victimized by the arbitrary cap.

The aura of crisis in medical malpractice insurance premiums is perpetrated, not so much by what medical malpractice insurance premiums are (currently between 1 to 3 1/2 percent of health care costs), but by what doctors fear they may become if current trends continue. The fires of panic have been fanned by wild speculation about future large jury awards and future malpractice insurance costs unless we put hobbles on a victim's right to recover.

The pervasive insurance problem, caused in part by insurance companies over-extending themselves in the late

1970's and the early 1980's, in competition for scarce premium dollars, has been brought to focus upon the medical community through rising insurance rates. Still, most physicians pay relatively modest rates in Kansas ($3,000 to $7,000 when after expense but before tax income for physicians averages $110,000 annually). Erratic cycles in the insurance industry have affected all liability insurance, but according to experts, the dramatic increases are stabilizing and premiums will be more reasonable.

Further, statutes passed in recent years to make the Health Care Stabilization Fund more actuarially sound have also resulted in short-term increases in premiums to repay past debts. Future solvency would be assured by careful monitoring of assets and liabilities.

In the interim we are being asked to subsidize the system out of the damages to which the most seriously injured victims of malpractice are now entitled. These 6 to 12 persons per year whose damages will be in excess of $1 million, (current damages plus current value of future damages) will arbitrarily be denied full recovery so the physicians can pay less in medical malpractice insurance premiums and insurance companies can be more free of risk.

Through limits on awards, health professionals transfer the burden of liability to their patients, most of whom cannot economically bear the loss. The physicians have, as one author puts it, "kept the benefits and socialized the risks of harm" inherent in the practice of medicine. The fact is limits on awards constitute special interest protectionism that has no basis as an appropriate public policy. Plain and simple, some of the majority's recommendations (caps on awards) are made solely because they erroneously perceive the legal community to be unjustly enriched by medical malpractice actions. This point begs the question. If there are things wrong with juries or judges or our court system, then we should strengthen the judicial system, not unilaterally deprive seriously injured persons full compensation from that court system.

The majority report barely touches on a significant part of the high premium surcharge for health care providers.

Actuaries hired by the insurance department indicate that one-third of the 110 percent premium surcharge in 1985-86 is to make up for a three-year period when physicians received unlimited coverage in the fund and paid no surcharge whatsoever and an additional year when such unlimited coverage was obtained for a mere 15 percent surcharge. Premium surcharges today would be one-third lower had a more prudent surcharge policy been in place from 1980 through 1983. Graphs in the National Conference of State Legislatures' document "What Legislators Need to Know About Medical Malpractice" show that during this time period, all indicators, including claims filed, the Medical Care Index of the Consumer Price Index, and basic insurance premiums were rising. The majority seems to be saying that victims who, in the future, seek full recovery for catastrophic injury resulting from medical negligence should be held responsible for the errors of judgment in the Insurance Commissioner's Office over which they had no control.

Ironically, the Medical Care Index has risen faster than medical malpractice insurance premiums over the last decade. It is the rise in costs of health care that will make the effect of the cap that much more tragic to a seriously injured victim.

Less restrictive alternatives are available. Actuaries hired by the Insurance Commissioner told the Committee that limits of $1 million on indemnity and $1 million per incident of liability on the fund result in the same reduction of premium surcharge. Under the second alternative, physicians would be free to choose whether or not to purchase excess insurance for coverage above $1 million.

To simply lower the limits of liability of the Health Care Stabilization Fund (HCSF) from $3 million to $1 million is expected to result in a 95 percent premium surcharge in 1986-87. A $1 million cap is expected to result in a 94.1 percent premium surcharge. The difference between the two alternatives is insignificant. Another alternative is a 1/4 of 1 percent tax on all insurance sold in this state. This places an insurance problem at the door of the insurance industry. If this cost were passed on, it would cost Kansas consumers $3 per person per year, and raise about $7 million for the Health Care

Stabilization Fund. If 80 to 90 percent of this amount were applied directly, it would reduce physician premium surcharges a very meaningful 20-30 percent. The majority rejected this idea. If, as everyone agrees, Kansans have a stake in the availability and affordability of quality medical care, this proposal would put more money into the fund faster without discriminating against any class of citizens. Further, by targeting a 10 to 20 percent portion of this fund to physicians who need assistance in underserved areas or who are practicing part-time, or are newly-practicing in high-risk specialties, we reach the real problem of availability of health care as it is impacted by rising medical malpractice insurance premiums.

The state of Indiana has had, for ten years, an arbitrary cap on awards to victims of malpractice. Recent reports show the system to be fiscally insolvent, to be a slow and cumbersome process, and to be more costly (an average of $15,000 more per case over ten years in Indiana than in the current Kansas system where cases are decided on an individual basis). A physician/lawyer from Indiana called the caps "unconscionable," because the arbitrary award failed to compensate the most seriously injured victims.

We oppose arbitrarily restricting the rights of innocent Kansas citizens, who have already suffered grave injury, unless there is a compelling public good. Until other reasonable alternatives are tried, and proved to have failed, it is irresponsible for the Kansas Legislature to curtail the rights of the public to protect the purses of a special interest.

The cycles of the insurance industry, which encouraged underpricing in the early 80s to lure investment income, and resulted in a drastic rise in premiums to offset lower interest rates, have helped to cause dramatic rate increases in liability insurance. The medical malpractice situation in Kansas is compounded by a state-run medical insurance company, the Health Care Stabilization Fund, which was never operated on an actuarially sound basis. Initial premiums for unlimited insurance coverage were quite low, and for three years, Kansas doctors paid no premium for unlimited dollar coverage above $100,000. This was during a time when medical costs were soaring.

The Committee recommendations are appropriate, requiring experience rating of the surcharge and reduction of Health Care Stabilization Fund liability from $3 million to $1 million per provider.

Kansas is the only state requiring physicians to purchase $3 million in coverage from its HCSF. Reducing liability coverage to $1 million is supported by almost everyone except the medical community who fear they cannot get excess coverage. The availability (or lack of availability) of excess insurance coverage is a prime reason health care providers want the limit on awards.

Most states already have fund liability limits at $1 million. Physicians in those states have been able to purchase excess coverage. St. Paul Insurance currently writes excess coverage for their insureds if their insureds have the basic policy with St. Paul. It is our understanding the American Medical Association is developing a program of providing excess coverage for their members.

Mandatory Screening Panels

The Committee report describes current malpractice screening panel law. Such panels are rarely used, because the panel results are not admissible as evidence in subsequent trials; so neither party usually wants the added expense of convening a panel.

Evidence also presented to the Committee indicated the number of claims continue to rise each year but the number of claims closed each year with payment remains fairly constant, between 147 and 167 between FY 1980 and FY 1984. These statistics indicate more claims are filed each year resulting in no awards, which indicates a need for a more thorough screening panel process.

However, a more thorough screening panel process does not require screening every claim.

The majority recommends making the results of screening panels admissible at trial, raising the compensation for panelists, and having the winner of the screening panel pay the costs. That response is simplistic. Either party can request a panel, and obviously, defendants will make the request in each case. The majority recommendation leaves solely in the hands of the defense the questions of whether or not a screening panel is needed and impaneled.

In states where mandatory screening panels have been ruled unconstitutional, the primary reason has been that the process constitutes an unreasonable bar for litigants proceeding to court with one's claim, or the panel as enacted is constitutional, but as applied causes unreasonable delays and burdens on the legal system. We heard testimony from practicing lawyers in Indiana where every case is screened, who indicated the screening panel process often adds 18 months to their litigation time. Changes in screening panel practices in Indiana, effective September 1, 1985, show their legislature is concerned about this delay. Yet our response is to implement their provisions in our law that cause similar delays. This is not a sensible proposal unless it is an attempt to frustrate plaintiffs' cases.

There are numerous questions relating to the majority's screening panel recommendation that must be answered. It is likely that substantial amending will have to take place. Otherwise, adoption, as is, of the recommendations will guarantee that these laws will be challenged repeatedly in court. Our work product will be found seriously flawed. We endorse increased use of the current frivolous lawsuit statute, which assesses penalties and fines to lawyers who file unwarranted cases.

In addition, unless a medical expert is available to certify that negligence has occurred, a panel of doctors to screen cases prior to trial may help to eliminate questionable cases. But if experienced counsel have reviewed a case file, and qualified medical experts are willing to testify that malpractice has occurred, a screening panel becomes a needlessly expensive, time-consuming, and cumbersome blockade for the victims.

Conclusion

The answer to medical malpractice insurance problems is not to further victimize those who have had the misfortune to have suffered a serious injury through medical negligence.

As a society, we want access to affordable quality health care, and also demand to be protected from tragic mistakes.

