Approved March 31, 1986
Date

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY.

The meeting was called to order by Senator Robert Frey at
Chairperson

10:00 a.m./~~p.m.~~ on March 25, 1986 in room 313-S of the Capitol.

All members were present except: Senators Frey, Hoferer, Burke, Feleciano, Gaines, Langworthy, Parrish, Steineger, Talkington and Winter.

Committee staff present: Mary Hack, Revisor of Statutes
Mike Heim, Legislative Research Department
Jerry Donaldson, Legislative Research Department

Conferees appearing before the committee:

Representative Joe Knopp
Jerry Slaughter, Kansas Medical Society
Paul Fleener, Kansas Farm Bureau
Harold Riehm, Kansas Association of Osteopathic Medicine
Morton Ewing, American Association of Retired Persons
David Litwin, Kansas Chamber of Commerce and Industry
Wayne Probasco, Kansas Podiatry Association

House Bill 2661 - Medical malpractice and health care provider regulation. Re Proposal No. 47.

Representative Joe Knopp testified within the next few weeks each of us will make a major policy decision that has long range implications for our entire court system and the people of Kansas. A critical element of the bill is the proposed cap on recovery for persons injured by medical malpractice. After serving on the interim committee and having heard all the arguments, I have come to the conclusion that $1 million cap may be a "necessary evil" and will be asking for your support. Copies of his handout plus a ballconversion of the bill indicating the House amendments attached (Attach. I). He then explained the substantive House amendments. Committee discussion with him followed.

Jerry Slaughter, Kansas Medical Society, testified the medical society participated in, and supported this comprehensive work product of the interim committee on medical malpractice. After five months of intensive study by the interim committee, the House Judiciary Committee also spent approximately one month further refining the bill. Throughout all of this, one point emerged; that the malpractice problem is complex, and a comprehensive solution is needed. The three main concepts in the bill must remain in the package for it to be successful: (1) peer review and risk management improvements, (2) insurance system refinements, and (3) tort reform issues. Mr. Slaughter stated we see malpractice affecting availability and access to care, especially in the rural communities. Seventy-five percent of the public thinks something should be changed. The attitudes of medical students at K.U. is that medical malpractice costs will have an effect on where they set up their practice. The strength of this bill is that for the first time it provides a link between the Board of Healing Arts, hospitals, physicians in private practice, and the various professional associations, all for the purpose of better reporting and accountability. The medical society feels with this bill the people can be adequately compensated. Mr. Slaughter explained this bill is copied from Nebraska and Indiana who have medical malpractice bills. He said the society is opposed to any substantive amendments that would water it down. They support the bill in its present form. A committee member inquired how many states have a medical malpractice law. Mr. Slaughter replied, Indiana, Nebraska, Louisiana, and I believe South Dakota has a bill on the governor's desk. A copy of his testimony and other material is attached (See Attachments II).

House Bill 2661 continued

Paul Fleener, Kansas Farm Bureau, appeared in support of the bill. He stated in the rural communities of this state, the medical malpractice problem poses not just serious, but dire prospects and consequences. A copy of his testimony is attached (See Attachment III).

Harold Riehm, Kansas Association of Osteopathic Medicine, testified we stand in support of most of the provisions of the bill, including most of the amendments that have been introduced to date. While the bill is aimed primarily at the issue of cost of insurance, in the osteopathic profession, we hold that availability remains a problem, and particularly for osteopathic physicians. He pointed out one amendment that came out of interim committee and they supported it. It emphasized not only cost of insurance but availability of insurance. During committee discussion a committee member inquired why the Kansas Medical Society opposed this amendment. Mr. Slaughter replied, the society opposed it because it has the effect of raising premiums for about half of the physicians and lowers them for the other half of the physicians. The Kansas Medical Society would like to address the problem as well. In response to an inquiry, Mr. Riehm stated there are four states where osteopaths can't be insured. A copy of his testimony is attached (See Attachment IV).

Morton Ewing, American Association of Retired Persons, testified AARP is pleased to be able to participate in the debate surrounding the medical malpractice issue. They are concerned about malpractice because the consumer's voice has not yet been heard in this debate and it is ultimately the consumer who gains or loses when changes are made to the current system. The three basic parts that must be addressed are medical negligence, liability insurance, and the tort system. A copy of his testimony is attached (See Attachment V).

David Litwin, Kansas Chamber of Commerce and Industry, testified KCCI fully endorses the bill, and urged the committee to adopt the bill this year. Our policy does depart from House Bill 2661 in one respect, however, in that it endorses the overall cap on awards, but states that medical expenses and out-of-pocket costs should not be included in such limitations. The so-called "pin-hole" in the cap for the most seriously injured people helps satisfy this concern to a considerable extent. A copy of his testimony is attached (See Attachment VI).

Wayne Probasco, Kansas Podiatry Association, testified the association is in favor of this bill with the hope and expectation that medical malpractice liability insurance premiums will go down. A copy of his testimony is attached (See Attachment VII).

The chairman announced the conference committee on House Bill 2050 is scheduled at 12:30 P.M. tomorrow.

The meeting adjourned.

A copy of testimony from the Kansas State Nurses Association is attached (See Attachment VIII).

Copy of the guest list is attached (See Attachment IX).

GUEST LIST

COMMITTEE: SENATE JUDICIARY COMMITTEE DATE: 3-25-86

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
PATRICIA HENSHALL	TOPEKA	OJA
Wayne Prokasco	"	Ks Podiatry Assn.
Marta Fisher Ehrenberger	"	KMS
[illegible]	"	KMS
[illegible]	"	"
Paul E. Fleener	Manhattan	Kansas Farm Bureau
Marsha J Hutchinson	Topeka	KS Medical Society
DOTSON BRADBURY	EUREKA	GREENWOOD Cnty Hosp.
Rodney Bates	Oakley	Logan Co Hospital
Imogene Hughes	Topeka	visitor
Kevin Reed	Lawrence	KTLA
[illegible]	Westmoreland KS	Taxpayer
[illegible]	"	KAOM
Rhonda L Mitchell	Topeka	Ins. Dept.
John O. Miller	Topeka	AARP
Morton F. Ewing	Hutchinson Ks.	AARP
[illegible]	Topeka	AARP
[illegible]	Wichita	Riverside Hosp.
Tom Bell	Topeka	KHA
Terri Rosselot	Topeka	KSNA
Bob Miller	Lyons	Hospital Dist. #1
Don Wilson	Topeka	KHA
PAT DAVIS	TOPEKA	GOVERNOR'S OFF.
Tom Smith	"	KBA
[illegible]	"	KCCI
Larry Buening	"	Healing Arts A

GUEST LIST

COMMITTEE: SENATE JUDICIARY COMMITTEE DATE: 3-25-86

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Kathleen Sebelius	Topeka	KTLA
Charlene Abbott	Topeka	Bd Healing Arts
Ramona Jones	~~Topeka~~ Wichita	Wichita Eagle-Beacon
Rebecca Crenshaw	Topeka	Prof / Psychologists
Ken Schafermeyer	Topeka	KS Pharmacists Assoc.
Kathy Apps	Topeka	Ks. Dental Assoc.
Sherman A. Parks, Jr.	Topeka	Ks Chiropract. Assn
Gary Robin	Topeka	Ks Optometric Assn
John F. Wiebe	Hillsboro	Salem Hospital
Bob Marshall	Lakeside	League

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3-25-86

STATE OF KANSAS

JOE KNOPP
REPRESENTATIVE, SIXTY-SEVENTH DISTRICT
RILEY COUNTY
410 HUMBOLDT
MANHATTAN, KANSAS 66502
(913) 776-4788

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
CHAIRMAN: JUDICIARY
MEMBER: TRANSPORTATION
LEGISLATIVE, JUDICIAL, AND
CONGRESSIONAL APPORTIONMENT
ELECTIONS

February 7, 1986

To Fellow Members of the Legislature

Re: $1 million cap contained in the malpractice bill (HB 2661)

Dear Colleagues:

Within the next few weeks each of us will make a major policy decision that has long range implications for our entire court system and the people of Kansas. A critical element of the medical malpractice bill (HB 2661) is the proposed cap on recovery for persons injured by medical malpractice.

I'd like to briefly explain that issue to you. I realize that this is a rather lengthy report, but the importance of the issue merits your consideration and I hope it will help you discuss this with your friends and colleagues.

After serving on the interim committee and having heard all the arguments, I have come to the conclusion that a $1 million cap may be a "necessary evil" and will be asking for your support. If you have any questions concerning this I would be glad to visit with you at your convenience.

Sincerely yours,

Joe Knopp

JK/js

S. Jud.
3/25/86
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(3) HB 2661 also provides that in lieu of a single verdict, the jury will answer a series of questions. That jury form might appear as follows:

VERDICT

All non-economic damages _____
(this includes pain and suffering, loss of consortium, disfigurement...)

	PRESENT (Damages incurred to date of trial)	FUTURE	OVER WHAT PERIOD OF TIME
lost wages	_____	_____	_____
medical expenses	_____	_____	_____
other economic expenses (remodel house, buy van, hire tutor, educational expenses, etc.)	_____	_____	_____

With this detailed verdict form, the court can know if the evidence supports the jury award and can make informed decisions on whether to reduce excessive awards. The parties and the public can also understand why the jury entered the amount it awarded.

II. WHAT IMPACT WILL A CAP OF $1 MILLION HAVE ON INJURED PATIENTS?

The $1 million limit is the limit on the "current value" of future damages. It is important to realize that over the lifetime of a patient, $1 million can provide much more than $1 million in benefits. There are several printouts for your consideration. A single premium of $300,000 for example, can produce $1.2 million in guaranteed benefits and a total of $2.6 million if the person lives to their entire life expectancy. In another example, $500,000 would produce $1.5 million in guaranteed benefits and potential benefits of $4.2 million.

I am convinced that a structured $1 million cap will provide for all <u>medical</u> expenses that might occur in the worst case scenario. What may not be <u>fully</u> compensated is the "pain and suffering" and "future lost wages", that are currently included in most awards.

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While I have a philosophical objection to denying full recovery for these items of pain and suffering, future wages, etc., the real question is, "who are we actually benefitting by creating a multi-million dollar estate for a brain damaged baby?"

The hypothetical question I have posed to myself is what would I set aside for my child if I had unlimited wealth and had no wife or other children. My conclusion was that the setting aside of any more than what was needed for medical expenses would be really designed to benefit someone besides my child. (Enclosed please find a proposed letter addressed to the insurance industry and their response for the cost of that care.)

III. THE PUBLIC POLICY QUESTION--WHAT IS THE TRADE OFF?

There is no question that a cap will restrict the amount that a few persons can recover. The restriction is that a person will receive "only" $1 million. If the other provisions of the bill are successful, we can hope that the number of persons who might have these significant damages will further reduce because there are fewer instances of negligence.

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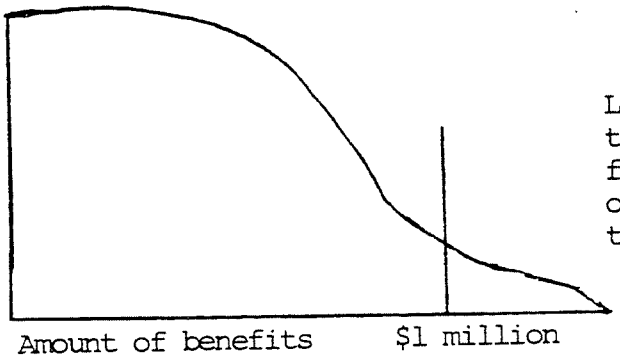

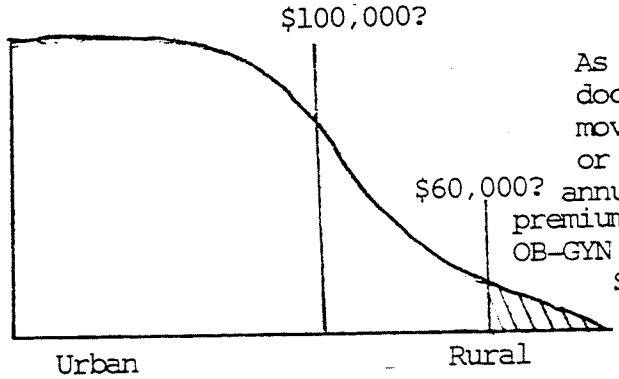

*The graphs are for illustration purposes only. No statistics available to specifically quantify the graft other

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However, if we don't impose the caps, some Kansans who need medical care in rural areas may not have the opportunity to obtain the necessary health care in emergency situations. For those patients who are injured as a result of this inability to get care, the recovery for their damages is zero, not $1 million, and the penalty is 100% of their damages rather than a small percentage reduction of their damages.

Thus, the public policy question is whether we limit a person (who has had the opportunity to choose a doctor) to $1 million for damages, in exchange for reduced premiums for Kansas doctors to increase availability of health care in underserved areas of Kansas.

IV. WHY MUST WE HAVE A CAP ON RECOVERY TO LOWER PREMIUMS?

The practical, pragmatic answer is that the cap is the only element of HB 2661 that the actuaries guarantee will have an impact on premiums.

The actuaries believe that the other changes contained in the bill could have some affect over a period of time. However, the actuaries will not reduce premiums based solely upon these conjectural elements. They can measure in black and white the impact of a cap on recovery.

Whether we want to believe that, whether we agree with those conclusions...the actuaries will control the price of the premiums, and they will commit to a reduction in premiums only if caps are imposed.

V. WHY CAN'T THE ALTERNATIVES WORK INSTEAD OF IMPOSING CAPS?

Many people have proposed alternatives to the cap as a way of reducing premiums. Some of those proposals are as follows:

(a) "Let's just reduce the coverage for the Health Care Stabilization Fund."