We support taking action on medical malpractice in 1986, and recommend a variety of proposals aimed at lowering insurance rates and protecting the public. Until these proposals become law and are judged to be ineffective, it is premature, unfair, and very probably unconstitutional to restrict the rights of innocent victims by (1) creating a special class of tortfeasors and according them special protection in the form of arbitrary caps on awards and (2) requiring a time consuming screening panel process before victims can obtain adequate compensation. We, therefore, recommend that these two proposals of the majority be scrutinized before the legislature stampedes to enact them.

As a footnote we are concerned that the majority chose to put all of these pieces of legislation into one bill, particularly when staff clearly warned the Committee that such action could result in the violation of the constitutional prohibition of having more than one subject in one bill. This is important legislation and it is important that we accomplish substantive action this session. We should not be playing constitutional roulette with this important legislative package.

Respectfully submitted,

Sen. Paul Feleciano, Jr.
Sen. Nancy Parrish
Sen. Jack Steineger
Rep. Marvin Wm. Barkis
Rep. Ruth Luzzati
Rep. John M. Solbach

Session of 1986

HOUSE BILL No. 2661

By Special Committee on Medical Malpractice

Re Proposal No. 47

12-17

AN ACT concerning certain health care providers; relating to medical malpractice liability and insurance coverage therefor; concerning regulation of certain health care providers; amending K.S.A. 7-121b, 65-430, 65-2809, 65-2812, 65-2813, 65-2814, 65-2822, 65-2833, 65-2836, 65-2837, 65-2838, 65-2840a, 65-2898a, 65-28,121, 65-28,122, 65-4902, 65-4904 and 65-4907 and K.S.A. 1985 Supp. 40-3003, 40-3401, 40-3403, 40-3404 and 40-3408 and repealing the existing sections.

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

New Section 1. As used in sections 1 through 10:

(a) "Department" means the department of health and environment.

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

(c) "License," "licensee" and "licensing" include comparable terms which relate to regulation similar to licensure, such as certification or registration.

(d) "Medical care facility" has the meaning provided by K.S.A. 65-425 and amendments thereto.

(e) "Reportable incident" means an act by a health care provider which is or may be below the applicable standard of care.

(f) "Risk manager" means the individual designated by a medical care facility to administer its internal risk management program and to receive reports of reportable incidents within the facility.

(g) "Secretary" means the secretary of health and environment.

New Sec. 2. (a) Each medical care facility shall establish and maintain an internal risk management program which shall consist of:

(1) A system for investigation and analysis of the frequency and causes of reportable incidents within the facility;

(2) measures to minimize the occurrence of reportable incidents and the resulting injuries within the facility; and

(3) a reporting system based upon the duty of all health care providers staffing the facility and all agents and employees of the facility directly involved in the delivery of health care services to report reportable incidents to the chief of the medical staff, chief administrative officer or risk manager of the facility.

(b) Not less than 60 days before the time for renewal of its license in 1987, each medical care facility shall submit to the department its plan for establishing and implementing an internal risk management program. Failure to submit such a plan shall result in denial of the renewal of the facility's license.

(c) Upon review of a plan submitted pursuant to subsection (b), the department shall determine whether the plan meets criteria of this section. If the plan does not meet such criteria, the department shall disapprove the plan and return it to the facility, along with the reasons for disapproval. Within 60 days, the facility shall submit to the department a revised plan which meets the objections of the department. No medical care facility shall be granted renewal of its license in 1988 unless its plan has been approved by the department.

New Sec. 3. (a) If a health care provider, or a medical care facility agent or employee who is directly involved in the delivery of health care services, has knowledge that a health care provider has committed an act which is or may be below the applicable standard of care, such health care provider, agent or employee shall report such knowledge as follows:

(1) If the reportable incident did not occur in a medical care facility, the report shall be made to the appropriate state or county professional society or organization, which shall refer the matter to a professional practices review committee duly constituted pursuant to the society's or organization's bylaws. The

committee shall investigate all such reports and take appropriate action. The committee shall have the duty to report to the appropriate state licensing agency any finding by the committee that a health care provider acted below the applicable standard of care so that the agency may take appropriate disciplinary measures.

(2) If the reportable incident occurred within a medical care facility, the report shall be made to the chief of the medical staff, chief administrative officer or risk manager of the facility. The chief of the medical staff, chief administrative officer or risk manager shall refer the report to the appropriate executive committee or professional practices peer review committee which is duly constituted pursuant to the bylaws of the facility. The committee shall investigate all such reports and take appropriate action. In making its investigation, the committee may also consider treatment rendered by the health care provider outside the facility. The committee shall have the duty to report to the appropriate state licensing agency any finding by the committee that a health care provider acted below the applicable standard of care so that the agency may take appropriate disciplinary measures.

(3) If the health care provider involved in the reportable incident is a medical care facility, the report shall be made to the chief of the medical staff, chief administrative officer or risk manager of the facility. The chief of the medical staff, chief administrative officer or risk manager shall refer the report to the appropriate executive committee which is duly constituted pursuant to the bylaws of the facility. The executive committee shall investigate all such reports and take appropriate action. The committee shall have the duty to report to the department of health and environment any finding that the facility acted below the applicable standard of care so that appropriate disciplinary measures may be taken.

(b) If a reportable incident is reported to a state agency which licenses health care providers, the agency may investigate the report or may refer the report to a review or executive committee to which the report could have been made under subsection (a) for investigation by such committee.

(c) Each review and executive committee referred to in subsection (a) shall submit to the appropriate state licensing agency, at least once every three months, a report summarizing the reports received by the committee pursuant to this section. The report shall include the number of reportable incidents reported, whether an investigation was conducted and any action taken.

(d) If a state agency that licenses health care providers determines that a review or executive committee referred to in subsection (a) is not fulfilling its duties under this section, the agency, upon notice and an opportunity to be heard, may require all reports pursuant to this section to be made directly to the agency.

New Sec. 4. (a) If a report to a state licensing agency pursuant to subsection (a)(1) or (2) of section 3 or any other report or complaint filed with such agency relates to a health care provider's inability to practice the 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 the appropriate state or county professional society or organization.

(b) The state licensing agency shall have the authority to enter into an agreement with the impaired provider committee of the appropriate state or county professional society or organization to undertake those functions and responsibilities specified in the agreement and to provide for payment therefor from moneys appropriated to the agency for that purpose. Such functions and responsibilities may include any or all of the following:

(1) Contracting with providers of treatment programs;

(2) receiving and evaluating reports of suspected impairment from any source;

(3) intervening in cases of verified impairment;

(4) referring impaired providers to treatment programs;

(5) monitoring the treatment and rehabilitation of impaired health care providers;

(6) providing posttreatment monitoring and support of reha-

bilitated impaired health care providers; and

(7) performing such other activities as agreed upon by the licensing agency and the impaired providers committee.

(c) The provider committee shall develop procedures in consultation with the licensing agency for:

(1) Periodic reporting of statistical information regarding impaired provider program activity;

(2) periodic disclosure and joint review of such information as the licensing agency considers appropriate regarding reports received, contacts or investigations made and the disposition of each report, except that the committee shall not disclose any personally identifiable information except as provided in subsections (c)(3) and (c)(4);

(3) 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 self;

(4) reporting to the licensing agency, in a timely fashion, any impaired provider who refuses to cooperate with the committee or 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;

(5) informing each participant of the impaired provider committee of the procedures, the responsibilities of participants and the possible consequences of noncompliance.

(d) If the licensing agency has reasonable cause to believe that a health care provider is impaired, the licensing agency may cause an evaluation of such health care provider 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.

(e) An impaired health care provider may submit a written request to the licensing agency for a restriction of the provider's 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 statutory procedure for reinstatement of license.

(f) 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 law of this state.

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

(h) Notwithstanding any other provision of law, a state or county professional society or organization and the impaired provider committee members thereof shall not be liable to any person for any acts, omissions or recommendations made in good faith while acting within the scope of the responsibilities imposed pursuant to this section.

New Sec. 5. (a) The following reports and records made pursuant to section 3 or 4 shall be confidential and are not admissible in any civil or administrative action other than a disciplinary proceeding by the appropriate state licensing agency:

(1) Reports and records of executive or review committees of medical care facilities or of a professional society or organization;

(2) reports and records of the chief of the medical staff, chief administrative officer or risk manager of a medical care facility; and

(3) reports and records of any state licensing agency or impaired provider's committee which pertain to impaired providers.

(b) No person in attendance at any meeting of an executive or review committee of a medical care facility or of a professional society or organization while such committee is engaged in the duties imposed by section 3 shall be compelled to testify in any civil, criminal or administrative action, other than a disciplinary proceeding by the appropriate licensing agency, as to any committee discussions or proceedings.

(c) No person in attendance at any meeting of an impaired provider committee shall be required to testify in any civil,

criminal or administrative action, other than a disciplinary proceeding by the appropriate state licensing agency, as to any committee discussions or proceedings.

New Sec. 6. Any person or entity which, in good faith, reports or provides information or investigates any health care provider as authorized by section 3 or 4 shall not be liable in a civil action for damages or other relief arising from the reporting, providing of information or investigation except upon clear and convincing evidence that the report or information was completely false, or that the investigation was based on false information, and that the falsity was actually known to the person making the report, providing the information or conducting the investigation at the time thereof. No claim arising from the making of such report, providing of such information or conduct of such investigation shall proceed to trial unless the court first determines that a substantial probability exists that the person making the claim will prevail.

New Sec. 7. (a) No person or entity shall be subject to liability in a civil action for failure to report as required by section 3 or 4.

(b) The license of a person or entity licensed to practice as a health care provider may be revoked, suspended or limited, or the licensee subjected to public or private censure, by the appropriate state licensing agency if the licensee is found, upon notice and an opportunity to be heard in accordance with the Kansas administrative procedures act, to have willfully and knowingly failed to make any report as required by section 3 or 4.

(c) Willful and knowing failure to make a report required by section 3 or 4 is a class C misdemeanor.

New Sec. 8. (a) No employer shall discharge or otherwise discriminate against any employee for making any report pursuant to section 3 or 4.

(b) Any employer who violates the provisions of subsection (a) shall be liable to the aggrieved employee for damages for any wages or other benefits lost due to the discharge or discrimination plus a civil penalty in an amount not exceeding the amount of such damages. Such damages and civil penalty shall be re-

coverable in an individual action brought by the aggrieved employee.

New Sec. 9. (a) The legislature of the state of Kansas recognizes the importance and necessity of providing and regulating certain aspects of health care delivery in order to protect the public's general health, safety and welfare. Implementation of risk management plans and reporting systems as required by sections 2, 3 and 4 effectuate this policy.

(b) Health care providers and review, executive or impaired provider committees performing their duties under sections 2, 3 and 4 for the purposes expressed in subsection (a) shall be agents of state agencies which license health care providers and all immunity of the state from federal and state antitrust laws shall be extended to such health care providers and committees when carrying out such duties.

(c) Nothing in this section shall be construed to require health care providers or review, executive or impaired provider committees to be subject to or comply with any other law relating to or regulating state agencies, officers or employees.

New Sec. 10. The provisions of sections 1 through 9 shall be supplemental to K.S.A. 65-28,121, 65-28,122 and 65-4909, and amendments thereto, and shall not be construed to repeal or modify those sections.

New Sec. 11. As used in sections 11 through 15:

(a) The words and phrases defined by K.S.A. 1985 Supp. 60-3401 and amendments thereto shall have the meanings provided by that section.

(b) "Current economic loss" means costs of medical care and related benefits, lost wages and other economic losses incurred prior to the verdict.

(c) "Future economic loss" means costs of medical care and related benefits, lost wages, loss of earning capacity or other economic losses to be incurred after the verdict.

(d) "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 to provide medical ser-

vices required due to the negligent rendering of or failure to render professional services by the liable health care provider.

New Sec. 12. (a) In any medical malpractice liability action:

(1) The total amount recoverable for all claims for noneconomic loss shall not exceed $250,000; and

(2) the total amount recoverable for all claims shall not exceed $1,000,000.

(b) If a medical malpractice liability action is tried to a jury, the court shall not instruct the jury on the limitations imposed by this section.

(c) In a medical malpractice liability action, after deduction of amounts pursuant to K.S.A. 60-258a and amendments thereto:

(1) If the verdict results in an award for noneconomic loss which exceeds $250,000, the court shall enter judgment for $250,000 for all claims for noneconomic loss and shall apportion that amount among the claimants.

(2) If the verdict results in an award for current economic loss which exceeds the difference between $1,000,000 and the amount of the judgment entered for damages for noneconomic loss, the court shall enter judgment for an amount equal to such difference for all claims for current economic loss and shall apportion that amount among the claimants.

(3) If the sum of the judgments entered for noneconomic loss and for current economic loss is $1,000,000 or more, no judgment shall be entered for future economic loss. If the sum of such judgments is less than $1,000,000 and the verdict results in an award for future economic loss which exceeds the difference between $1,000,000 and the sum of such judgments, the court shall enter judgment for an annuity contract which: (A) Has a present value equal to such difference or, if there is more than one claimant, for annuity contracts apportioned among the claimants which have an aggregate present value equal to such difference; and (B) which, to the greatest extent possible, will provide for the payment of benefits over the period of time specified in the verdict in the amount awarded by the verdict for future economic loss.

(d) The provisions of this section shall not be construed to

repeal or modify the limitation provided by K.S.A. 60-1903 and amendments thereto in wrongful death actions.

New Sec. 13. (a) In every medical malpractice liability action in which the verdict awards compensatory damages, the verdict shall be itemized to reflect the amounts awarded for economic loss and noneconomic loss. The amount awarded for economic loss shall be further itemized to show current economic losses and future economic losses.

(b) In every medical malpractice liability action in which the verdict awards damages for future economic losses, the verdict shall specify the period of time over which payment for such losses will be needed.

New Sec. 14. (a) In any medical malpractice liability action in which the verdict awards damages for future economic loss, the verdict shall not reduce such damages to their present value and the jury shall be instructed to that effect. Except as provided by section 12, the court shall enter judgment, with respect to such damages, for an annuity contract which will provide for the payment of benefits over the period of time specified in the verdict in the amount awarded by the verdict for future economic loss.

(b) In a medical malpractice liability action, that portion of the attorney fees which relates to an award for future economic loss shall be calculated on the present value of the annuity contract.

(c) Benefits paid under an annuity contract awarded pursuant to this section or section 12 shall not be assignable or subject to levy, execution, attachment, garnishment or any other remedy or procedure for the recovery or collection of a debt, and this exemption cannot be waived.

New Sec. 15. The provisions of sections 11 through 14 shall apply only to medical malpractice liability actions which are based on causes of action accruing on or after July 1, 1986.

New Sec. 16. In any medical malpractice liability action, as defined in K.S.A. 1985 Supp. 60-3401 and amendments thereto, in which the standard of care given by a practitioner of the healing arts is at issue, no person shall qualify as an expert

witness on such issue unless at least 50% of such person's professional time within the two-year period preceding the incident giving rise to the action is devoted to actual clinical practice in the same profession in which the defendant is licensed, and in the same specialty if the defendant is a specialist.

New Sec. 17. (a) In any medical malpractice liability action, as defined by K.S.A. 1985 Supp. 60-3401 and amendments thereto, the court shall require a settlement conference to be held not more than 30 days after the close of discovery.

(b) The settlement conference shall be conducted by the trial judge or the trial judge's designee. The 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.

(c) Offers, admissions and statements made in conjunction with or during the settlement conference shall not be admissible at trial or in any subsequent action.

(d) Subject to the provisions of subsections (e), (f) and (g), in addition to assessment of costs pursuant to K.S.A. 60-2002 and amendments thereto:

(1) If, during the settlement conference, a party against whom a claim is asserted proposes an offer of settlement which is rejected by the claimant and the final judgment against such party is at least 25% less than such offer, the party against whom the claim was asserted shall be entitled to recover reasonable attorney fees incurred from the date of the offer.

(2) If, during the settlement conference, a claimant proposes an offer of settlement which is rejected by the party against whom the claim is asserted and the final judgment against such party is at least 25% greater than such offer, the claimant shall be entitled to recover reasonable attorney fees incurred from the date of the offer.

(e) If both the party making a claim and the party against whom such claim is asserted would otherwise be entitled to recover reasonable attorney fees under subsection (d), neither such party shall be entitled to recover such fees.

(f) If attorney fees are awarded to a claimant pursuant to this

section in an action in which the health care stabilization fund is a party, such fees, and any costs awarded pursuant to K.S.A. 60-2002 and amendments thereto, shall not be assessed against the fund if the fund has demanded that the insurer or self-insurer providing basic coverage offer to pay the limit of such insurer's or self-insurer's liability and such insurer or self-insurer has failed to offer to pay such limits as of the date of the settlement conference. In such a case such fees and costs shall be assessed to such insurer.

(g) In adition to those cases in which the health care stabilization fund is assessed attorney fees pursuant to subsection (d), in any action in which the fund is a party, if the fund makes an offer for more than 80% but less than 100% of the maximum amount for which it may be liable and the amount awarded by the jury to the claimant is at least 25% greater than the fund's offer, the claimant shall be entitled to recover reasonable attorney fees incurred from the date of the offer. Such fees, and any costs awarded pursuant to K.S.A. 60-2002 and amendments thereto, shall be assessed against the fund.

(h) The court in its discretion may relieve any party of the penalty imposed by subsection (d), (f) or (g) if the witnesses, exhibits or evidence presented at trial were not reasonably available at the time of the settlement conference to the party against whom the penalty would otherwise be assessed.