For some doctors who don't need more than $1 million coverage that proposal will be fine. I suspect that few doctors will be satisfied with just $1 million of coverage, if they know that a multi-million dollar claim can bankrupt them. A limit on the Health Care Stabilization Fund's exposure to $1 million will reduce the surcharge for all physicians. However a significant element of this crisis is the cost of insurance for doctors in the high risk specialties such as surgery, OB-GYN, etc. For these specialties, more than $1 million of coverage is essential. Thus, under this proposal, the doctor would pay for "primary coverage" + "Health Care Stabilization Fund surcharge" + excess coverage over $1 million. The total of the insurance for these physicians in these

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specialties would be equivalent to or higher than the current amount paid for the primary coverage and Health Care Stabilization fund. Thus, no rate reductions for these specialties. Again, if part of the crisis is the lack of these specialties in underserved areas, the simple proposal to lower the Health Care Stabilization Fund will not reduce their premiums.

(b) "Let other reforms have an opportunity to work."

We hope that the changes in the Health Care Stabilization Fund, the Board of Healing Arts, the peer review process, and other changes in the tort system will have an impact on the incidents of malpractice and the court's response to malpractice cases.

However, these topics contained in HB 2661 in reality are just refinements and modifications of what was passed in the original malpractice reforms of 1976. Hopefully HB 2661 will correct the loopholes that exist in the current law, but...the actuaries will not commit to a reduction unless there is a limit on awards.

(c) "Let's put the pressure on the insurance companies to lower their rates."

Many argue that the insurance companies have conspired to create this crisis or that improper supervision by the Insurance Commissioner or by the insurance companies have created this crisis. While those arguments may apply to other property and casualty lines, the testimony before the committee was that there has never been price competition for malpractice premiums in order to gain business. Note the broad disparity of premiums currently charged by companies. As a matter of fact, most companies since 1976 have been very wary of the malpractice line and the trend has been to get out of the malpractice business rather than get in and "skim off the gravy".

In a free market, it seems inconsistent that insurance companies would voluntarily overlook the opportunity to make money if great deals of money were to be made in malpractice. The fact that there are currently only about five companies writing the business in Kansas and that the major carrier (St. Paul) has imposed a moratorium on writing any new insurance, indicates that these charges against medical malpractice carriers are unfounded.

Others argue that there may be a conspiracy to monopolize the various markets and that there is not true competition in the medical malpractice field. My only response is that if the Securities and Exchange Commission, the Federal Trade Commission, the Internal Revenue Service, the Federal Bureau of Investigation, the United States Congress, the legislatures of Connecticut, Massachusetts where many of these companies

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are founded, and other regulatory grounps cannot find evidence of conspiracy, how are we in Kasnas in a 90 day session going to be able to verify that claim.

I have to operate from the reality that the insurance companies, whether justified or not, are holding most of the cards right now and our choice is to play or not play.

(d) "Let's wait until the insurance industry sorts out its financial crisis before we take this drastic step to cap recoveries."

I believe that with the rates increasing as fast as they are we cannot afford to wait. It will take some time for the solutions contained in HB 2661 to take effect. We must act now. If we err, let us err on the side of assuring health care for those in rural areas who are in jeopardy of losing access to health care rather than to err on the side of delay and procrastination.

(e) "Let's find alternate methods of paying premiums."

I agree with those who say that if Kansas can afford to pay for car insurance, they can afford to pay for the cost of malpractice insurance which is less than $15 per person per year. It does not make sense to have 3,000 doctors to pay for the protection of all Kansans.

While this solution makes a lot of sense to me, it appears to be a "tax on the sick and injured" if we ask to have them pay a malpractice surcharge as a part of their hospital admission or a part of their health insurance premium. Likewise, many philosophically object to having a patient directly pay to cover his doctor's negligence. These arguments make this alternative politically unacceptable.

(f) "A $1 MILLION CAP IS TOO DRASTIC."

The law currently has many drastic measures. A patient who has a bona fide claim for $1 million will receive <u>nothing</u> if it is filed more than two years after the injury or four years after the operation (whether the patient knew that he was negligently injured or not.)

We have come to accept a statute of limitations as a reasonable necessity. I submit that a $1 million cap is a similar "necessary evil."

CONCLUSION

It is my conclusion that after weighing all of the factors and looking at all of the information that a $1 million cap is "a necessary evil" and a critical step that we must

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take in response to a crisis that threatens the health, welfare and safety of a number of Kansans.

Joe Knopp

Enclosed are:
1. Current jury instructions for medical malpractice
2. Samples of what "$1 million cap" would pay in benefits
3. Listing of all claims paid out of Health Care Stabilization Fund
4. Portion of interim committee majority and minority reports dealing with caps and a copy of the Governor's recommendation on malpractice.

ATTACHMENT #1

These are sample instructions that may be given to a jury in a medical malpractice case. Other instructions may be given, but these will give an indication of the standard of care required and the method for determination of damages.

PIK 9.01 ELEMENTS OF PERSONAL INJURY DAMAGE

If you find for the plaintiff you will then determine the amount of his recovery. You should allow him such amount of money as will reasonably compensate him for his injuries and losses resulting from the occurrence in question including any of the following shown by the evidence:

a. Pain, suffering, disabilities, or disfigurement, and any accompanying mental anguish suffered by plaintiff to date (and those he is reasonably certain to experience in the future);

b. The reasonable expenses of necessary medical care, hospitalization and treatment received (and reasonable expense of necessary medical care, hospitalization and treatment reasonably certain to be needed in the future);

c. Loss of time or income to date by reason of his disabilities (and that which he is reasonably certain to lose in the future); and

d. Aggravation of any pre-existing ailment or condition.

In arriving at the amount of your verdict you should consider plaintiff's age, condition of health before and after, and the nature, extent and duration of the injuries. For such items as pain, suffering, disability and mental anguish there is no unit value and no mathematical formula the Court can give you. You should award such sum as will fairly and adequately compensate him. The amount to be awarded rests within your sound discretion.

The total amount of your verdict may not exceed $ ...., the amount of plaintiff's claim.

PIK 15.01 DUTY OF PHYSICIAN OR DENTIST

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

A failure to do so is a form of negligence that is called malpractice.

PIK 15.03 DUTY OF CARE IN EMERGENCY CASES

Where a (physician) (dentist) (hospital) undertakes to treat a patient under emergency circumstances, those circumstances should be considered in determining whether ordinary care was exercised at the time the services were provided.

When you retire to the jury room, you will first select one of your members to preside over your deliberations, speak for the jury in court, and sign the verdict upon which you agree.

Your verdict must be founded entirely upon the evidence admitted and the law as given in these instructions.

Your agreement upon a verdict must be unanimous.

.....
District Judge

....., 19..... [PIK 10.01]

VERDICT

We, the jury, present the following answers to the questions submitted by the court:

1. Considering all of the fault at one hundred percent what percentage of the total fault do you attribute to each of the parties?

The plaintiff, Mary Smith ..... ____% (O to 100%)
The defendant, Ideal Stores..... ____% (O to 100%)
Total ____% 100%

2. Without considering the percentage of fault found in question one, what total amount of damages do you find was sustained by the plaintiff, Mary Smith ..... $____.

.....
Presiding Juror [PIK 20.03]

ATTACHMENT #2

The examples that follow show the cost of purchasing an annuity to provide compensation for an injured party over their lifetime. For even the most significant injuries, $500,000 is adequate to take care of their future medical expenses.

Case Background: Mis-diagnosed urinary tract infection resulting in the loss of both kidneys. A kidney transplant was required and permanent hearing and balane impairment occurred.

PLAN	COST	BENEFITS	GUARANTEED BENEFITS
Up-Front Cash	$120,000	$120,000	$120,000
Commencing 11-1-83,			
$750/mo. for 1st 15 years		$135,000	$135,000
$1,250/mo. for 2nd 15 years		$225,000	$225,000
$2,000 for life thereafter		$1,488,000*	- 0 -
Commencing 11-1-84,			
$5,000/yr. for 4 years		20,000	20,000
$ 20,000 payable 11-1-88		20,000	20,000
$ 30,000 payable 11-1-93		30,000	30,000
$ 40,000 payable 11-1-98		40,000	40,000
$ 50,000 payable 11-1-03		50,000	50,000
$ 60,000 payable 11-1-08		60,000	60,000
$ 70,000 payable 11-1-13		70,000	70,000
$ 80,000 payable 11-1-18		80,000	80,000
$ 90,000 payable 11-1-23		90,000	90,000
$100,000 payable 11-1-28		100,000	100,000
$150,000 payable 11-1-33	$180,334	150,000	150,000
TOTAL COST AND BENEFITS	$300,334	$2,678,000	$1,190,000

*Benefits based on the normal additional life expectancy of a 17 year old female - 62.0 years.

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Case Background: Claimant sustained brain damage during birth: resulting in severe neurological and functional impairment.

PLAN	COST	BENEFITS	GUARANTEED BENEFITS
Up-Front Cash	$200,000	$200,000	$200,000
To Mother as Guardian: Pay $1,250/mo. for life with 30 years guaranteed compounding 3% annually		$3,431,023*	$740,803
To Mother and Father, individually and as husband and wife			
$ 25,000 payable 11-15-88		25,000	25,000
$ 50,000 payable 11-15-93		50,000	50,000
$ 75,000 payable 11-15-98		75,000	75,000
$100,000 payable 11-15-03		100,000	100,000
$150,000 payable 11-15-08		150,000	150,000
$200,000 payable 11-15-13	$295,414	200,000	200,000
TOTAL COST AND BENEFITS	$495,414	$4,231,023	$1,540,803

*Benefits based on the normal additional life expectancy of a three year old male - 68.3 years.

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STATE OF KANSAS

JOE KNOPP
REPRESENTATIVE SIXTY-SEVENTH DISTRICT
RILEY COUNTY
410 HUMBOLDT
MANHATTAN KANSAS 66502
913-776-4788

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
CHAIRMAN: JUDICIARY
MEMBER: TRANSPORTATION
LEGISLATIVE JUDICIAL AND
CONGRESSIONAL APPORTIONMENT
ELECTIONS

September 28, 1985

Dear Friends,

As I'm considering my position on limits for recovery, I want to put myself in the hypothetical position of a wealthy father who is concerned about the financial security of his child.

For this example assume the following:

A. My wife died in childbirth. No negligence... she just died.
B. My child lived, but with the injuries described in the attached letter. Again, no neglience caused it... it just happened.
C. My doctor informs me that I have 3 weeks to live.
D. I have unlimited resources. However I don't want any more than is necessary to be set aside for my child.
E. I also want to set aside enough so that the State of Kansas or Federal Government do not directly subsidize the care for my child.
F. My brother and sister in law (who I've generously assisted) wil provide the care in their home normally provided by my wife and myself.

Please assume the following assumptions are accurate (or please advise me as to the inaccuracies contained therein)

A. That the cost of care shown in the attached report is accurate.
B. That the duration of the care needed is accurate.
C. That the cost of those items will increase as shown.

My question is this: I want my insurance agent to quote me a price on a single premium policy that will pay the amounts shown on the attached schedule B.

I would also appreciate your thoughts on why I should provide my child with enough money to "pay" him for his "lost lifetime income"; and what will happen to that money if all of his medical needs are taken care of. (I will take care of his heirs independently so they shouldn't be a consideration)

Please do not hesitate to call if this request is not clear and to provide alternate schedules if more appropriate.

Sincerely yours,

Joe Knopp

I've sent this letter to Kathleen Sebelius, KTLA; Ron Smith, KBA; Jerry Slaughter, KMS: and directed that Mike Heim make additional copies available for other interested individuals. I will try to review this letter and your responses to arrive at a presentation for the committee that will facilitate discussion of this specific issue. I don't believe that I or members of the committee can intelligently understand "caps" until the costs are broken down for us on an annual basis.

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SCHEDULE B

STATE OF KANSAS

JOE KNOPP
REPRESENTATIVE SIXTY SEVENTH DISTRICT
RILEY COUNTY
410 HUMBOLDT
MANHATTAN KANSAS 66502
913 776 4788

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
CHAIRMAN JUDICIARY
MEMBER TRANSPORTATION
LEGISLATIVE JUDICIAL AND
CONGRESSIONAL APPORTIONMENT
ELECTIONS

Mr Insurance Agent;

From the attached report it appears that I'll need to do the following:

Age 1-8

Orthopeadic	45/yr	Laundry	288/yr
Pediatrician	90/yr	Drugs	800/yr
Child Dev'p	90/yr	Nursing Care	10,920/yr
Opthamalogist	30/yr		
Audiologist	30/yr	Total	12,893.80 for 1980 and a 2%
Climate Control	600/yr		net growth for each year (3.5% -

Age 8-16

Total in group 1-8 is now 14,810 per year and in addition we need:

Transportation Depreciation	3,136/yr
Transportation Maintenance	1,696/yr
School Assistance	8,000/yr
Maintenance on Medical Equip't	150/yr

Total is 27,792.68 peryear commencing in 1988 and with a net growth of 2% per year

Age 17-67

SRS care at the rate of 110.60 per day for a total of 40,369.80
(This 110.69 is arrived at by increasing the 79.00 per day in 1980 at 2% per year to arrive at the cost in 1997)

Orthapedic	45/yr
Internist	90/yr
Drugs	800/yr
	935/yr in 1980 prices equals 1,309.23 in 1997 prices (2% grow

In addition, we need the following lump sum payments:

A. 1980 , 135,000 for new house with structural requirements
B. 1988 4,729 for medical equipment
C. 1988 19,600 for van
D. 1997 The house is sold,since it is no longer needed,for $75,000.

From these conclusions, it appears to me that I will need the cash flow as shown on the attached sheet.

Again please tell me what a single premium policy will cost to providethese benef I don't want any of the annual payments guaranteed i.e. the benefits will terminate on death of the child. (Since I've independently given money to the heirs, they are not a concern.) Please guarantee the payments for the house, van, burial, etc.

By my calculations, the total amount over the next 65 years is $4.2 million approximately. The economist says that $4.8 million is needed <u>now</u> . (Total of $6.061 mi less the future income of $1.2 million.)

I believe that the present value of $4.2 to be paid over the next 65 years is less. To avoid any misunderstanding, I'd like to explain my methodology.

I started in 1980 with a total of 12,893.80 in medical expenses. I added 2% to that figure for 1981, and 2% of 1981 to arrive at the 1982 figure, etc until I had compounded it for each year until 1987.

In 1988, I used the basic medical expenses shown in 1980. I compounded them by 2% per year to arrive at their value in 1988. To that amount I added transportatio maintance and depreciation of 20% of the original value of the van. Likewise school expense was added. I note that I did not have school expense for a full 12 years and that medical equipment depreciation was not added in. This may partially explain the differance in the figures between me and the economist.

For the years of 1997 through 2048, I started with the SRS charge for institutional care. The 1979 charge of $79/day was recalculated at the 2% per year rate to arrive at the 1997 charge of 110.79/day. I added the medical expenses. I assumed that the transportation and medical equipment expenses were included in the charge for care by SRS. This totaled $41,679.

Again I took my simple calculator and multiplied $41,679 by 2%, added it to $41,679, and then compounded that process for the next 51 years.

With the recent disclosures about our state hospitals, you may wonder if we shouldn't try to set aside more for a better,private institution. I want to know what the basics cost. Perhaps you can talk me into buying more insurance.

Sincerely yours,

Concerned Father

P.S. If you would rather just start from the economist's report and base your calculations on his assumptions to arrive at your figure, that would be fine with me.

I

CASH FLOW ANALYSIS

Year	Amount needed:	
1980	12,893	+ 135,000 for house
1981	13,150	
1982	13,413	
1983	13,682	
1984	13,955	
1985	14,234	
1986	14,519	
1987	14,810	
1988	27,792	+ 24,329 for van, etc.
1989	28,348	
1990	28,915	
1991	29,493	
1992	30,083	
1993	30,685	
1994	31,299	
1995	31,925	
1996	32,563	
1997	41,679	(Sell house, net 75,000)
1998	42,512	
1999	43,362	
2000	44,230	
2001	45,114	
2002	46,017	
2003	46,937	
2004	47,879	
2005	48,883	
2006	49,810	
2007	50,806	
2008	51,822	
2009	52,859	
2010	53,916	
2011	54,944	
2012	56,094	
2013	57,216	
2104	58,360	
2015	59,527	
2016	60,718	
2017	61,932	
2018	63,171	
2019	64,343	
2020	65,723	
2021	67,038	
2022	68,379	
2023	69,746	
2034	71,141	
2025	72,564	
2026	74,015	
2027	75,495	
2028	77,005	
2029	78,545	
20302	80,116	
2031	81,719	
2032	83,353	
2033	85,020	
2034	86,720	
2035	88,455	
2036	90,224	
2037	92,028	
2038	93,869	
2039	95,746	
2040	97,771	
2041	99,615	
2042	101,607	
2043	103,639	
2045	105,712	
2045	107,826	
2046	109,983	
2047	112,182	
2048	115,000	

Burial Expenses $25,000

I

ARRIER #1 A+ 15 *

* STRUCTURED SETTLEMENT *
* HYPOTHETICAL PROJECTION *

DATE TODAY 7/85

DATE/LOSS :03/20/80
DATE/BIRTH :03/20/80
CLIENT MALE(BIRTH TRAUMA)
AGE : 0
ATTORNEY :

% ANNUAL ESCALATION : 2.00
BENEFIT : 4182883.77
(ANNU/CASH) TOTAL COST : 389569.00*
UP/FRONT CASH : 135000.00

AGE	YEAR	ANNUAL AMOUNT	LUMP/SUM PAYMENTS	AGE	YEAR	ANNUAL AMOUNT	LUMP/SUM PAYMENTS
0	1980	12893.00	0.00	45	2025	72564.15	0.00
1	1981	13150.86	0.00	46	2026	74015.43	0.00
2	1982	13413.88	0.00	47	2027	75495.74	0.00
3	1983	13682.15	0.00	48	2028	77005.65	0.00
4	1984	13955.80	0.00	49	2029	78545.77	0.00
5	1985	14234.91	0.00	50	2030	80116.68	0.00
6	1986	14519.61	0.00	51	2031	81719.02	0.00
7	1987	14810.00	0.00	52	2032	83353.40	0.00
8	1988	27792.00	24329.00	53	2033	85020.46	0.00
9	1989	28347.84	0.00	54	2034	86720.87	0.00
10	1990	28914.80	0.00	55	2035	88455.29	0.00
11	1991	29493.09	0.00	56	2036	90224.40	0.00
12	1992	30082.95	0.00	57	2037	92028.89	0.00
13	1993	30684.61	0.00	58	2038	93869.46	0.00
14	1994	31298.31	0.00	59	2039	95746.85	0.00
15	1995	31924.27	0.00	60	2040	97661.79	0.00
16	1996	32562.76	0.00	61	2041	99615.02	0.00
17	1997	41679.00	0.00	62	2042	101607.33	0.00
18	1998	42512.58	0.00	63	2043	103639.47	0.00
19	1999	43362.83	0.00	64	2044	105712.26	0.00
20	2000	44230.09	0.00	65	2045	107826.51	0.00
21	2001	45114.69	0.00	66	2046	109983.04	0.00
22	2002	46016.98	0.00	67	2047	112182.70	0.00
23	2003	46937.32	0.00	68	2048	114426.35	25000.00
24	2004	47876.07	0.00	69	2049	0.00	0.00
25	2005	48833.59	0.00	70	2050	0.00	0.00
26	2006	49810.26	0.00	71	2051	0.00	0.00
27	2007	50806.47	0.00	72	2052	0.00	0.00
28	2008	51822.60	0.00	73	2053	0.00	0.00
29	2009	52859.05	0.00	74	2054	0.00	0.00
30	2010	53916.23	0.00	75	2055	0.00	0.00
31	2011	54994.56	0.00	76	2056	0.00	0.00
32	2012	56094.45	0.00	77	2057	0.00	0.00
33	2013	57216.34	0.00	78	2058	0.00	0.00
34	2014	58360.66	0.00	79	2059	0.00	0.00
35	2015	59527.88	0.00	80	2060	0.00	0.00
36	2016	60718.43	0.00	81	2061	0.00	0.00
37	2017	61932.80	0.00	82	2062	0.00	0.00
38	2018	63171.46	0.00	83	2063	0.00	0.00
39	2019	64434.89	0.00	84	2064	0.00	0.00
40	2020	65723.58	0.00	85	2065	0.00	0.00
41	2021	67038.06	0.00	86	2066	0.00	0.00
42	2022	68378.82	0.00	87	2067	0.00	0.00
43	2023	69746.39	0.00	88	2068	0.00	0.00
44	2024	71141.32	0.00	89	2069	0.00	0.00

MPORTANT..
THESE ARE NOT FIRM
QUOTES, BUT RATEBOOK
QUOTES..COULD CHANGE

STRUCTURE ELEMENT	COST	BENEFIT
1.ANNUAL MAINTENANCE	243777.00	4133554.77
2.LUMP/SUM PAYMENTS	10792.00	49329.00

8 1985

THE STRUCTURED SETTLEMENTS COMPANY

5757 West Century Blvd., Suite 620
Post Office Box 45023
Los Angeles, California 90045-0023
(213) 642-1999 • (800) 421-2022
Telex 653-446 • TSSC LSA

October 7, 1985

Mr. Robert S. Peterson
Division Manager
Law Department
THE MEDICAL PROTECTIVE COMPANY
Fort Wayne, Indiana 46885

Dear Mr. Peterson,

As you requested we have analyzed the documentation you provided that relates to a hypothetical structured settlement. In order to provide you with as accurate information as we could, we had to assume that the payments would commence in 1985 and not 1980 as outlined in the economic workup.

We described the birth defect to a few of our markets and on average, they suggested a child with these injuries would be rated with an age of about 45 years. The markets we spoke with are rated A+ Excellent and are recognized entities in providing structured settlement annuities.

Including $135,000 front cash to purchase a home, it would cost a total of $381,000 to provide all of the benefits described in the economic workup. If the youngster were considered to have a normal life expectancy for a female born March 20, 1985, the cost to provide the home and the benefits would be $500,000.

I hope that the information we provided is of value to you and I would be pleased to hear from you if you have any additional questions.

Sincerely,

THE STRUCTURED SETTLEMENTS COMPANY

Neil H. Small

NHS/mmm

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Merrill Lynch Settlement Services, Inc.

The Financial Plaza
400 Town Center Drive
Suite 400
Dearborn, Michigan
48126

Telephone
313/336-4500

October 8,1985

Robert Peterson
Medical Protective Company
5814 Reed Road
Fort Wayne, Indiana 46815

Dear Bob,

As per our conversation and my interpretation of the hypothetical case file that you sent me, I've enclosed ratebook quotes from two (A+15) carriers. These are not firm quotes and are for illustrative purposes only, but should give you a fair idea of where the litigation annuity market is. In fact, both of these quotes are on the "high yield-low cost" end of the spectrum.

Bob, I hope this is what you needed and arrives in time to meet your deadline. It was difficult to know how to treat the burial expenses, so I just assumed that the child lived his normal life expectancy. This contingency might also be met through the use of a reversionary trust since no one but the Lord knows when this child is going to die. In any event, it looks like the cost could be held under $500,000 (excluding attorneys fees) even placed with a less competitive carrier.

I would encourage you to use Merrill Lynch Settlement Services on an actual file in the near future; you will recieve our packet shortly. Thank you for the opportunity to serve you.

Respectfully,

Barry Keeley

Barry M. Keeley
Settlement Consultant

ATTACHMENT #3

To help you evaluate the number of people impacted by a cap, I have attached a list of all settlements and judgments against the Health Care Stabilization Fund for 1976 to July 1, 1985. Under the column entitled "primary or Excess" if the entry is excess, then the patient received an additional $100,000 in 1976-1984 and an additional $200,000 since 1984. Please note that the predominant number of million dollar cases involve birth related injuries.

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

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

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

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

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

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

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

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

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

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

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ATTACHMENT #4

Enclosed is the interim committee report pertaining to caps, the minority report, and that portion of the Governor's message dealing with malpractice. Also attached is the actuarial reports on the impact of various caps and a listing of insurance premiums charged Kansas doctors as of July 1, 1985.

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MAJORITY REPORT PERTAINING TO CAPS

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.

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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.

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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.

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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 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 pe[illegible]t tax on all insurance sold in this state. This places an insu[illegible]e 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.

MEDICAL MALPRACTICE

This year, more than ever before, a fundamental state concern is the assurance that Kansas citizens have access to quality medical care at an affordable cost. Of equal concern is the assurance that just compensation is available when medical malpractice occurs. Balancing these two concerns is a difficult task with potentially serious long-term ramifications.

I recognize that rising costs of medical malpractice insurance affect the cost of medical care to the patient. I also am aware that doctors, particularly those in high-risk specialties, may choose to limit their practices or retire from the profession altogether. I do not want Kansas to lose doctors because of the burden of insurance premiums. Further, I do not want to see the availability of rural health care threatened. I cannot, however, justify the wholesale abandonment of the rights of victims solely for the sake of lowering premiums.

The unfortunate fact is that medical malpractice does occur and the state has a duty to ensure that protection and redress is available for its injured citizens. Our civil law system has always guaranteed the fundamental right of an individual injured by the negligence of another to be justly compensated. Therefore, any solutions must not only address the problem but also protect this fundamental right.

In the past six months, numerous solutions have been proposed to address the problem before us. I have devoted a great deal of time evaluating these proposals and their implications. I am struck by the stark reality that many of the proposed solutions ignore the larger picture and simply seek to limit the recovery rights of medical malpractice victims. If we are to preserve equity in this state, these proposals should not become law.

I recommend legislative measures which balance the right to be compensated for injury against the need to mitigate escalating medical liability insurance costs. In addition, my proposals are directed toward reducing the frequency of medical malpractice.

I propose that the liability of the Health Care Stabilization Fund (HCSF) be limited to $1 million per claim. This measure would result in an immediate reduction of the amount of surcharge doctors must pay, while providing enough reserves to maintain a healthy Fund balance.

I propose that the Fund surcharge be merit-rated. This would require that a doctor's contribution to the Fund (the surcharge) rise in proportion to the number of claims the Fund pays on his behalf.

I propose that the Fund surcharge be averaged. Kansas doctors can obtain primary insurance coverage, some at greater expensive than others, from a number of companies. A set percentage of that primary coverage is required as a surcharge to the Fund. Doctors who pay a greater amount for primary coverage also pay a greater surcharge than those who are able to obtain less

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expensive coverage. This proposal would bring equity to the surcharge system by requiring an average payment be determined for all doctors within the same rating class.

I propose that a minimum surcharge of 15 percent be established, regardless of the Fund balance. Fund reserves are created by the payment of surcharge. Because of instability in the insurance market from year to year, decisions to forego surcharge payments in years past placed the Fund in jeopardy.

I propose that the Joint Underwriting Association (JUA) be allowed to refuse or cancel coverage of a doctor if the HCSF has refused or terminated coverage. The JUA plan provides that the Insurance Department contract with a private insurance carrier, who then is statutorily required to provide medical liability coverage to those doctors who cannot obtain it elsewhere. That mandate no longer serves the interests of this state. In the event that the Fund determines a particular doctor presents too great a risk to justify coverage, the state should not require that the JUA provide it. The JUA was not intended to provide sanctuary for negligent doctors.

I propose that every doctor in the state be required to carry a minimum of $1.2 million in malpractice coverage, whether he is insured partially by the Fund or totally by a private carrier. This will prevent the situation whereby the Fund cancels coverage of a doctor but he continues practicing with only $200,000 worth of primary coverage for which to compensate injured parties.

I propose mandating the use of settlement conferences prior to trial in all medical malpractice actions. These conferences would be presided over by a judge other than the trial judge. All parties would participate, including those ultimately responsible for payment of claims or awards. This measure will ensure that all involved parties are aware of the claim early in the process and will help facilitate communication between them. In the past, malpractice actions have reached trial and, in some cases, been resolved before the Fund was aware of the claim.