New Sec. 18. (a) Any insurer providing professional liability insurance coverage to a health care provider, as defined by K.S.A. 40-3401 and amendments thereto, who is licensed in Kansas shall report to the appropriate state health care provider regulator agency and the state department of insurance any written or oral claim or action for damages for medical malpractice. The report shall be filed no later than 30 days following the insurer's receipt of notice of the claim or action and shall contain:

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

(2) the date of the occurrence giving rise to the claim, the date the occurrence was reported to the insurer, and the date legal action, if any, was initiated.

(b) Upon request of an agency to which a report is made under subsection (a), the insurer making the report shall provide to the agency no later than 30 days following receipt of the request or receipt of the information, whichever is later:

(1) The names of all defendants involved in the claim; and

(2) a summary of the occurrence, 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.

(c) Reports required to be filed pursuant to this section shall be confidential and shall not be admissible in any civil or criminal action or in any administrative proceeding other than a disciplinary proceeding of a health care provider involved in the reported occurrence.

(d) Any insurer which fails to report any information as required by this section shall be subject, after proper notice and an opportunity to be heard, to:

(1) A civil fine assessed by the commissioner of insurance in an amount not exceeding $1,000 for each day after the thirty-day period for reporting that the information is not reported; and

(2) suspension, revocation, denial of renewal or cancellation of the insurer's certificate of authority to do business in this state or certificate of self-insurance.

The commissioner of insurance shall remit promptly to the state treasurer any moneys collected from fines assessed pursuant to this subsection. Upon receipt thereof, the state treasurer shall deposit the entire amount in the state treasury and credit it to the state general fund.

(e) Any insurer which, in good faith, reports or provides any information pursuant to this act shall not be liable in a civil action for damages or other relief arising from the reporting or providing of such information.

(f) As used in this section, "insurer" means insurer or self-insurer, as defined by K.S.A. 40-3401 and amendments thereto, or joint underwriting association operating pursuant to K.S.A. 40-3413 and amendments thereto.

New Sec. 19. (a) The state board of healing arts, in addition to any other penalty prescribed under the Kansas healing arts act, may assess a civil fine, after proper notice and an opportunity to be heard, against a licensee for a violation of the Kansas healing arts act in an amount not to exceed $5,000 for the first violation, $10,000 for the second violation and $15,000 for the third violation and for each subsequent violation. All fines assessed and collected under this section shall be remitted promptly to the state treasurer. Upon receipt thereof, the state treasurer shall deposit the entire amount in the state treasury and credit it to the state general fund.

(b) This section shall be part of and supplemental to the Kansas healing arts act.

New Sec. 20. Any resident or nonresident inactive health care provider who does not qualify for fund coverage under K.S.A. 40-3403 and amendments thereto shall submit to the commissioner of insurance satisfactory proof of equivalent professional liability insurance coverage.

Sec. 21. K.S.A. 7-121b is hereby amended to read as follows: 7-121b. *(a)* Whenever a civil action is commenced by filing a petition or whenever a pleading ~~shall state~~ *states* a claim in a district court for damages for personal injuries or death arising out of the rendering of or the failure to render professional services by any health care provider, compensation for reasonable ~~attorneys'~~ *attorney* fees to be paid by each litigant in the action shall be approved by the judge *after an evidentiary hearing and* prior to final disposition of the case by the district court. Compensation for reasonable ~~attorneys'~~ *attorney* fees for services performed in an appeal of a judgment in any such action to the court of appeals shall be approved *after an evidentiary hearing* by the chief judge or by the presiding judge of the panel hearing the case. Compensation for reasonable ~~attorneys'~~ *attorney* fees for services performed in an appeal of a judgment in any such action to the supreme court shall be approved *after an evidentiary hearing* by the departmental justice for the department in which the appeal originated. In ~~approving~~ *determining*

the reasonableness of 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.~~ *consider the following:*

(1) The time and labor required, the novelty and difficulty of the questions involved and the skill requisite to perform the legal service properly.

(2) The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the attorney.

(3) The fee customarily charged in the locality for similar legal services.

(4) The amount involved and the results obtained.

(5) The time limitations imposed by the client or by the circumstances.

(6) The nature and length of the professional relationship with the client.

(7) The experience, reputation and ability of the attorney or attorneys performing the services.

(8) Whether the fee is fixed or contingent.

(b) As used in this section: ~~(a)~~ *(1)* "Health care provider" means a person licensed to practice any branch of the healing arts, a person who holds a temporary permit to practice any branch of the healing arts, a person engaged in a postgraduate training program approved by the state board of healing arts, a licensed medical care facility, a health maintenance organization, a licensed dentist, a licensed professional nurse, a licensed practical nurse, a licensed optometrist, a registered podiatrist, a registered pharmacist, 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 registered physical therapist or an officer, employee or agent thereof acting in the course and scope of ~~his or her~~ *such person's* employment or agency; and ~~(b)~~ *(2)* "professional services" means those services which require licensure, registration or certifica-

tion by agencies of the state for the performance thereof.

Sec. 22. K.S.A. 1985 Supp. 40-3003 is hereby amended to read as follows: 40-3003. (a) This act shall apply to direct life insurance policies, health insurance policies, *annuity contracts awarded pursuant to section 12 or 14* and contracts supplemental to life and health insurance policies issued by persons authorized to transact insurance in this state at any time.

(b) This act shall not apply to:

(1) Any such ~~policies or contracts, or any part of such policies or contracts,~~ *policy or contract or part thereof* under which the risk is borne by the policyholder;

(2) any such policy or contract or part thereof assumed by the impaired insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued;

(3) any such policy or contract issued by persons transacting business pursuant to the provisions of K.S.A. 40-202 and amendments thereto; and

(4) any annuity ~~contracts except~~ *contract, except: (A)* With respect to contractual obligations of impaired insurers for which the association has become liable prior to July 1, 1985*; and (B) an annuity contract awarded pursuant to section 12 or 14.*

Sec. 23. K.S.A. 1985 Supp. 40-3401 is hereby amended to read as follows: 40-3401. As used in this act the following terms shall have the meanings respectively ascribed to them herein:

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

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

tice 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 who, at the time a claim is made for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider, does not have basic coverage or self-insurance in effect solely because such person *or entity* is no longer engaged in rendering professional service as a health care provider~~;~~.

(h) "Insurer" means any corporation, association, reciprocal exchange, inter-insurer and any other legal entity authorized to write bodily injury or property damage liability insurance in this state, including workmen's compensation and automobile liability insurance, pursuant to the provisions of 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 postgraduate 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. 24. K.S.A. 1985 Supp. 40-3403 is hereby amended to read as follows: 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 time that such health care provider or self-insurer has qualified for coverage under the provisions of this act, there is hereby established the health care stabilization fund. The fund shall be held in trust in a segregated fund in the state treasury. The commissioner shall administer the fund or contract for the administration of the fund with an insurance company authorized to do business in this state.

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

(A) *Provide* technical assistance with respect to administration of the fund;

(B) *provide* such expertise as the commissioner may reasonably request with respect to evaluation of claims or potential

claims;

(C) *provide* advice, information and testimony to the appropriate licensing or disciplinary authority regarding the qualifications of a health care provider~~.~~*;*

(D) approve the rating schedule formulated by the commissioner to impose the higher surcharge required by subsection (c)(2) of K.S.A. 40-3404 and amendments thereto.

(2) The board shall consist of 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 member appointed from the public at large who is not affiliated with any health care provider; (C) three members licensed to practice medicine and surgery in Kansas who are doctors of medicine; (D) three members who are representatives of Kansas hospitals; (E) two members licensed to practice medicine and surgery in Kansas who are doctors of osteopathic medicine; (F) one member licensed to practice chiropractic in Kansas; and (G) two members of other categories of health care providers. Meetings shall be called by the chairperson or by a written notice signed by three 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 (i)*, 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 *of* or the failure to render professional services within this state~~.~~, *but* 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 *arising out 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 *of* or failure to render professional services within this state~~.~~ *prior to July 1, 1986, but* 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 into the fund either of the following or a combination thereof for at least three consecutive years: (i) The applicable annual premium surcharge, or (ii) an amount equal to the annual premium surcharge paid by a health care provider in the rate classification which was applicable to such inactive health care provider for the most recent year professional services were rendered; (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 75-3744, inclusive~~ *through 75-3744*, 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 75-3744, inclusive~~ *through 75-3744*, and amendments thereto; ~~(8)~~ *(9)* annually to the plan or plans, any amount due pursuant to subsection (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) ~~or~~, (4) *or 5* of subsection (c) ~~of this section~~ shall be paid promptly and in full ~~if less than $300,000, or if~~, *except that, in any case arising out of a cause of action which accrued before July 1, 1986, if the amount for which the fund is liable is* $300,000 or more, *it shall be paid* 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 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~~.~~ *and* any ~~attorney's~~ *attorney* fees payable from such installment shall be similarly prorated.

(e) 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~~ *on* and after July 1, 1984, *and before 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 $6,000,000 for each provider.

(f) *In no event shall the fund be liable to pay in excess of $1,000,000 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 on 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 $3,000,000 for each provider.

(g) 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.

~~(g)~~ *(h) A health care provider who is 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 inside or outside this state by any other health care provider who is also qualified for coverage under the fund.*

(i) Notwithstanding the provisions of K.S.A. 40-3402 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 30 days after the date of the determination by the board of governors. The board of governors, upon termination of the liability of the fund under this subsection ~~(g)~~, 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. 25. K.S.A. 1985 Supp. 40-3404 is hereby amended to read as follows: 40-3404. (a) Except for any health care provider whose participation in the fund has been terminated pursuant to subsection ~~(g)~~ *(i)* of K.S.A. 40-3403 and amendments thereto, the commissioner shall levy an annual premium surcharge on each

health care provider who has obtained basic coverage and upon each self-insurer for each fiscal year. Such premium surcharge shall be an amount equal to a percentage of the *average* annual premium paid by ~~the~~ *all* health care ~~provider~~ *providers within the rate classification of the health care provider* for the basic coverage required to be maintained as a condition to coverage by the fund by subsection (a) of K.S.A. 40-3402 and amendments thereto. The annual premium surcharge upon each self-insurer, except for the university of Kansas medical center, shall be an amount equal to a percentage of the *average* amount ~~such self-insurer~~ *all self-insurers within the rate classification of the self-insurer* would pay for basic coverage as calculated in accordance with rating procedures approved by the commissioner pursuant to K.S.A. 40-3413 and amendments thereto. The annual premium surcharge upon 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 postgraduate training program approved by the state board of healing arts and operated by the university of Kansas medical center shall be an amount equal to a percentage of an assumed aggregate premium of $600,000.

(b) In the case of a resident health care provider who is not a self-insurer, the premium surcharge shall be collected in addition to the annual premium for the basic coverage by the insurer and shall not be subject to the provisions of K.S.A. 40-252, 40-1113 and 40-2801 *et seq.*, and amendments ~~to these sections~~ *thereto*. The amount of the premium surcharge shall be shown separately on the policy or an endorsement thereto and shall be specifically identified as such. Such premium surcharge shall be due and payable by the insurer to the commissioner within 30 days after the annual premium for the basic coverage is received by the insurer, but in the event basic coverage is in effect at the time this act becomes effective, such surcharge shall be based upon the unearned premium until policy expiration and annually thereafter. Within 15 days immediately following the effective date of this act, the commissioner shall send to each insurer information necessary for their compliance with this subsection.

The certificate of authority of any insurer who fails to comply with the provisions of this subsection shall be suspended pursuant to K.S.A. 40-222 and amendments thereto until such insurer shall pay the annual premium surcharge due and payable to the commissioner. In the case of a nonresident health care provider or a self-insurer, the premium surcharge shall be collected in the manner prescribed in K.S.A. 40-3402 and amendments thereto.

(c) The premium surcharge shall be an amount deemed sufficient by the commissioner to fund anticipated claims based upon reasonably prudent actuarial principles. In setting the amount of such surcharge, the commissioner: (1) May require any health care provider who has paid a surcharge for less than 24 months to pay a higher surcharge than other health care providers; *(2) shall require a health care provider with a poor loss experience with respect to medical malpractice liability actions to pay a higher surcharge than other health care providers;* and ~~(2)~~ *(3)* shall amortize any anticipated deficiencies in the fund over a reasonable period of time. *The rating schedule formulated by the commissioner to impose a higher surcharge required by subsection (c)(2) shall be approved by the board of governors.*

Sec. 26. K.S.A. 1985 Supp. 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. 40-3402 and amendments thereto to maintain professional liability insurance in effect as a condition to rendering professional services as a health care provider in this state.

Sec. 27. K.S.A. 65-430 is hereby amended to read as follows: 65-430. The licensing agency may deny, suspend or revoke a license in any case in which it finds that there has been a substantial failure to comply with the requirements established under this law, *a failure to report any information required to be reported by K.S.A. 65-28,121 and amendments thereto or a failure to maintain a risk management program as required by section 2,* after notice and an opportunity for hearing to the applicant or licensee in accordance with the provisions of the Kansas administrative procedure act.

Sec. 28. K.S.A. 65-2809 is hereby amended to read as follows: 65-2809. *(a)* The license shall expire on June 30 each year and may be renewed annually upon request of the licensee. The request for renewal shall be on a form provided by the board and shall be accompanied by the prescribed fee, which shall be paid not later than the expiration date of the license.

(b) Except as otherwise provided in this section, ~~from and after July 1, 1978,~~ the board shall require every licensee in the active practice of the healing arts within the state to submit evidence of satisfactory completion of a program of continuing education required by the board. The requirements for continuing education for licensees of each branch of the healing arts shall be established by the members of such branch on the board. The board by duly adopted rules and regulations shall establish the requirements established by the members of each branch of the healing arts for each program of continuing educa-

tion as soon as possible after the effective date of this act. In establishing such requirements the members of the branch of the healing arts so establishing shall consider any programs of continuing education currently being offered to such licensees. If, immediately prior to the effective date of this act, any branch of the healing arts is requiring continuing education or annual postgraduate education as a condition to renewal of a license of a licensee of such branch of the healing arts, such requirement as a condition for the renewal of such license shall continue in full force and effect notwithstanding any other provision of this section to the contrary.

(c) Prior to renewal of a license, the board shall require the licensee, if in the active practice of the healing arts within the state, to submit to the board evidence satisfactory to the board that the licensee is maintaining a policy of professional liability insurance as required by K.S.A. 40-3402 and amendments thereto and has paid the annual premium surcharge as required by K.S.A. 40-3404 and amendments thereto.

(d) At least ~~thirty~~ ~~(30)~~ *30* days before the expiration of ~~his or her~~ *a licensee's* license, the secretary of the board shall notify ~~each~~ *the* licensee *of the expiration* by mail addressed to ~~his or her~~ *the licensee's* last place of residence as noted upon the office records. ~~Any licensee who~~ *If the licensee* fails to pay the annual fee ~~within thirty (30) days after~~ *by the date of* the expiration of ~~his or her~~ *the* license, *the licensee* shall be given a second notice that ~~his or her~~ *the licensee's* license has expired ~~and~~, that the board will suspend action for ~~ninety (90)~~ *30* days following the date of expiration ~~and~~, that~~,~~ upon receipt of the annual fee~~,~~ together with an additional fee of not to exceed ~~fifty dollars ($50)~~ *$500* within the ~~ninety (90) day~~ *thirty-day* period no order of revocation will be entered~~, but that upon the failure to receive the amount then due, including the additional fee of not to exceed fifty dollars ($50)~~ *and, if both fees are not received within the thirty-day period,* the license shall be canceled.

(e) Any licensee who allows ~~his or her~~ *the licensee's* license to lapse by failing to renew as herein provided may be reinstated upon recommendation of the board and upon payment of the

renewal fees then due and from and after July 1, 1978, upon proof of compliance with the continuing educational requirements established by the board.

Sec. 29. K.S.A. 65-2812 is hereby amended to read as follows: 65-2812. (a) For the purpose of administering the provisions of this act, the governor shall appoint a state board of healing arts consisting of ~~13~~ *15* members. ~~At least 30 days before the expiration of any term, other than that of the member appointed from the general public and the registered podiatrist member of the board, the professional society or association shall submit to the governor a list of three or more names of persons of recognized ability who have the qualifications prescribed for board members for each member of the board who will be appointed from its branch of the healing arts. The governor shall consider the list of persons in making the appointment to the board. In case of a vacancy on the board, other than that of the member appointed from the general public and the registered podiatrist member of the board, prior to the expiration of a term of office, the governor shall appoint a qualified successor to fill the unexpired term, and in making the appointment the governor shall give consideration to the list of persons last submitted to the governor.~~

(b) The provisions of the Kansas sunset law apply to the state board of healing arts appointed pursuant to this section and the board is subject to abolition under that law.