I propose the following administrative changes to the Board of Healing Arts. The position of Chairman shall become a full-time administrative position held by a physician. The Chairman will remain a voting member of the Board. The position of Executive Secretary shall become an Administrative Assistant to the Chairman and shall be responsible for providing management assistance in the daily operation of the Board. I also propose that two investigative positions be added. The lines of administrative authority for the Board's staff have never been clearly defined. In the absence of such definition, the Board's ability to police the medical profession has been adversely affected. This proposal will provide the needed structure to resolve this problem, and the addition of the investigators will enhance the investigation of malpractice complaints.

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Finally, I propose that the recommendations of Legislative Post Audit and the Board of Healing Arts be adopted requiring that various public and private entities, including insurance companies, expediently report to the Board any knowledge of medical malpractice claims. A recent Legislative Post Audit report determined that the Board is hampered by the fact that entities possessing knowledge of malpractice claims are not formally required to report that information. Such information is imperative to the Board's ability to carry out its oversight mission.

These proposals will address the financial burden imposed by high medical liability insurance costs on the medical profession, while maintaining the rights of injured victims. I cannot support any proposal which arbitrarily limits the rights of victims to recover damages. Such an approach is unacceptable for several reasons.

First, I believe it is an unnecessary step. If all the other recommendations are enacted, they will immediately have a positive impact on this economic problem.

Second, I find unacceptable a solution which punishes the victims further by limiting their rights of recovery and which rewards the wrong-doers by limiting their liability. That is simply bad public policy.

Third, it is unacceptable because the liability insurance problem is not limited just to the health care industry. This problem is spreading rapidly across every industry, profession and group of service providers. Almost daily we read of another group being denied liability insurance or being faced with substantial premium increases. For example, liability coverage is becoming prohibitive or unavailable to manufacturers for injuries caused by defective products, toxic waste or chemical spills; to municipalities for injuries caused in the delivery of services such as police, fire and ambulance; and to professional groups such as architects and engineers for defective designs leading to catastrophes such as the collapse of buildings and bridges.

All of these groups are watching closely the actions which will be taken by this legislature to deal with the liability insurance problem in the health care industry. Clearly, any remedies enacted for health care providers will immediately lead to calls for similar relief in all these other areas.

Once the state has begun to deal with the economic problem of medical malpractice insurance by limiting the liability of wrong-doers, it becomes difficult, if not impossible, to deny similar relief to other groups. Such action becomes the first step in the major rewriting of our most basic laws designed to protect the personal and property rights of individuals and to hold wrong-doers fully accountable for infringing upon those rights.

I am convinced that such a major overhaul of the basic principles of our civil law is both unnecessary and inherently bad public policy. I find that unacceptable.

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Addressing the issue of medical malpractice represents a significant legislative challenge. We must act carefully and responsibly, with full knowledge of the pertinent facts, to facilitate changes that are equitable, effective and do not merely shift the burden from one party to the other.

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.

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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
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.

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the appropriate medical care facility. 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) When a report made under this section is investigated pursuant to the procedure set forth under this section, the ~~reporting entity shall not be liable for any penalty for failure to report as required under K.S.A. 65-2836,~~ 65-28,121 or 65-28,122, and amendments thereto.

When a report is made under this section, the person making the report shall not be required to report the reportable incident pursuant to K.S.A. 65-28,122 and amendments thereto.

person or entity to which the report is made shall not be required to report the reportable incident pursuant to K.S.A.

~~(c)~~ (d) 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)~~ (e) If a state agency that licenses health care providers

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committee discussions or proceedings.

New Sec. ~~6~~ 7. 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 **4 or 5** 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~~ 8. (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 **4 or 5**.

(b) The license of a person or entity ~~licensed to practice as a health care provider~~ **required to report under subsection (a) of section 4** 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~~ **pursuant to** the Kansas administrative procedures act, to have willfully and knowingly failed to make any report as required by section ~~3 or~~ 4 **4 or 5**.

(c) Willful and knowing failure to make a report required by section ~~3 or~~ 4 **4 or 5** is a class C misdemeanor.

New Sec. ~~8~~ 9. (a) No employer shall discharge or otherwise discriminate against any employee for making any report pursuant to section ~~3 or~~ 4 **4 or 5**.

(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-

(d) In no event shall a medical care facility or a professional society or organization be liable in damages for the alleged failure to properly investigate or act upon any report made pursuant to section 4.

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coverable in an individual action brought by the aggrieved employee. **If the aggrieved employee substantially prevails on any of the allegations contained in the pleadings in an action allowed by this section, the court, in its discretion, may allow the employee reasonable attorney fees as part of the costs.**

New Sec. ~~9~~ **10.** (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 **3, 4 and 5 and peer review pursuant to K.S.A. 65-4915 and amendments thereto** effectuate this policy.

(b) Health care providers and review, executive or impaired provider committees performing their duties under sections ~~2,~~ 3 ~~and~~ 4 **3, 4 and 5 and peer review pursuant to K.S.A. 65-4915 and amendments thereto** for the purposes expressed in subsection (a) ~~shall be agents of state agencies which license health care providers and all~~ **and 65-4915 and amendments thereto shall have** ~~the 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.~~ all the immunity of state officers, including immunity from federal and state antitrust laws

(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~~ **11.** The provisions of sections ~~1 through 9~~ **2 through 10** 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~~ **12.** As used in sections ~~11 through 15~~ **12 through 16:**

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

New Sec. ~~12~~ 13. (a) In any medical malpractice liability action:

(1) The total amount recoverable **by each party from all defendants** for all claims for noneconomic loss shall not exceed a **sum total of** $250,000; and

(2) **subject to section 28** the total amount recoverable **by each party from all defendants** for all claims shall not exceed **a sum total of** $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 **or on the ability of the claimant to obtain supplemental benefits under section 28.**

(c) In a medical malpractice liability action, ~~after deduction of amounts~~ **subject to apportionment of fault** 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 **the party's** 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 **the party's** claims for current economic loss ~~and shall apportion that amount among the claimants~~.

awarded by the court

(3) If the sum of the ~~judgments entered verdicts rendered~~ for noneconomic loss and for current economic loss is $1,000,000 or more, no judgment shall be entered for future economic loss. If

amounts awarded by the court

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the sum of such ~~judgments verdicts~~ amounts 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 verdicts~~ amounts, 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, **the cost of such annuity not to exceed the difference between $1,000,000 and the sum of the** ~~verdicts~~ amounts awarded by the court **for noneconomic loss and current economic loss.**

(d) The limitations on the amount of damages recoverable for noneconomic loss under this section shall be adjusted annually on July 1 by rule of the supreme court in proportion to the net change in the United States city average consumer price index for all urban consumers during the preceding 12 months.

~~(d)~~ (e) 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.

(f) The provisions of this section shall expire on July 1, 1993.

New Sec. ~~13~~ 14. (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~~ 15. (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. **The court shall reduce such damages to their present value and,** except as

provided by section ~~12~~ 13, the court shall enter judgment, with respect to such damages, for an annuity contract [which has a present value equal to the present value of such damages and 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. The judgment shall incorporate the intervals of the annuity payments, which shall be fixed and determinable as to amounts and dates of payments[,] and shall be in such form as necessary to assure that periodic payments through the annuity will be excluded from the beneficiary's taxable income under section 104(a)(2) of the federal internal revenue code[.]

— strike

— strike

~~(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.~~

(b) The health care stabilization fund or insurer shall purchase the annuity provided for in section 13 or this section upon approval of the court and, upon payment by the fund or insurer of the cost of such annuity, the judgment will be satisfied as to such annuity.

(c) If an annuity is purchased pursuant to section 13 or this section, the ~~beneficiary~~ shall not own, receive by assignment or otherwise have any interest in the ownership or purchase of the annuity and periodic payments made through such annuity shall not be accelerated, deferred, increased or decreased by the ~~beneficiary~~. If the fund or insurer assigns the annuity, the assignee shall not provide to the ~~beneficiary~~ rights against the assignee which are greater than those of a general creditor and the assignee's obligation shall be no greater than the obligation of the assignor.

annuitant

~~(c)~~ (d) Benefits paid under an annuity contract awarded pursuant to this section or section ~~12~~ 13 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~~ 16. The provisions of sections ~~11 through 14~~ 12

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~~ 20. (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~~ 21. 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~~ health care provider whose fund coverage has been terminated under subsection (i) of K.S.A. 40-3403 and amendments thereto shall, as a condition of licensure, ~~submit to the commissioner of insurance satisfactory proof of professional liability insurance coverage equivalent to that provided by the fund!~~ maintain and shall submit to the commissioner of insurance satsifactory proof of such coverage, as required by the commissioner

Sec. ~~21~~ 22. 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

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.

strike

New Sec. 25. [(a)] **The commissioner shall establish by rules**

and regulations an experience rating system to become effective on July 1, 1987, ~~for determining rates to be charged for basic~~ coverage and surcharges assessed for coverage by the fund. In adopting such system, the commissioner shall provide for differences between different health care professions, different branches of the healing arts and different specialties with those professions or branches but shall otherwise determine appropriate means for determining premiums and surcharges based upon the actual loss experience of each health care provider with respect to professional liability actions.

(b) As used in this section, the terms defined by K.S.A. 40-3401 and amendments thereto shall have the meanings provided by that statute.

Sec. 26. K.S.A. 1985 Supp. 40-3402 is hereby amended to read as follows: 40-3402. (a) A policy of professional liability insurance approved by the commissioner and issued by an insurer duly authorized to transact business in this state in which the limit of the insurer's liability is not less than $200,000 per occurrence, subject to not less than a $600,000 annual aggregate for all claims made during the policy period, shall be maintained in effect by each resident health care provider as a condition to rendering professional service as a health care provider in this state, unless such health care provider is a self-insurer or is a person who is 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 and is insured pursuant to K.S.A. 40-3414, and amendments thereto. Such policy shall provide as a minimum coverage for claims made during the term of the policy which were incurred during the term of such policy or during the prior term of a similar policy.

(1) Each insurer providing basic coverage shall within 30 days after the premium for the basic coverage is received by the insurer or within 30 days from the effective date of this act, whichever is later, notify the commissioner that such coverage is or will be in effect. Such notification shall be on a form approved

that requires a higher surcharge from health care providers based upon past claims paid from the fund on behalf of such providers. In establishing such rating system, the commissioner shall give consideration to the number, size and frequency of the claims paid, and the classification of the health care provider, from the date the fund was established

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~~;~~; and

~~(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 experience rating system established by the commissioner pursuant to section 25 prior to the establishment of such system; and~~

(D) **review and determine claims for supplemental benefits under section 28.**

(2) The board shall consist of ~~13~~ 14 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~~ two members appointed from the public at large who ~~is~~ are 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 chair-

For each claim submitted for review under section 28, the commissioner shall appoint a review committee for the purpose of reviewing such claim and making recommendations to the board. The review committee shall consist of three members, two of whom shall be members of the board of governors and one of whom, as chairperson, shall not be a member of the board and shall be admitted to practice law in Kansas.

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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*~~ **Except as provided by section 28, the fund shall not** *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.* **The provisions of this subsection shall apply to all claims filed on or after the effective date of this act.**

for any party

(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~~ **or** *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.

New Sec. 28. (a) As used in this section, "medical care and related benefits" and "medical malpractice liability action" have the meanings provided by section 12.

(b) If a claimant in a medical malpractice liability action has ~~been awarded~~ the maximum amount allowable under section 13 and the amount so awarded ~~has been exhausted in the payment of medical care and related benefits, and is substantially insufficient to pay for future medical care and related benefits~~, the board of governors of the health care stabilization fund may, in its discretion, grant the claimant supplemental benefits to pay for future medical care and related benefits. Any application for supplemental benefits shall be on a form prescribed by the commissioner.

(c) The claimant has the burden of showing the board of governors that all amounts ~~awarded~~ for medical care and related benefits pursuant to ~~section 13~~ have been actually used to pay for medical care and related benefits and that ~~the amounts awarded~~ are insufficient to pay for future medical care and related benefits.

(d) In reaching its decision on whether to grant supplemental

recovered, pursuant to a settlement agreement or judgment,

is insufficient to pay for necessary medical care and related benefits

recovered

the settlement agreement or judgment

such amounts

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benefits, the board of governors shall consider: (1) The needs of the claimant; (2) the availability of payments from collateral sources or governmental benefits to the claimant; and (3) the ability of the health care stabilization fund to pay supplemental benefits.

(e) ~~In no event shall~~ the supplementary grant, when added to the amount previously received by the claimant, ~~exceed the~~ amount specified in the jury verdict for medical care and related benefits or the amount actually necessary to pay for medical care and related benefits.

(f) Any grant pursuant to this section may be in the form of an annuity contract.

Sec. ~~25~~ 29. 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

If the claimant recovered damages pursuant to a judgment, shall not

other insurer participating in the plan or to any insurer participating in the plan. Such commission shall be reasonably equivalent to the usual customary commission paid on similar types of policies issued in the voluntary market.

(g) The provisions of this section shall expire on July 1, 1987, but any plan created hereunder shall continue to exist for the purpose of allowing policies then in effect to expire, transferring surplus to the fund, completing the payment of claims and receiving reimbursement therefor.

~~**New Sec. 32. The health care stabilization fund shall not be required to purchase a cash appeal bond.**~~

New Sec. 33. The health care stabilization fund may own or assign any annuity purchased by the fund pursuant to section 13, 15 or 28 or pursuant to K.S.A. 40-3410 and amendments thereto in settlements of the liability of the fund.

Sec. ~~27~~ 34. 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~~ 3, 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~~ 35. 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

New Sec. 32. In any medical malpractice liability action, as defined by K.S.A. 1985 Supp. 60-3401 and amendments thereto, the proceedings shall be stayed on appeal by the filing of a supersedeas bond in the full amount of the judgment against the health care provider signed by the commissioner of insurance as administrator of the health care stabilization fund without surety or other security.

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~~ 43. 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 **failure to adhere to the**

by section 21 or

~~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~~ are 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

Subject to the provisions of subsection (c) of section 4,

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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~~ 48. 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~~ 49. 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~~

Subject to the provisions of subsection (c) of section 4,

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I. MECHANICS OF AWARDING DAMAGES

CURRENT LAW: Currently a jury must find that there is liability and also determine the amount of compensation for that injury. Thus a jury finds that there is negligence, Kansas statutes currently allow the jury to issue a general verdict, i.e., how much do you believe the plaintiff is entitled to? (See sample verdict forms which are attached.)