Sec. 30. K.S.A. 65-2813 is hereby amended to read as follows: 65-2813. Five ~~(5)~~ members of the board shall hold a degree of doctor of medicine from an accredited medical school and shall be residents of and have been actively engaged in the practice of medicine and surgery in the state of Kansas under license issued in this state, for a period of at least six ~~(6)~~ consecutive years immediately preceding their appointment; three ~~(3)~~ members shall hold a degree of doctor of osteopathy from an accredited school of osteopathic medicine and surgery and shall be residents of and have been actively engaged in the practice of osteopathic medicine and surgery in the state of Kansas under license issued in this state, for a period of at least six ~~(6)~~ consec-

utive years immediately preceding their appointment; ~~and~~ three ~~(3)~~ members shall hold a degree of doctor of chiropractic from an accredited school of chiropractic and shall be residents of and have been actively engaged in the practice of chiropractic in the state of Kansas under license issued in this state, for a period of at least six ~~(6)~~ consecutive years immediately preceding their appointment; ~~and~~ one member shall be a registered podiatrist and shall be a resident of and have been actively engaged in the practice of podiatry in the state of Kansas under license issued in this state for a period of at least six ~~(6)~~ consecutive years immediately preceding appointment; and ~~one member shall be from~~ *three members shall be appointed to represent* the general public of this state *and no two of such members representing the general public shall be from the same United States congressional district.*

Sec. 31. K.S.A. 65-2814 is hereby amended to read as follows: 65-2814. Whenever a vacancy ~~shall occur~~ *occurs* in the membership of the board, the governor shall appoint a successor of like qualifications. All appointments made shall be for a term of four ~~(4)~~ years, but no member shall be appointed for more than three ~~(3)~~ successive four-year terms, except that any term served by a member as secretary shall not be considered in applying successive term limitations. ~~The term of the board member from the general public, first appointed, and the term of the registered podiatrist, first appointed, shall commence on July 1, 1975, in the case of the member from the general public and July 1, 1976, in the case of the registered podiatrist.~~ Each *member* shall serve until ~~his or her~~ *a* successor is appointed and qualified. Whenever a vacancy ~~shall occur~~ *occurs* in the membership of the board for any reason other than the expiration of a member's term of office, the governor shall appoint a successor of like qualifications to fill the unexpired term.

Sec. 32. K.S.A. 65-2822 is hereby amended to read as follows: 65-2822. ~~Seven (7)~~ *Eight* members shall constitute a quorum for the transaction of business.

Sec. 33. K.S.A. 65-2833 is hereby amended to read as follows: 65-2833. The board, without examination, may issue a

license to a person who has been in the active practice of a branch of the healing arts in some other state, territory, the District of Columbia or other country upon certificate of the proper licensing authority of that state, territory, District of Columbia or other country certifying that the applicant is duly licensed, that ~~his or her~~ *the applicant's* license has never been *annulled,* suspended or revoked, *that the licensee has never been censured or had other disciplinary action taken* and that, so far as the records of such authority are concerned, the applicant is entitled to its endorsement. The applicant shall also present proof satisfactory to the board:

(a) That the state, territory, District of Columbia or country in which the applicant last practiced has and maintains standards at least equal to those maintained by Kansas.

(b) That the applicant's original license was based upon an examination at least equal in quality to the examination required in this state and that the passing grade required to obtain such original license was comparable to that required in this state.

(c) Of the date of the applicant's original and any and all endorsed licenses and the date and place from which any license was attained.

(d) That the applicant has been actively engaged in practice under such license or licenses since issued, and if not, fix the time when and reason why the applicant was out of practice.

(e) That the applicant has a reasonable ability to communicate in English.

An applicant for endorsement registration shall not be licensed unless the applicant's individual qualifications meet the Kansas legal requirements.

In lieu of any other requirement prescribed by law for satisfactory passage of any examination in any branch of the healing arts the board may accept evidence satisfactory to it that the applicant or licensee has satisfactorily passed an equivalent examination given by a national board of examiners in chiropractic, osteopathic medicine and surgery or medicine and surgery as now required by Kansas statutes for endorsement from other states.

Sec. 34. K.S.A. 65-2836 is hereby amended to read as follows: 65-2836. A *licensee's* license may be *annulled,* revoked, suspended or limited ~~when the licensee has been found to have committed any of the following acts~~, *or the licensee may be publicly or privately censured, upon a finding of the existence of any of the following grounds*:

(a) *The licensee has committed* fraud ~~in~~ *or misrepresentation in applying for or* securing ~~the~~ *an original or renewal* license.

(b) *The licensee has committed an act of* immoral, unprofessional or dishonorable conduct or professional incompetency.

(c) ~~Conviction~~ *The licensee has been convicted* of a felony ~~if the board determines, after investigation, that such person has not been sufficiently rehabilitated to warrant the public trust~~ *or class A misdemeanor, whether or not related to the practice of the healing arts.*

(d) ~~Use of~~ *The licensee has used* fraudulent or false advertisements.

(e) ~~Addiction to or distribution of~~ *The licensee is addicted to or has distributed* intoxicating liquors or drugs for any other than lawful purposes.

(f) ~~Willful or repeated violation of~~ *The licensee has willfully or repeatedly violated* this act, the pharmacy act of the state of Kansas or the uniform controlled substances act, or any rules and regulations adopted pursuant thereto, or any rules and regulations of the secretary of health and environment which are relevant to the practice of the healing arts.

(g) ~~Unlawful invasion of~~ *The licensee has unlawfully invaded* the field of practice of any branch of the healing arts in which the licensee is not licensed to practice.

(h) ~~Failure~~ *The licensee has failed* to pay annual renewal fees specified in this act.

(i) ~~Failure~~ *The licensee has failed* to take some form of postgraduate work each year or as required by the board.

(j) ~~Engaging~~ *The licensee has engaged* in the practice of the healing arts under a false or assumed name, or the impersonation of another practitioner. The provisions of this subsection relating to an assumed name shall not apply to licensees practicing under a professional corporation or other legal entity duly authorized to provide such professional services in the state of Kansas.

(k) *The licensee has the* inability to practice the branch of the healing arts for which ~~such person~~ *the licensee* is licensed with reasonable skill and safety to patients by reason of illness, alcoholism, excessive use of drugs, controlled substances, chemical or any other type of material or as a result of any mental or physical condition. In determining whether or not such inability exists, the board, upon probable cause, shall have authority to compel a licensee to submit to mental or physical examination by such persons as the board may designate. The licensee shall submit to the board a release of information authorizing the board to obtain a report of such examination. Failure of any licensee to submit to such examination when directed shall constitute an admission of the allegations against the licensee, unless the failure was due to circumstances beyond the control of the licensee, and the board may enter a default and final order in any case of default without just cause being shown to the board without the taking of testimony or presentation of evidence. A person affected by this subsection shall be offered, at reasonable intervals, an opportunity to demonstrate that such person can resume the competent practice of the healing arts with reasonable skill and safety to patients. For the purpose of this subsection, every person licensed to practice the healing arts and who shall accept the privilege to practice the healing arts in this state by so practicing or by the making and filing of an annual renewal to practice the healing arts in this state shall be deemed to have consented to submit to a mental or physical examination when directed in writing by the board and further to have waived all objections to the admissibility of the testimony or examination report of the person conducting such examination at any proceeding or hearing before the board on the ground that such testimony or examination report constitutes a privileged communication. In any proceeding by the board pursuant to the provisions of this subsection, the record of such board proceedings involving the mental and physical examination shall not be used in any other administrative or judicial proceeding.

(l) *The licensee has* had a license to practice the healing arts *annulled*, revoked, suspended~~,~~ or limited ~~or~~, *has been censured or has* had other disciplinary action taken, or an application for a license denied, by the proper licensing authority of another state, territory, District of Columbia, or other country, *a certified copy of the record of the action of the other jurisdiction being conclusive evidence thereof.*

(m) *The licensee has* violated any lawful rule ~~or~~ *and* regulation promulgated by the board or violated any lawful order or directive of the board previously entered by the board.

(n) ~~Failure~~ *The licensee has failed* to report or reveal the knowledge required to be reported or revealed under K.S.A. 65-28,122 *and amendments thereto.*

(o) ~~Failure by persons~~ *The licensee, if* licensed to practice medicine and surgery, *has failed* to inform a patient suffering from any form of abnormality of the breast tissue for which surgery is a recommended form of treatment, of alternative methods of treatment specified in the standardized summary supplied by the board. The standardized summary shall be given to each patient specified herein as soon as practicable and medically indicated following diagnosis, and this shall constitute compliance with the requirements of this subsection ~~(o)~~. The board shall develop and distribute to persons licensed to practice medicine and surgery a standardized summary of the alternative methods of treatment known to the board at the time of distribution of the standardized summary, including surgical, radiological or chemotherapeutic treatments or combinations of treatments and the risks associated with each of these methods. Nothing in this subsection ~~(o)~~ shall be construed or operate to empower or authorize the board to restrict in any manner the right of a person licensed to practice medicine and surgery to recommend a method of treatment or to restrict in any manner a patient's right to select a method of treatment. The standardized summary shall not be construed as a recommendation by the board of any method of treatment. The preceding sentence or words having the same meaning shall be printed as a part of the standardized summary. The provisions of this subsection ~~(o)~~

shall not be effective until the standardized written summary provided for in this subsection ~~(o)~~ is developed and printed and made available by the board to persons licensed by the board to practice medicine and surgery.