PERCEIVED PROBLEM: (1) Juries have difficulty in reducing awards for future damages to their present value. Expert economists can show that due to inflation and uncertain medical expenses, injured patients over a lifetime may need millions of dollars. The concern is that jurors look at the total lifetime needs of a patient and do not take into account the investment income that a plaintiff will have available to him on the lump sum verdict that he will receive at the conclusion of the trial.

(2) The defense does not do an adequate job of presenting the "present value" arguments and arguing for reduced damages at the trial because it is usually taking the position that the doctor did not do anything wrong. As a matter of defense strategy, to refute the amount of damages may appear to be a concession that the plaintiff is entitled to some compensation. This dilemma places a doctor or his insurance company at an unfair disadvantage.

(3) One check on the jury system is that the judge can reduce the award if he believes it was the result of emotional, unfounded conclusion by the jury. However, we find that judges are reluctant to reduce awards because they do not know why a jury is awarding the amount contained in the verdict. When the verdict is given in a lump sum, the court and all the parties have no way of knowing if an excessive amount was awarded for "pain and suffering", "lost wages", "future medical", etc.

SOLUTIONS: Under HB 2661, these issues have been addressed as follows: (1) The jury is not asked to reduce future damages to current value. The jury is requested to give the total amount of future economic damage and the period over which the jury expects the future economic loss to be incurred. The court shall then enter a judgment for an annuity which will provide for the benefits indicated by the jury's verdict. (It is anticipated that the parties will enter into negotiations which will assist the court in finding the best deal.)

(2) By "automatically" reducing future damages, the parties and jury are freed from complicated, conflicting testimony concerning the "time use of money."

3-25-86

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue · Topeka, Kansas 66612 · (913) 235-2383

Testimony of the Kansas Medical Society on HB 2661
March 25, 1986

The Kansas Medical Society appreciates the opportunity to comment on the medical malpractice reform bill, HB 2661. We participated in, and support this comprehensive work product of the interim committee on medical malpractice. After five months of intensive study by the interim committee, the House Judiciary Committee also spent approximately one month further refining the bill. Throughout all of this, one point emerged - that the malpractice problem is complex, and a comprehensive solution is needed. The three main concepts in the bill must remain in the package for it to be successful: 1. peer review and risk management improvements; 2. insurance system refinements; and 3. tort reform issues. The following testimony touches on all three issues, but first we would like to briefly review some aspects with the current situation.

Over the last several years the number and size of malpractice claims has risen astronomically. In 1986 there will be an estimated 300 lawsuits filed, up from 26 in 1979, a 1,000% increase. The dollars paid out in awards and settlements this year will approach $23 million, up from $3.6 million in 1980. The total malpractice premium paid by doctors and hospitals this year will reach $48 million, up from $11 million in 1982. Malpractice coverage, required by law for all doctors, will cost a family practitioner who delivers babies $8,000-$12,000 this year. An obstetrician or a surgical specialist will pay $30,000-$45,000. Premiums are predicted to reach $100,000 for many physicians within two years.

These numbers are just one facet of the complex malpractice crisis which Kansas faces. Its effects are felt in many ways. It increases the cost of medical care for everyone. The cost of malpractice insurance is borne by all of us, including patients of doctors who have never been sued. The notion that million-dollar verdicts are paid by rich insurance companies is false. All Kansans pay when juries grant vast sums to plaintiffs and their lawyers.

The malpractice crisis has a profoundly corrosive effect on the doctor-patient relationship. The bond of trust and concern which enhanced patient care in the past is being pushed out by an attitude that doctor and patient may be adversaries in the courtroom if results aren't perfect.

The malpractice crisis has already restricted availability of care, notably in obstetrics, which is the fastest growing area of malpractice litigation. In a recent survey, one-fourth of Kansas doctors doing obstetrics had stopped, and another third were planning to drop obstetrics, all because of malpractice pressures. In the near future access to obstetrical care may be severely restricted in many areas of our state. Experts estimate that a young obstetrician entering practice today can expect to be sued eight times during his or her career.

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One of the most disturbing aspects of this whole problem is its effect on young people contemplating a medical career in Kansas. We recently surveyed almost 600 medical students and residents in training in Kansas. Their responses paint a bleak picture about the message we are sending to young physicians in training. 99% of those surveyed express concern over the medical malpractice problem as it might affect their career in medicine. Almost 8 of 10 said medical malpractice insurance costs would affect their decision on where to locate a medical practice. Clearly, as Kansas malpractice insurance rates outpace our surrounding midwest states, it puts us at a competitive disadvantage for young, highly trained physicians. Possibly the most disturbing trend we noticed in the survey was that 86% of those surveyed felt that they would be sued for medical malpractice at some point during their medical career. It seems that our young physicians, among the best trained in the world, have resigned themselves to the fact that medical malpractice suits are unavoidable and inevitable.

We would like to comment at some length, about the "quality assurance" provisions contained in HB 2661. We support the various provisions which give the Board of Healing Arts additional authority, require better reporting by health professionals and mandate risk management programs in hospitals.

Unquestionably, health care providers, regulators, and legislators, all of us, must do everything possible to assure that the health care delivered in this state is of the finest quality. We cannot tolerate incompetent practitioners. The Kansas Medical Society is renewing its commitment to quality assurance activities, and I assure you we will do everything possible to support and participate in the strengthening of the quality assurance network. The peer review, risk management, disciplinary and reporting enhancements contained in HB 2661 probably represent the most comprehensive quality assurance approach found anywhere in the nation. We support these changes and believe they will be beneficial to the public health and welfare.

The quality assurance provisions of this bill create comprehensive systems of accountability for the actions of health care providers. We must also demand accountability from the Board of Healing Arts. Those responsible for its appointment, operations and policies must do their jobs, or share the responsibility for its shortcomings.

Our critics find it convenient to blame the malpractice problem on the "bad doctor." The misguided theory is that a few doctors are causing multiple suits and huge claims which have caused malpractice premiums to skyrocket. The available data just doesn't support that argument, however. Over 40% of all Kansas physicians have been sued at least once for malpractice, but I doubt anyone would concede that four out of ten physicians are incompetent. Almost 2/3 of the obstetricians in this state have been sued for malpractice, and over

half of those have been sued 2-4 times. The dramatic increase in suits against obstetricians comes at a time when the infant and maternal death rates in our state have declined by about 50% in the last decade. In fact, our infant and maternal death rates are among the lowest in the nation. These reductions in rates are directly related to improved medical care of high risk mothers and newborns by well trained physicians and support systems and staff.

We analyzed the data provided to the Interim Committee by the Health Care Stabilization Fund concerning the "bad doctors" - those physicians who have multiple claims against them. From the inception of the Fund through 1984, 115 physicians had more than one claim closed against them. The high in the group was a physician with 15 claims, 8 of which resulted in some payment to the patient. The group average was 2.8 claims per physician. Since the inception of the Fund through 1984, these multiple claim physicians accounted for about 16% of all the claims paid out of the Health Care Stabilization Fund, but only about 10% of the total dollars paid by the Fund. From this data we believe it is extremely difficult to conclude that the "bad doctor" theory has any significant effect on claim payments or insurance premiums.

The fact is that, for whatever reason, more suits are filed today than ever before in our history. This year there will be a medical malpractice lawsuit filed every working day. The explosion in the number of suits filed along with the staggering increase in awards and settlements have caused premiums to spiral to the point that we will collect $45-48 million from doctors, hospitals and other health care providers this year.

These statistics underscore the shortcomings of our tort system: there is no objective standard of liability; there is no definite measure of compensation; the entire process is conducted at a high level of emotion and subjectivity; the cost of litigation is enormous; there is no restraint mechanism to prevent unnecessary litigation; there is no encouragement for prompt settlement; and the system encourages higher and higher awards.

The quality assurance sections of the bill which are under discussion today are an important element in solving the malpractice problem. However, even the most rigorous peer review and quality assurance systems won't significantly reduce premiums, affect the frequency and severity of claims or solve the malpractice problem. However, a strong quality assurance system is in the public interest, and it must be done. The strength of this bill is that it for the first time provides a link between the Board of Healing Arts, hospitals, physicians in private practice, and the various professional associations, all for the purpose of better reporting and accountability. Provisions of HB 2661 will allow us to work cooperatively with the Board of Healing Arts in the identification, reporting and disciplining of health care providers. The requirement that hospitals implement risk management programs in conjunction with better reporting of negligence will require hospitals to give up a little autonomy in return for a better, systemwide approach to identification of problem areas.

The sections of the bill which deal with impaired professionals will allow the Board of Healing Arts to utilize the tremendous resources we have available to rehabilitate physicians, and at the same time assure that the public is protected.

As you have by now anticipated, there is virtual agreement among all concerned parties on the quality assurance aspects of the bill. The controversial portions of HB 2661 are contained in the third, and critical part, of this bill - those recommendations relating to tort reform. All of the quality assurance refinements discussed above are important, but the fact is that the problem simply cannot be solved without some fundamental reform of our tort system.

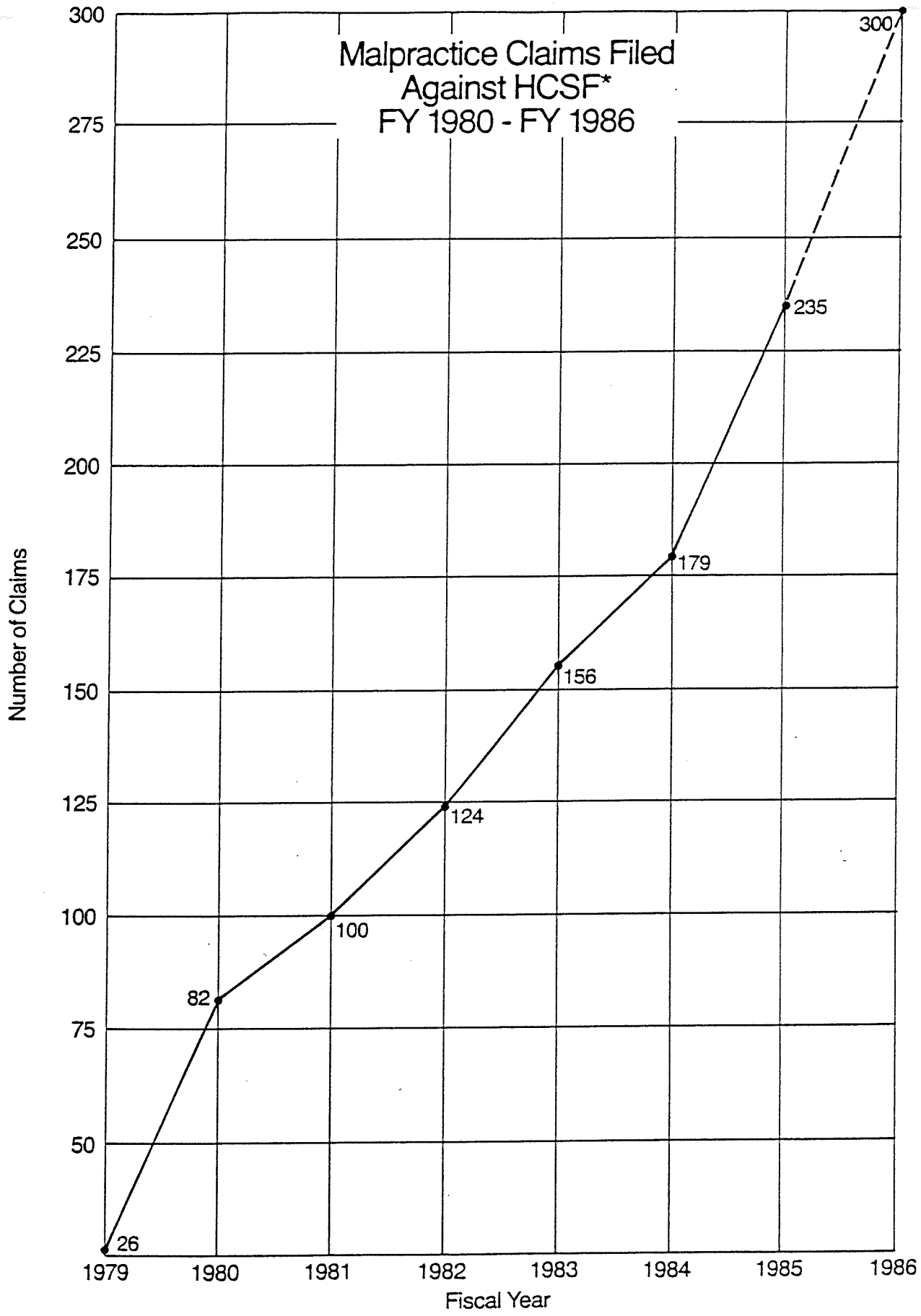
The limitations on awards in the bill have been the most heavily criticized part of the legislation. However, actuarial experts testified during the summer interim study that the only provision which would impact premiums is award limitations. Experience from other states such as Nebraska and Indiana have shown that reasonable limitations will help malpractice premium costs, and still compensate injured patients fairly. In fact, the award limits in HB 2661 are more liberal than Indiana's or Nebraska's. The bill also contains an important requirement that future economic losses be funded through an annuity, or installment payment mechanism. This means that far in excess of $1 million in benefits can be provided at a relatively modest cost upfront. One example of an annuity purchased recently for an injured child had a cost of $200,000 up front, and would pay out over $12 million in benefits during the child's life. Even the cases with the greatest need can be taken care of with the $1 million limit using such annuities. The House Judiciary Committee amendment concerning a "safety valve" or "pinhole" in the cap, provides additional protection in the unlikely event someone's need was not taken care of by the annuity purchased. This safety valve would give such a person the opportunity to obtain a supplementary grant from the Health Care Stabilization Fund in the event their actual needs exceeded the amount awarded.