(p) The licensee has cheated on or attempted to subvert the validity of the examination for a license.

(q) The licensee has been found to be mentally ill, disabled, not guilty by reason of insanity or incompetent to stand trial by a court of competent jurisdiction.

(r) The licensee has prescribed, sold, administered, distributed or given a controlled substance: (1) For other than medically accepted therapeutic purposes; (2) to the licensee's self; (3) to a member of the licensee's family; or (4) except as permitted by law, to a habitual user or addict.

(s) The licensee has violated a federal law or regulation relating to controlled substances.

(t) The licensee has failed to furnish the board, or its investigators or representatives, any information legally requested by the board.

(u) Sanctions or disciplinary actions have been taken against the licensee by a peer review committee, health care facility or a professional association or society for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(v) The licensee has failed to report to the board any adverse action taken against the licensee by another state or licensing jurisdiction, a peer review body, a health care facility, a professional association or society, a governmental agency, by a law enforcement agency or a court for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(w) The licensee has surrendered a license or authorization to practice the healing arts in another state or jurisdiction or has surrendered the licensee's membership on any professional staff or in any professional association or society while under investigation for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under

this section.

(x) The licensee has failed to report to the board surrender of the licensee's license or authorization to practice the healing arts in another state or jurisdiction or surrender of the licensee's membership on any professional staff or in any professional association or society while under investigation for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(y) The licensee has an 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 disciplinary action under this section.

(z) The licensee has failed to report to the board any adverse judgment, settlement or award against the licensee resulting from a medical malpractice liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section.

(aa) The licensee has failed to maintain a policy of professional liability insurance as required by K.S.A. 40-3402 and amendments thereto.

(bb) The licensee has failed to pay the annual premium surcharge as required by K.S.A. 40-3404 and amendments thereto.

Sec. 35. K.S.A. 65-2837 is hereby amended to read as follows: 65-2837. As used in K.S.A. 65-2836 and amendments thereto and in this section:

(a) "Professional incompetency" means:

(1) One or more instances involving gross negligence~~; or~~, *as determined by the board.*

(2) Repeated instances involving ordinary negligence, *as determined by the board.*

(3) A pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice medicine.

(b) "Unprofessional conduct" means:

(1) Solicitation of professional patronage through the use of fraudulent or false advertisements, or profiting by the acts of those representing themselves to be agents of the licensee.

(2) ~~Receipt of fees on the assurance~~ *Representing to a patient* that a manifestly incurable disease, *condition or injury* can be permanently cured.

(3) Assisting in the care or treatment of a patient without the consent of the patient, the attending physician or the patient's legal representatives.

(4) The use of any letters, words, or terms, as an affix, on stationery, in advertisements, or otherwise indicating that such person is entitled to practice a branch of the healing arts for which such person is not licensed.

(5) Performing, procuring or aiding and abetting in the performance or procurement of a criminal abortion.

(6) Willful betrayal of confidential information.

(7) Advertising professional superiority or the performance of professional services in a superior manner.

(8) Advertising to guarantee any professional service or to perform any operation painlessly.

(9) Participating in any action as a staff member of a medical care facility which is designed to exclude or which results in the exclusion of any person licensed to practice medicine and surgery from the medical staff of a nonprofit medical care facility licensed in this state because of the branch of the healing arts practiced by such person or without just cause.

(10) Failure to effectuate the declaration of a qualified patient as provided in subsection (a) of K.S.A. 65-28,107 and amendments thereto.

(11) Prescribing, ordering, dispensing, administering, selling, supplying or giving any amphetamines or sympathomimetic amines, except as authorized by K.S.A. 65-2837a *and amendments thereto.*

(12) Conduct likely to deceive, defraud or harm the public.

(13) Making a false or misleading statement regarding the licensee's skill or the efficacy or value of the drug, treatment or remedy prescribed by the licensee or at the licensee's direction in the treatment of any disease or other condition of the body or

mind.

(14) Aiding or abetting the practice of the healing arts by an unlicensed, incompetent or impaired person.

(15) Allowing another person or organization to use the licensee's license to practice medicine.

(16) Commission of any act of sexual abuse, misconduct or exploitation related to the licensee's practice of medicine.

(17) The use of any false, fraudulent or deceptive statement in any document connected with the practice of the healing arts.

(18) Obtaining any fee by fraud, deceit or misrepresentation.

(19) Directly or indirectly giving or receiving any fee, commission, rebate or other compensation for professional services not actually and personally rendered, other than through the legal functioning of lawful professional partnerships, corporations or associations.

(20) Failure to transfer medical records to another physician when requested to do so by the subject patient or by such patient's legally designated representative.

(c) "False advertisement" means any advertisement which is false, misleading or deceptive in a material respect. In determining whether any advertisement is misleading, there shall be taken into account not only representations made or suggested by statement, word, design, device, sound or any combination thereof, but also the extent to which the advertisement fails to reveal facts material in the light of such representations made.

(d) "Advertisement" means all representations disseminated in any manner or by any means, for the purpose of inducing, or which are likely to induce, directly or indirectly, the purchase of professional services.

Sec. 36. K.S.A. 65-2838 is hereby amended to read as follows: 65-2838. (a) The board shall have jurisdiction of ~~the~~ proceedings to ~~revoke, suspend or limit the license of~~ *take disciplinary action authorized by K.S.A. 65-2836 and amendments thereto against* any licensee practicing under this act. Any *such* action ~~for the revocation, suspension or limitation of a license~~ shall be taken in accordance with the provisions of the Kansas administrative procedure act.

(b) Either before or after formal charges have been filed, the board and the licensee may enter into a stipulation which shall be binding upon the board and the licensee entering into such stipulation, and the board may enter its findings of fact and enforcement order based upon such stipulation without the necessity of filing any formal charges or holding hearings in the case. An enforcement order based upon a stipulation may ~~revoke, suspend or limit the license of~~ *order any disciplinary action authorized by K.S.A. 65-2836 and amendments thereto against* the licensee entering into such stipulation.

(c) The board may temporarily suspend or temporarily limit the license of any licensee in accordance with the emergency adjudicative proceedings under the Kansas administrative procedure act if the board determines that there is cause to believe that grounds exist under K.S.A. 65-2836 and amendments thereto~~,~~ for ~~the revocation, suspension or limitation of the license of a~~ *disciplinary action authorized by K.S.A. 65-2836 and amendments thereto against the* licensee and that the licensee's continuation in practice would constitute an imminent danger to the public health and safety.

Sec. 37. K.S.A. 65-2840a is hereby amended to read as follows: 65-2840a. The state board of healing arts shall appoint a disciplinary counsel, who shall not otherwise be an attorney for the board, with *the* duties ~~as~~ set out in this act. The disciplinary counsel shall be an attorney admitted to practice law in the state of Kansas. The disciplinary counsel shall have the power and the duty to investigate or cause to be investigated all matters involving professional incompetency, unprofessional conduct or any other matter which may result in ~~revocation, suspension or limitation of a license~~ *disciplinary action against a licensee* pursuant to K.S.A. 65-2836 ~~to 65-2844, inclusive~~ *through 65-2844*, and amendments thereto. In the performance of these duties, the disciplinary counsel may apply to any court having power to issue subpoenas for an order to require by subpoena the attendance of any person or by subpoena *duces tecum* the production of any records for the purpose of the production of any information pertinent to an investigation. Subject to approval by

the state board of healing arts, the disciplinary counsel shall employ clerical and other staff necessary to carry out the duties of the disciplinary counsel. The state board of healing arts may adopt rules and regulations necessary to allow the disciplinary counsel to properly perform the functions of such position under this act.

Sec. 38. K.S.A. 65-2898a is hereby amended to read as follows: 65-2898a. (a) Any complaint or report, record or other information relating to a complaint which is received, obtained or maintained by the board shall be confidential and shall not be disclosed by the board or its employees in a manner which identifies or enables identification of the person who is the subject or source of such information except:

(1) In a disciplinary proceeding conducted by the board pursuant to law or in an appeal of the order of the board entered in such proceeding, or to any party to such proceeding or appeal or such party's attorney.

(2) To the proper licensing or disciplinary authority of another jurisdiction, if ~~the person's license to practice in this state has been at any time revoked, suspended or limited~~ *any disciplinary action authorized by K.S.A. 65-2836 and amendments thereto has at any time been taken against the licensee* or the board has at any time denied a license to the person.

(3) To a hospital committee which is authorized to grant, limit or deny hospital privileges, if ~~the person's license to practice in this state has been at any time revoked, suspended or limited~~ *any disciplinary action authorized by K.S.A. 65-2836 and amendments thereto has at any time been taken against the licensee* or if the board has at any time denied a license to the person.