Limits on awards are crucial if we want to seriously address the liability problem. It is the occasional, but rapidly growing, number of multi-million dollar awards and settlements that is creating such chaos in the liability system in Kansas. The truth is, this bill will not prevent injured patients from recovering reasonable and necessary expenses. Experience from other states has shown that we don't have to guarantee unlimited recovery in order to provide adequate compensation.

Critics of this legislation will urge you to reform the insurance industry before reforming the tort system. It is convenient to blame insurance companies for building up unnecessary reserves, and for charging premiums that aren't justified. A look at the data, however, destroys that myth, at least as it relates to medical malpractice in Kansas. Over the last several years, insurance companies writing physicians in Kansas have not been making huge profits. Currently only two or three companies will even touch medical malpractice and then only selectively. If the malpractice insurance business is so profitable, where are all the companies?

To summarize, without a comprehensive approach, the malpractice problem simply can't be solved. What is the solution? How can an individual's rights be preserved and the malpractice system brought under control? The answer lies in adopting reasonable reforms to the legal system and strengthening the peer review and quality assurance systems. Those three critical elements are contained in HB 2661. If this bill is adopted by the legislature we will see a tremendous improvement in the liability system. Insurance experts have testified that the passage of this bill will allow them to hold the line on premiums. Additionally, the premium surcharge every doctor pays into the Health Care Stabilization Fund will level off, and should drop somewhat within a couple of years, according to actuarial experts. Unquestionably, this bill will have a stabilizing effect on malpractice premiums. Without the bill, premiums will increase about 30-40% this year and probably at least that amount again in 1987. We urge you to act favorably on HB 2661, without substantive amendment. This bill will help assure access to obstetrical and other high risk services in the rural areas will be preserved, and the runaway cost of the system brought under control. Thank you for the opportunity to comment on HB 2661.

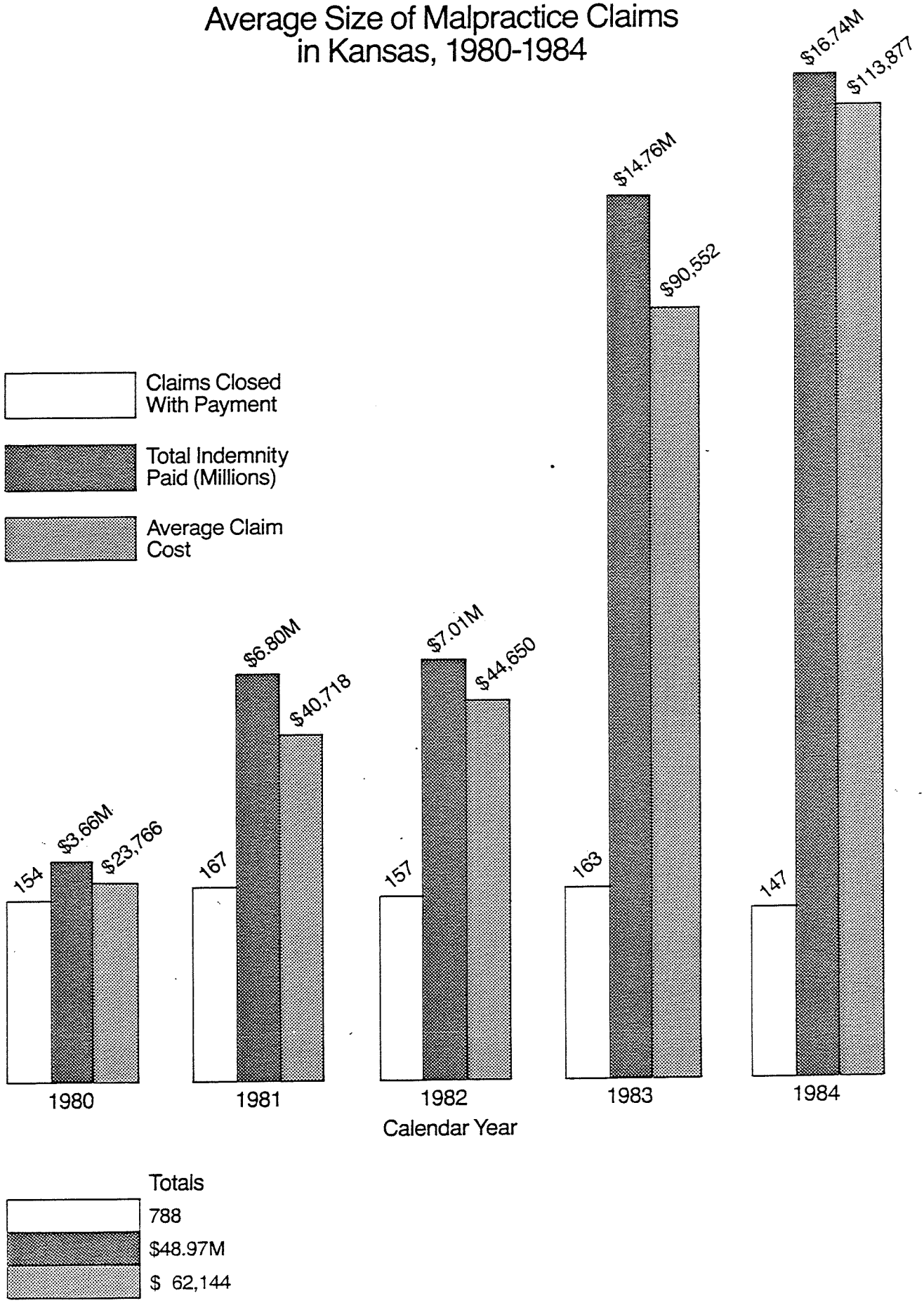
Jerry Slaughter
Executive Director



*Health Care Stabilization Fund

II

Average Size of Malpractice Claims in Kansas, 1980-1984



3-25-86

K s Farm Bureau

PUBLIC POLICY STATEMENT

Statement To:

SENATE JUDICIARY COMMITTEE

RE: Medical Malpractice . . . Tort Reform . . . H.B. 2661

Topeka, Kansas
March 25, 1986

Presented by:
Paul E. Fleener, Director
Public Affairs Division
Kansas Farm Bureau

Mr. Chairman and Members of the Committee:

My name is Paul E. Fleener. I am the Director of Public Affairs for Kansas Farm Bureau. We appreciate the opportunity to make brief comments on the important ... the VITAL issue of medical malpractice reform.

Our members have followed with interest the legislative activity on Medical Malpractice. We were present during the 1976 Interim when exhaustive studies were held and **many** remedies were advanced. A package of 13 bills was the product of that Interim Committee study. Twelve of those bills passed into law. Yet, **the problem continues nearly unabated.**

Awards are astronomical. Medical practitioners are regrouping, retrenching, or retiring.

In the rural communities of this state, the medical malpractice problem poses not just serious, but dire prospects and

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consequences. Our farmers and ranchers have continued to study this issue. They examined it again before our 1985 Annual Meeting and expressed themselves this way on this issue:

Health Care and Professional Liability

We believe there is a threat to health care in this state because of the cost and availability of professional liability insurance coverage for health care providers.

The increased incidence of medical malpractice claims has caused the cost of insurance coverage to soar, reduced the availability of coverage, and contributed to higher patient fees. We believe health care delivery would be improved and the medical malpractice insurance problem corrected by the enactment of state legislation which would:

1. **Prohibit publication of the dollar amount sought in a medical malpractice suit;**
2. **Limit the amount of money which can be recovered in a medical malpractice suit;**
3. **Modify and restrict the use of the contingency fee system by the legal profession; and**
4. **Reduce the statute of limitations and time of discovery for an alleged act of negligence or omission.**

Mr. Chairman, and Members of the Committee, to the extent H.B. 2661 addresses the items of greatest concern to our members ... namely procedures to stabilize the soaring costs of medical malpractice insurance and the availability of that coverage, and the **limitation on the amount of money which can be recovered in a medical malpractice suit**, we support the legislation.

We thank you for giving us an opportunity to make our policy position known and available to all of your committee members.

III

3-25-86

TESTIMONY OF THE KANSAS ASSOCIATION OF OSTEOPATHIC MEDICINE ON HB 2661 - PRESENTED TO THE SENATE JUDICIARY COMMITTEE - MARCH 25, 1986

Mr. Chairman and Members of the Committee:

My name is Harold Riehm and I represent The Kansas Association of Osteopathic Medicine. There are approximately 240 D.O.s practicing in Kansas, most of them in general practice and many in the practice of obstetrics and surgery as a part of their overall practice.

We stand in support of most of the provisions of HB 2661, including most of the amendments that have been introduced to date. Exceptions are noted later in this testimony. I repeat, that we endorse all parts of this bill--the quality assurance provisions, the changes in the health care stabilization fund, the reporting and disciplinary provisions pertaining to providers, and the tort changes.

We view the State as an important partner in resolving the primary problem at which this Bill is directed--namely the rapidly spiraling upward costs of medical professional liability insurance. We appreciate the efforts the State made in the mid 1970's to resolve what was then primarily a problem of availability. And, while not all the institutions established at that time are without flaw, that observation is steeped in hindsight. While HB 2661 is aimed primarily at the issue of cost of insurance, in the osteopathic profession we hold that availability remains a problem, and particularly for osteopathic physicians.

The case for change has been presented so many times in recent years, that a restatement borders on redundancy. Permit me, then, just to make a few observations.

OBSERVATION 1: Many providers need rate relief. Testimony given yesterday by the rural M.D. physician could be repeated with few differences, by a large number of osteopathic physicians. He did not include one partial remedy, however, and that is ceasing the practice of obstetrics. A few have done so; many more will follow if insurance rates continue to spiral upward at 30 to 40 percent each year. A problem of unaffordable rates then also becomes one of a shortage of physician services, with all its attendant consequences.

Rarely does any provider allude to seeking lower rates. What physicians feat most of all is a continuation of the upward spirals. And it is these that we think HB 2661 will at least partially remedy.

OBSERVATION 2: THE ULTIMATE REMEDY IS TO CHANGE THE ENVIRONMENT OF MEDICAL PROFESSIONAL LIABILITY IN KANSAS. Throughout testimony to date, statements have been made that any one major focus of this Bill will not resolve the problem. Those statements are probably true. What it emphasizes is that all of them are needed, and that together they may impact upon the actors in the process in a way that gradually changes the environment of medical professional liability insurance. Part of that environment is the extent of litigation in the State. Some states are more litigious than others. By approaching the problem from the many perspective of HB 2661, we think that environment can be changed.

Another part of that environment is that the physician has lost much of the ability to control the pricing mechanism. There was a time when any increase in overhead was automatically passed on to health care consumers. But with the advent of HMOs, PPOs, Medicare freezes, Medicaid cutbacks, major carrier Cap programs, etc., pass through is

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no longer an automatic recourse. This, then, just changes the nature of the problem. Instead of increasing health care costs, it becomes physician affordability. And as heard yesterday, the Deep Pocket perspective of physicians is often inaccurate.

OBSERVATION 3: THIS IS TOTALLY A PHYSICIANS BILL WITH MUCH GET AND LITTLE GIVE. Few osteopathic physicians would so characterize this bill. The quality assurance provisions of this bill we strongly endorse. But this is not to say that all physicians feel at ease with all of them. Many feel rather strongly that the issue of bad doctors contributing appreciably to the cost of insurance is overplayed. Many, while recognizing the importance of the reporting provisions, question that which makes them report a colleague who has done something that is below the applicable standard of care, but also any such action that may be below that standard. Such is a standard of reporting found in few other professions.

KAOM also endorses the substantially increased involvement in the professional associations of providers in playing a key role in reporting and in investigating their own respective houses.

OBSERVATION 4: THE PROPOSED CAPS ON RECOVERY ARE REASONABLE AND OFFER SUBSTANTIAL OPPORTUNITY FOR FAVORABLY ALTERING THE PROFESSIONAL LIABILITY ENVIRONMENT. We think that the $250,000 cap on nonpecuniary losses and the overall $1,000,000 cap on recovery reflects a compromise between adequacy for injured consumers and a level offering a chance at significantly contributing to an alteration of the medical malpractice environment. We think the creative structuring aspects will provide adequate compensation for incurred injuries. No doctor making a mistake ever takes it lightly, and there is general condemnation of careless negligence such as was illustrated to you by some who testified yesterday to this Committee. But it is indeed a valid question as to why awards for a lost leg, for example, incurred at the hands of a negligent driver in an automobile accident, or a leg loss in an industrial act of negligence, should be worth substantially less than a leg lost in the course of medical malpractice. The proposed caps, we think, will help in addressing the underlying reasons explaining part of these differences.

In sum, Mr. Chairman, it is as unlikely that this is a panacea anymore than it is likely that it stands to do the permament harm to injured parties as claimed by the Bill's opponents. We think it is a major step in the right direction and urge your support.

The Kansas Association of
Osteopathic Medicine

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SELECTED CLASS OF COVERAGE (1)	PREMIUM FOR BASE COVERAGE (1)				TOTAL PREMIUM - BASE + 110% FUND SURCHARGE (1)				TOTAL PREMIUMS (BASE + FUND SC) ASSUMING APPROVAL OF SUGGESTED '86-87 RATE INCREASES (2)			
	MED PRO	ST. PAUL	MED DEF	JUA	MED PRO	ST. PAUL	MED DEF	JUA	MED PRO	ST. PAUL	MED DEF	JUA
PHYSICIANS, NO SURGERY OR MINOR SURGERY	$ 3,408	$ 4,596 (3) (50% Cl Hist. SC)	$ 2,893	$ 5,515 (4) $ 8,273	$ 7,157	$ 9,562	$ 6,075	$ 11,582 $ 17,372	$ 9,304	$ 13,995	---	$ 16,794 $ 25,190
GENERAL PRACTITIONERS	1,363	2,676 (50% Cl Hist. SC)	1,330	3,211 4,817	2,862	5,620	2,793	6,743 10,115	3,721	8,148	---	9,778 14,666

NOTES: (1) Source: Information provided in Interim Committee Report, Pages 840-41.

(2) Source: In testimony presented to the House Judiciary Committee on February 3, it was indicated the Medical Protective and St. Paul Companies either had requested, or planned to request, annual premium increases as follows: Medical Protective, 30%; St. Paul 45%. These increaes are subject to change and have not been approved by the Kansas Insurnace Department. They are offered for illustration purposes only. Information not available on increases of Medical Defense Company. JUA rates based on the assumption of 45% increase in rates of St. Paul.

(3) Where a range of premiums is presented in the Interim Report, a mid point figure is used.

At present time, only these four sources are available to osteopathic physicians for medical professional liability insurance. St. Paul, as of January 1, 1986, is writing no new business in Kansas (or nationwide), and Medical Protective Company will not insure any D.O. that does obstetrics.

During 1985, a company that worte approximately one-fourth of all D.O.s in Kansas, lost its license to write in Kansas, due to insufficient reserves.

(4) The JUA currently utilizes a claims history surcharge. If within a six year period a provider accumulates 4 or more "points", a surcharge is assessed. 4 points activates a surcharge of 50%; 5 points, 100%; up to 10 or more points, 500%. One point is assessed if reserves in excess of $20,000 have been set aside to cover a claim; two points if in excess of $20,000 has been paid out in a claim. Premium figures in the boxes, above, assume an accumulation of 4 points (which could be total payouts of $40,002.00) & imposes a 50% SC.

3-25-86

AARP

1985-1986
KANSAS STATE LEGISLATIVE COMMITTEE

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Mr. Morton F. Ewing
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Hutchinson, KS 67501
(316) 665-8767

VICE CHAIRMAN
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Satanta, KS 67870
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SECRETARY
Mr. Oscar M. Haugh
1512 University Drive
Lawrence, KS 66044
(913) 843-7613

MEDICAL MALPRACTICE TESTIMONY as presented to the Judiciary Committee of the Senate of Kansas on March 25, 1986.
The first part of the testimony is the position that the National AARP can support and the last page (15 points) are the points that were decided upon at a special conference held in Kansas City early in December. There were representatives there from three states in this area and a research specialist from Washington. THE KANSAS STATE LEGISLATIVE COMMITTEE AT THEIR MEETING IN TOPEKA, JAN. 23 AND 24, ADOPTED THESE POINTS AS THE POSITION TO SUPPORT ON THIS ISSUE IN KANSAS THIS YEAR.

We appreciate the opportunity to present this testimony to the Committee.

Thank you
Morton F. Ewing

Morton F. Ewing, Chr. State Legislative Committee of AARP

1806 Tracy Lane
Hutchinson, Kansas 67502

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MEDICAL MALPRACTICE TESTIMONY

WE, AT THE AMERICAN ASSOCIATION OF RETIRED PERSONS, ARE PLEASED TO BE ABLE TO PARTICIPATE IN THE DEBATE SURROUNDING THE MEDICAL MALPRACTICE ISSUE. WE ARE CONCERNED ABOUT MALPRACTICE BECAUSE THE CONSUMER'S VOICE HAS NOT YET BEEN HEARD IN THIS DEBATE AND IT IS ULTIMATELY THE CONSUMER WHO GAINS OR LOSES WHEN CHANGES ARE MADE TO THE CURRENT SYSTEM.

THERE ARE THREE BASIC PARTS OF THE MEDICAL MALPRACTICE SYSTEM THAT MUST BE ADDRESSED. THEY ARE: MEDICAL NEGLIGENCE, LIABILITY INSURANCE, AND THE TORT SYSTEM. MEANINGFUL REFORM SHOULD SEEK IMPROVEMENTS IN ALL THREE AREAS. HOWEVER, THE MOST IMPORTANT AREA IS THE PREVENTION OF NEGLIGENCE. IF IMPROVEMENTS ARE MADE IN THE QUALITY OF HEALTH CARE THEN MANY NEEDLESS INJURIES COULD BE PREVENTED.

THE REMAINDER OF MY TESTIMONY WILL FOCUS ON THE ISSUES SURROUNDING THE THREE PARTS OF THE SYSTEM. AS A CONCLUSION I WILL LAY OUT THE TYPE OF MALPRACTICE REFORM LEGISLATION THAT AARP CAN SUPPORT.

PREVENTION OF MEDICAL NEGLIGENCE

THE MOST IMPORTANT PART OF THE SYSTEM IS PREVENTION OF NEGLIGENCE. PREVENTION WOULD REDUCE MEDICAL COSTS AND MORE IMPORTANTLY -- HUMAN MISERY. THUS PREVENTION IS ONE OF THE MOST

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IMPORTANT REFORM GOALS.

THE STATES HAVE TRADITIONALLY LICENSED PHYSICIANS, HOSPITALS, AND OTHER PROVIDERS AND HAVE TAKEN A MAJOR RESPONSIBILITY FOR ENSURING THAT PROVIDERS DELIVER GOOD QUALITY CARE. UNFORTUNATELY, STATES HAVE NOT BEEN EFFECTIVE, PARTICULARLY IN PHYSICIAN LICENSURE. THE FEDERATION OF STATE MEDICAL BOARDS' RECORDS SHOW THAT THERE WERE ONLY 563 SERVICES ACTIONS TAKEN AGAINST 400,000 PHYSICIANS NATIONWIDE IN 1983. THIS LACK OF DISCIPLINE OCCURRED DESPITE THE FACT THAT A PAST PRESIDENT OF THE FEDERATION ESTIMATES THAT 5% OF PHYSICIANS ARE INCOMPETENT.

OPTIONS FOR IMPROVING PHYSICIAN AND HOSPITAL QUALITY OF CARE

THERE ARE METHODS FOR IMPROVING THE SITUATION THAT I HAVE DESCRIBED. THE MOST IMPORTANT INVOLVE STRENGTHENING PHYSICIAN LICENSURE AND GIVING FACILITIES REVIEWING PHYSICIANS' CREDENTIALS PROTECTION FROM UNFOUNDED SUITS.

LICENSURE WOULD BE STRENGTHENED BY:

1. REQUIRING INSURERS TO REPORT MEDICAL MALPRACTICE SETTLEMENTS TO THE MEDICAL LICENSURE BOARD. THUS BOARDS WOULD HAVE MORE INFORMATION ABOUT PHYSICIANS' POSSIBLE NEGLIGENCE.

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2. MANDATING THAT THE BOARD INVESTIGATE PHYSICIANS WITH POOR RECORDS, PERHAPS WHEN PHYSICIANS HAVE TWO LARGE MALPRACTICE SUITS SETTLED AGAINST THEM. IN ADDITION, BOARDS SHOULD CHECK PHYSICIANS' LICENSURE RECORDS IN OTHER STATES. GIVEN THESE RESPONSIBILITIES BOARDS WOULD HAVE TO INVESTIGATE QUESTIONABLE PHYSICIAN CONDUCT.

3. LAY PEOPLE SHOULD BE ON THE BOARD TO ENSURE THAT DISCIPLINARY ACTIVITIES ARE FAIR AND NOT BIASED TOWARD THE MEDICAL PROFESSION.

4. BOARDS SHOULD ALSO CLOSELY EXAMINE FOREIGN MEDICAL GRADUATES' CREDENTIALS AND REQUIRE CONTINUING EDUCATION AS A CONDITION OF LICENSURE. THIS WOULD ENSURE THE EDUCATIONAL QUALIFICATIONS OF PHYSICIANS IN THE STATE.

5. LICENSES SHOULD BE RENEWED ON AN ANNUAL BASIS TO FACILITATE DISCIPLINE OF THE PROFESSION.

IN ADDITION TO THESE PHYSICIAN LICENSURE REFORMS HOSPITALS SHOULD HAVE RESPONSIBILITY FOR ENSURING THE QUALITY OF THEIR MEDICAL STAFFS. FACILITIES MUST BE REQUIRED TO REVIEW THEIR STAFFS' CREDENTIALS. HOSPITALS' TASKS WOULD BE EASIER IF PEER REVIEW COMMITTEES HAD CIVIL IMMUNITY WHEN DISCIPLINING NEGLIGENT PHYSICIANS. IN FACT, PARTICIPANTS AND WITNESSES IN ANY TYPE OF DISCIPLINARY ACTION SHOULD HAVE PROTECTION FROM SUITS.

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MEDICAL LIABILITY INSURANCE

THE INSURANCE INDUSTRY IS THE SECOND PART OF THE MEDICAL MALPRACTICE SYSTEM THAT MERITS ATTENTION AND REFORM. PHYSICIANS CLAIM THAT PREMIUMS ARE OUT-OF-LINE AND INCREASING DRAMATICALLY. IN FACT, THE AMERICAN MEDICAL ASSOCIATION'S (AMA) OWN DATA SHOWS THAT THE AVERAGE MEDICAL MALPRACTICE PREMIUM IS LESS THAN 5% OF PHYSICIANS' GROSS INCOME. HOWEVER, DOCTORS IN SPECIALITIES SUCH AS OBSTETRICS, ANESTHESIOLOGY AND SURGERY MAY HAVE HIGHER THAN AVERAGE PREMIUMS.

IT COULD BE THAT SOME OF THESE HIGH PREMIUMS ARE NOT JUSTIFIABLE. THE NATIONAL CONFERENCE OF STATE LEGISLATURES STATES THAT MEDICAL LIABILITY INSURERS' PREMIUM INCOME EXCEEDED PAID LOSSES BETWEEN 1977 AND 1982. NET PREMIUM INCOME WAS $7.2 BILLION WHILE LOSS AND LOSS EXPENSE TOTALED $1.7 BILLION. THESE FIGURES INDICATE THAT INSURERS NEED CLOSER SUPERVISION.

THERE ARE SOME REFORMS THAT COULD HELP IMPROVE THIS SITUATION. ONE IS THAT STATE INSURANCE DEPARTMENTS COULD REGULATE THE INDUSTRY MORE CLOSELY. MALPRACTICE INSURERS SHOULD BE REQUIRED TO JUSTIFY PREMIUM INCREASES. IN ADDITION, INSURERS SHOULD BE HELD ACCOUNTABLE FOR HOW THEY HANDLE INVESTMENT INCOME AND PROFITS.

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ANOTHER SET OF REFORMS COULD REQUIRE ALL PHYSICIANS TO CARRY INSURANCE AND TO MANDATE THAT SUCH INSURANCE BE EXPERIENCE RATED. CURRENTLY MANY INSURERS DO NOT DO THIS, LETTING PHYSICIANS WITH POOR SETTLEMENT RECORDS PAY THE SAME PREMIUM AS PHYSICIANS WITH NO SUITS SETTLED AGAINST THEM.

THE TORT SYSTEM

AS I'VE STATED EARLIER, MOST REFORMS FOCUS ON THE TORT SYSTEM, PRIMARILY BECAUSE PHYSICIAN GROUPS CLAIM THAT THERE ARE TOO MANY FRIVOLOUS MEDICAL MALPRACTICE SUITS AND THESE SUITS CAUSE EXCESSIVE PREMIUM INCREASES. IF WE EXAMINE THE AVAILABLE EVIDENCE WE FIND THAT THESE GROUPS MAY BE OVERSTATING THEIR CASE.

THE MILLS STUDY, COMMISSIONED BY THE CALIFORNIA HOSPITAL AND MEDICAL ASSOCIATIONS, PROVIDES SOME INTERESTING DATA. NINETY PERCENT OF ALL NEGLIGENTLY INJURED PATIENTS DO NOT FILE MALPRACTICE CLAIMS. ONLY HALF OF THOSE WHO DO FILE CLAIMS GET AWARDS. AS A RESULT AT MOST 5% OF THE NEGLIGENTLY INJURED ARE COMPENSATED. THIS DATA COULD LEAD US TO CONCLUDE THAT, DESPITE AN INCREASING NUMBER OF CLAIMS PER PHYSICIAN, NOT EVERYBODY DESERVING COMPENSATION GETS IT.

IN ADDITION IT IS ALREADY VERY DIFFICULT FOR PATIENTS TO PROVE THEIR CASES. A RAND CORPORATION REVIEW SHOWS THAT ABOUT HALF OF CLAIMS ARE DROPPED WITHOUT PAYMENT. TEN PERCENT OF CASES ARE TRIED ALL THE WAY TO VERDICT AND OF THE CASES RESOLVED BY JURY

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THE VERDICTS FAVOR DEFENDANTS 75% OF THE TIME.

GIVEN THE ABOVE SITUATION THE ASSOCIATION OPPOSES MOST REFORMS DESIGNED TO LIMIT CONSUMER ACCESS TO THE COURTS AND/OR MAKE IT MORE DIFFICULT FOR PATIENTS TO PROVE THEIR CASES.

HOWEVER THERE IS SOME EVIDENCE SUGGESTING THAT THE MEDICAL MALPRACTICE SYSTEM IS NOT AS EFFICIENT AS IT COULD BE. THE RAND CORPORATION STATES THAT ONLY 28% TO 40% OF THE PREMIUM DOLLAR GOES TO COMPENSATE PATIENTS -- THE REST IS ABSORBED BY THE SYSTEM. THUS THE COURT SHOULD HAVE THE AUTHORITY TO EVALUATE ATTORNEYS' FEES TO ENSURE THAT THEY ARE NOT EXCESSIVE.

IN ADITION, PATIENT AWARDS INFREQUENTLY CAN BE EXCESSIVE, ADDING TO SYSTEM COSTS. THUS THE COURT SHOULD ALSO HAVE THE AUTHORITY TO ADJUST AWARDS WHEN THEY ARE TRULY OUT OF LINE.

FINALLY, PATIENTS SHOULD BE EDUCATED ABOUT THEIR RIGHTS IN THE MEDICAL SYSTEM. THIS WOULD HELP THEM TO BE MORE EFFECTIVE CONSUMERS OF MEDICAL CARE. FOR EXAMPLE, IF PATIENTS WERE AWARE OF THEIR RIGHTS TO APPEAL EARLY MEDICARE DISCHARGE THEY MIGHT NOT ACQUIESCE WHEN THEY ARE DISCHARGED BEFORE THEY ARE ABLE TO LEAVE THE HOSPITAL SAFELY.