(4) To the person who is the subject of the information, but the board may require disclosure in such a manner as to prevent identification of any other person who is the subject or source of the information.

(b) This section shall be part of and supplemental to the Kansas healing arts act.

Sec. 39. K.S.A. 65-28,121 is hereby amended to read as follows: 65-28,121. ~~(a) If the medical staff of any firm, facility, corporation, institution or association which has granted practice privileges to, or which has employed or is employing, any person licensed, registered or certified by the state board of healing arts, recommends that the practice privileges of any such person be terminated, suspended or restricted for reasons relating to such person's professional competence or finds that such person has committed an act which is a ground for the revocation, suspension or limitation of such person's license, registration or certification under law, the chief of the medical staff shall immediately report the same, under oath, to the state board of healing arts. If the medical staff has not made such a recommendation or finding, but the governing board of any such firm, facility, corporation, institution or association has made such recommendation or finding, the chief administrative officer thereof shall immediately report the same, under oath, to the state board of healing arts.~~

~~(b) Any report made pursuant to this section shall contain the name and business address of the chief of the medical staff or the chief administrative officer making the report and of the person named in the report, information regarding the report, and any other information which the chief of the medical staff or the chief administrative officer believes might be helpful in an investigation of the case.~~ *(a) A medical care facility licensed under K.S.A. 65-425 et seq. and amendments thereto shall, and any person may, report under oath to the state board of healing arts any information such facility or person has which appears to show that a person licensed to practice the healing arts has committed an act which may be a ground for disciplinary action pursuant to K.S.A. 65-2836 and amendments thereto.*

(b) A medical care facility shall inform the state board of healing arts whenever the medical care facility recommends that the practice privileges of any person licensed to practice the healing arts be terminated, suspended or restricted or whenever such privileges are voluntarily surrendered or limited for reasons relating to such person's professional competence.

(c) Any medical care facility which fails to report within 30

days after the receipt of information required to be reported by this section shall be reported by the state board of healing arts to the secretary of health and environment and shall be subject, after proper notice and an opportunity to be heard, to a civil fine assessed by the state board of healing arts in an amount not exceeding $1,000 per day for each day thereafter that the incident is not reported. All fines assessed and collected under this section shall be remitted promptly to the state treasurer. Upon receipt thereof, the state treasurer shall deposit the entire amount in the state treasury and credit it to the state general fund.

Sec. 40. K.S.A. 65-28,122 is hereby amended to read as follows: 65-28,122. (a) Any person licensed to practice the healing arts who possesses knowledge not subject to the physician-patient privilege that another person so licensed has committed any act enumerated under K.S.A. 65-2836 and amendments thereto which ~~is~~ *may be* a ground for ~~the revocation, suspension or limitation of a license~~ *disciplinary action pursuant to K.S.A. 65-2836 and amendments thereto* shall immediately report such knowledge, under oath, to the state board of healing arts. A person licensed to practice the healing arts who possesses *such* knowledge ~~not subject to the physician-patient privilege concerning another person so licensed~~ shall reveal fully such knowledge upon ~~proper~~ *official* request of the state board of healing arts.

(b) This section shall be part of and supplemental to the Kansas healing arts act.

Sec. 41. K.S.A. 65-4902 is hereby amended to read as follows: 65-4902. The district judge or, if the district court has more than one division, the administrative judge of such court shall notify the parties to the action that a screening panel has been convened and that the members of such screening panel are to be appointed within ~~ten~~ ~~(10)~~ *10* days of the receipt of such notice. If the plaintiff and the defendant or, if no petition has been filed, the claimant and the party against whom the claim is made are unable to jointly select a health care provider within ~~ten~~ ~~(10)~~ *10* days after receipt of notice that a screening panel has been

convened, the judge of the district court or, if the district court has more than one division, the administrative judge of such court shall select such health care provider. ~~Members of such screening panel shall receive compensation and expenses as may be provided by rules of the supreme court of Kansas.~~

Sec. 42. K.S.A. 65-4904 is hereby amended to read as follows: 65-4904. (a) Within ~~ninety~~ ~~(90)~~ *90* days after the screening panel is commenced, such panel shall make written recommendations on the issue of whether the health care provider departed from the standard of care in a way which caused the plaintiff or claimant damage. A concurring or dissenting member of the screening panel may file a written concurring or dissenting opinion. All written opinions shall be supported by corroborating references to published literature and other relevant documents.

(b) The screening panel shall notify all parties when its determination is to be handed down, and, within seven ~~(7)~~ days of its decision, shall provide a copy of its opinion and any concurring or dissenting opinion to each party and each attorney of record and to the 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 of insurance.

(c) The written report of the screening panel shall ~~not be admitted into evidence~~ *be admissible* in any subsequent legal proceeding, ~~but~~ *and* either party may subpoena any and all members of the panel as witnesses for examination relating to the issues at trial.

Sec. 43. K.S.A. 65-4907 is hereby amended to read as follows: 65-4907. ~~Unless otherwise provided by order of the judge of the district court or, if the district court has more than one division, the administrative judge of such court, the costs shall be allowed to the party in whose favor the final determination of the screening panel was made.~~ *(a) Each health care provider member of the screening panel shall be paid a total of $150 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 chairperson of the panel shall be paid a total of $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 chairperson 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.

(b) Costs 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 the panel is unable to make a recommendation, then each side shall pay 1/2 of the costs. Items which may be included in the taxation of costs shall be those items enumerated by K.S.A. 60-2003 *and amendments thereto.*

New Sec. 44. If any provisions of this act or the application thereof to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provisions or application and, to this end, the provisions of this act are severable.

Sec. 45. K.S.A. 7-121b, 65-430, 65-2809, 65-2812, 65-2813, 65-2814, 65-2822, 65-2833, 65-2836, 65-2837, 65-2838, 65-2840a, 65-2898a, 65-28,121, 65-28,122, 65-4902, 65-4904 and 65-4907 and K.S.A. 1985 Supp. 40-3003, 40-3401, 40-3403, 40-3404 and 40-3408 are hereby repealed.

Sec. 46. This act shall take effect and be in force from and after its publication in the statute book.

Session of 1986

HOUSE BILL No. 2662

By Special Committee on Medical Malpractice

Re Proposal No. 47

12-17

AN ACT concerning interest on judgments; amending K.S.A. 1985 Supp. 16-204 and repealing the existing section.

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

Section 1. K.S.A. 1985 Supp. 16-204 is hereby amended to read as follows: 16-204. Except as otherwise provided in accordance with law, and including any judgment rendered on or after July 1, 1973, against the state or any agency or political subdivision of the state:

(a) Any judgment rendered by a court of this state before July 1, 1980, shall bear interest as follows:

(1) On and after the day on which the judgment is rendered and before July 1, 1980, at the rate of 8% *per annum*;

(2) on and after July 1, 1980, and before July 1, 1982, at the rate of 12% per annum; ~~and~~

(3) on and after July 1, 1982, *and before July 1, 1986*, at the rate of 15% per annum~~.~~*; and*

(4) on and after July 1, 1986, at a rate equal to the coupon issue yield equivalent (as determined by the Secretary of the United States Treasury) of the average accepted auction price for the last auction of fifty-two week United States Treasury bills settled immediately prior to July 1, 1986.

(b) Any judgment rendered by a court of this state on or after July 1, 1980, and before July 1, 1982, shall bear interest as follows:

(1) On and after the day on which the judgment is rendered and before July 1, 1982, at the rate of 12% per annum; ~~and~~

(2) on and after July 1, 1982, *and before July 1, 1986*, at the

rate of 15% per annum.; *and*

(3) on and after July 1, 1986, at a rate equal to the coupon issue yield equivalent (as determined by the Secretary of the United States Treasury) of the average accepted auction price for the last auction of fifty-two week United States Treasury bills settled immediately prior to July 1, 1986.

(c) Any judgment rendered by a court of this state on or after July 1, 1982, *and before July 1, 1986,* shall bear interest *as follows:*

(1) On and after the day on which the judgment is rendered *and before July 1, 1986,* at the rate of 15% per annum.; *and*

(2) on and after July 1, 1986, at a rate equal to the coupon issue yield equivalent (as determined by the Secretary of the United States Treasury) of the average accepted auction price for the last auction of fifty-two week United States Treasury bills settled immediately prior to July 1, 1986.

(d) Any judgment rendered by a court of this state on or after July 1, 1986, shall bear interest on and after the day on which the judgment is rendered at a rate equal to the coupon issue yield equivalent (as determined by the Secretary of the United States Treasury) of the average accepted auction price for the last auction of fifty-two week United States Treasury bills settled immediately prior to the date of judgment. The judicial administrator shall distribute notice of the rate and any changes to the administrative judge of each judicial district.

Sec. 2. K.S.A. 1985 Supp. 16-204 is hereby repealed.

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