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CONCLUSION

IN CONCLUSION, THE ASSOCIATION HAS EXAMINED THE MEDICAL MALPRACTICE SYSTEM AND FOUND THAT DISCIPLINE OF THE HEALTH CARE PROFESSIONS IS INADEQUATE. WE BASE THIS ON A NUMBER OF FACTORS, ONE OF THEM BEING THAT THE MILLS STUDY SHOWS THAT 1 IN 126 PEOPLE ENTERING HOSPITALS RECEIVE AN INJURY DUE TO NEGLIGENCE. THUS IMPROVEMENT IN THE QUALITY OF CARE AND PREVENTION OF INJURY ARE OUR PRIMARY GOALS.

THE SYSTEM'S OTHER PROBLEMS RELATE TO INADEQUATE INSURANCE REGULATION AND CONSUMER ACCESS TO THE COURT SYSTEM. THEREFORE REFORMS SHOULD ALSO MAKE INSURERS JUSTIFY THEIR PREMIUMS AND ENSURE THAT CONSUMERS HAVE REASONABLE ACCESS TO THE COURTS.

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MEDICAL NEGLIGENCE AND TORT REFORM

SUMMARY: Points to Remember for
Balanced Malpractice Legislation

1. Stricter licensure of Foreign Medical Graduates.
2. Experience rating for liability premiums.
3. Continuing education.
4. Facilities review professionals credentials.
5. Insurers report settlement.
6. Everybody have liability as a condition of licensure.
7. Give the court authority to evaluate fees or review awards.
8. License renewal on an annual basis.
9. Lay people on licensure board.
10. Strengthening licensure board.
11. Increase fees to support board activities.
12. Expanding civil immunity to communities, witnesses, etc.
13. Requiring states to investigate physicians records in previous states.
14. Insurers accountable for how handling premiums, investment income -- profits.
15. Education on patient rights.

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3-25-86

LEGISLATIVE TESTIMONY

Kansas Chamber of Commerce and Industry

500 First National Tower One Townsite Plaza Topeka, KS 66603-3460 (913) 357-6321

A consolidation of the Kansas State Chamber of Commerce, Associated Industries of Kansas, Kansas Retail Council

HB 2661

March 25, 1986

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

Senate Judiciary Committee

by

David S. Litwin

Mr. Chairman, members of the committee. I am David Litwin, representing the Kansas Chamber of Commerce and Industry. We appreciate the chance to comment today on HB 2661.

The Kansas Chamber of Commerce and Industry (KCCI) is a statewide organization dedicated to the promotion of economic growth and job creation within Kansas, and to the protection and support of the private competitive enterprise system.

KCCI is comprised of more than 3,000 businesses which includes 200 local and regional chambers of commerce and trade organizations which represent over 161,000 business men and women. The organization represents both large and small employers in Kansas, with 55% of KCCI's members having less than 25 employees, and 86% having less than 100 employees. KCCI receives no government funding.

The KCCI Board of Directors establishes policies through the work of hundreds of the organization's members who make up its various committees. These policies are the guiding principles of the organization and translate into views such as those expressed here.

On February 4, 1986, the KCCI Board of Directors addressed this issue and adopted a broad policy, a copy of which is attached to my testimony. On the basis of that

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policy, we endorse HB 2661 strongly and urge that it receive favorable consideration.

We followed closely the proceedings over the summer before the legislative interim committee and Commissioner Bell's citizens' panel. We feel that the evidence produced there showed beyond doubt that a crisis of major proportions exists in the medical liability insurance field, with rates climbing exponentially and the issue of coverage at any affordable price for some specialties rapidly coming into focus. It appears that at the present time, with the exception of certain practices such as obstetrics and family practice in smaller cities and rural areas, the problem has not yet driven many health care providers out of their practices or resulted in major loss of medical services. However, the trend is deeply disturbing, and it is obvious that no system can withstand an indefinite continuation of geometric increases in load without eventually breaking down. Thus the time to act is now, not after the system has suffered irreparable damage.

Turning briefly to the reforms proposed under HB 2661, we support the cap on awards for pain and suffering. The sad truth of the matter is that no amount of money can ever make people whole from some kinds of injuries. $250,000 is a lot of money and goes a good distance to compensate victims for intangible kinds of loss that are nonetheless very hurtful, yet it draws a line at a point where the understandable desire to compensate such people would not threaten the viability of the entire compensation system. The House committee amendment, on the other hand, that would annually adjust this cap for inflation seems very fair.

Structured awards for future economic loss are a sound means both to maximize the yield of any award and to assure the patient that the funds will be there as long as they are needed. Itemization of jury awards would not only facilitate such structuring, but would require an appropriate degree of accountability from our juries.

Allowing screening panels' decisions to be admitted in evidence should add real teeth to that concept, without unfairly prejudicing the losing side, since members could be called for examination and cross-examination at trial. Requiring expert

witnesses to have been recently active in clinical practice should help end what many feel is a shabby practice of retaining "hired guns" who travel all over the country, testifying for hire, and rarely if ever actually practicing medicine. Mandatory settlement conferences hopefully will result in pretrial settlement of many cases that would otherwise inexorably drift toward trial. However, we feel the original bill's provision for sanctions for refusal of reasonable settlement offers at conferences helped provide the sting that would make such conferences effective and regret that the House amended it out.

Last session's major limitation of the collateral source rule in malpractice actions should have a very salutary effect in the long run. It has always struck me as strange that we profess to have great faith in the jury system, yet at the same time we have consciously withheld from jurors many facts that are very pertinent because we have feared that they could not handle such facts responsibly.

The proposals to reduce the liability of the Health Care Stabilization Fund and to restore interest rates on judgments to realistic levels also strike us as essential ingredients of reform.

Our policy does depart from HB 2661 in one respect, however, in that it endorses the overall cap on awards, but states that medical expenses and out-of-pocket costs should not be included in such limitations. KCCI's Liability Insurance and Tort Reform Committee had such reservations, and hence they are embodied in our current policy. In any event, the so-called "pinhole" in the cap for the most seriously injured people helps satisfy this concern to a considerable extent.

We also strongly endorse in principle all of the provisions that are designed to improve and accelerate discipline of licensees, require the creation of effective risk management and peer review systems, curtail the activities of impaired providers, impose fines and expand the bases for malpractice, and protect people who in good faith report malpractice incidents.

Finally, I cannot overstate that while KCCI feels strongly that the medical malpractice liability situation is serious enough to justify special legislative

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treatment this year, our friends in the health care professions are only very slightly ahead in their difficulties of many other business and professional groups and political subdivisions, and in fact may be in better shape than some businesses. We view the possible enactment of HB 2661 as a partial solution to a much broader problem. While the evidence in Kansas is still somewhat anecdotal, there is no question but that there has recently been a wide and profound realization throughout the state that we have a very disturbing liability situation.

Hardly a day goes by that we do not hear about a Kansas business' inability to get any affordable coverage, or paying sharply higher premiums and receiving much lower policy limits and higher deductibles. We believe that a major part of the problem lies in our inefficient, slow, and grindingly expensive system for adjudicating torts, in which an appallingly low percentage of the funds expended find their way to the innocent victims. We will be supporting reforms that would give desperately needed relief to general business, while at the same time assuring that adequate insurance coverage is available both for the sake of such businesses and for those who might make valid claims against them. That, however, awaits another day, and with the reservation I have mentioned, we most strongly urge the enactment of HB 2661 during the 1986 session.

Thank you again for this opportunity to testify. If there are questions, I will try to answer them.

Kansas Chamber of Commerce and Industry
Tort Reform Policy

February 1986

The Kansas Chamber of Commerce and Industry supports reforms which, in medical malpractice actions, would impose caps on damage awards with the exception of past and future medical expenses and other out-of-pocket costs, provide for structured awards of future economic loss, require itemization of jury awards, make decisions of pretrial screening panels admissible in evidence, require expert witnesses to be active in clinical practice, establish mandatory settlement conferences, link postjudgment interest rates to the yield of United States Treasury bills, require evidentiary hearings on the reasonableness of attorneys' fees, and reduce the exposure of the Health Care Stabilization Fund.

KCCI further supports, in principle, the enactment of provisions which would curtail the activities of impaired health care providers, accelerate and improve practitioner discipline, impose mandatory requirements concerning the reporting of malpractice incidents, immunize good faith reporting of such incidents, require the implementation of peer review and risk management programs, and impose civil fines for malpractice.

KCCI further believes that there is an equally serious crisis in the cost and availability of liability insurance in a wide range of industries and professions and for public entities, and in the cost of litigating tort claims. KCCI believes that reforms that are necessary and appropriate in the medical malpractice area should, on the whole, be adopted in these more general spheres as well, and urges the legislature to enact remedial legislation as soon as possible. Such legislation should include provisions that would eliminate or significantly restrict the award of punitive damages, place caps on awards for pain and suffering, authorize structured awards, limit attorney contingent fees, eliminate the collateral source rule, eliminate discovery abuse and control discovery costs, provide for alternate dispute resolution in appropriate cases, limit venue shopping in tort actions, and effect such other procedural and substantive reforms as may be necessary.

3-25-86

KANSAS PODIATRY ASSOCIATION

615 S. TOPEKA AVE., TOPEKA, KANSAS 66603
913-354-7611

March 25, 1986

RE: House Bill 2661 Medical Malpractice

Chairman Robert Frey and Members of the Judiciary Committee

My name is Wayne Probasco. I represent the Kansas Podiatric Medical Association.

Podiatry has been included in the Health Care Stabilization Fund since its inception.

There has never been a lawsuit filed against a Podiatrist that has required the Fund to get involved because it never got past the threshhold of $100,000, now $200,000.

But, Podiatry is included in the 110% surcharge to make up the Fund's fund.

Therefore, the Kansas Podiatric Medical Association is in favor of this bill with the hope and expectation that Medical Malpractice liability insurance premiums will go down.

Respectfully submitted,

Wayne Probasco

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KSNA
the voice of Nursing in Kansas

For Further Information Contact:

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March 25, 1986

H.B. 2661 Medical Malpractice

The Kansas State Nurses' Association which represents the professional nurses in Kansas has been monitoring the interim and legislative hearings on H.B. 2661. The Special Committee on Medical Malpractice and the House Judiciary Committee are to be commended for their direct and persistent attention to this very complex issue. H.B. 2661 has both a direct and indirect effect on registered nurses practicing in health care institutions and also with health care practitioners covered by the health care stabilization fund. CRNA's (Certified Registered Nurse Anesthetists) are the only registered nurses that are covered under the current law requiring malpractice liability insurance, however, registered nurses practice in a variety of settings, under the direct supervision and in interdependent roles with physicians and are also employed by hospitals covered under the fund. The Peer Review issues that H.B. 2661 addresses are concerns that registered nurses have had in the workplace. There are over 22,000 R.N.'s licensed in the state of Kansas. Nurses and physicians work in collegial relationships to provide health care to the citizens of Kansas.

PEER REVIEW

The Kansas State Nurses' Association acknowledges that there are nurses who are caught in the middle, between their employer, the

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physician and the patient when incompetent or impaired "health care providers" practice. The proposals under New Section 4 (a) should alleviate the need to blame individuals (hospitals, nurses, collegues) when reporting in good faith occurs. Line 0093 states that "a employee who is directly involved in the delivery of health services" shall report and lists the formal mechanisms for reporting. This gives specific direction to registered nurses who have legitimate concerns about quality of care by "health care providers".

Retaliation by employers and physicians has been an unneccessary fear of registerd nurses' caught in their legal relationships as patient advocates. KSNA would like to commend Senator Nancy Parrish whose interim committee suggestion is responsible for the New Section 9 (page 8, line 0297) which states that:

"(a) No employer shall discharge or otherwise discriminate against any employee for making any report pursuant to section 4 or 5.
(b) Any employer who violates the provisions for 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 recoverable in an individual action by the aggreieved employee. If the aggrieved employee substantially prevails on any of the allegations contained in the pleadings in an action allowed by this section, the court, in its discretion, may allow the employee reasonable attorney fees as part of the costs.

Mandatory reporting in the peer review arena imposes legal obligations and responsibilities to hospitals and other "health care practitioners", thus alleviating the voluntary element and retribution in the workplace. KSNA believes these changes in reporting responsibilities and the increased disciplinary options of the Board of Healing Arts for "health care providers" are positive.

RISK MANAGEMENT

Nurses have been actively involved in quality assurance in hospitals, both through nursing service and in total hospital quality assurance programs. New Section 3 provides for establishing and maintaining internal risk programs for medical care facilities. Mandatory risk management programs should facilitate quality assurance in hospitals that are not JCAH (Joint Committee of the Accreditation of Hospitals) accredited and have inactive quality assurance programs.

IMPAIRED HEALTH CARE PROVIDER PROGRAMS

KSNA has a Peer Assistance program in cooperation with the Kansas State Board of Nursing (KSBN) to pursue the issue of nurses' addicted to the use of habit forming drugs or alcohol. It is a voluntary program, funded in total by KSNA. Compliant nurses are monitored and allowed in the workplace in continued employment.

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Impaired nurses that are not in compliance with the KSNA Peer Assistance Program are reported to the Kansas State Board of Nursing. The KSBN is then responsible for investigation and possible disciplinary action. The distinction between the administration by the professional organization and confidentiality related to the program has been an extremely important factor in the success of the KSNA Peer Assistance Program. KSNA supports Section 5 acknowledging the existence of such programs and particularly (h) that provides civil immunity for actions in good faith related to impaired providers committee work.

FISCAL NOTES

KSNA questions the need to hire two additional investigators to the staff of the Healing Arts Board proposed by the Governor's budget message. The Board of Nursing is responsible for disciplining four (4) times the number of licensees as the Board of Healing Arts and there exists no formal mechanism for nursing peer review like the medical staff privileges system that exists in many Kansas hospitals. KSNA encourages critical analysis of additional staff to the Board of Healing Arts for such activity. The increased reporting responsibilities for medical care facilities and health care practitioners should reduce the reporting problem, thus eliminating the often tedious pursuit of facts.