Approved April 2, 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 26, 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:

John Meyers, Office of the Governor
Ron Smith, Kansas Bar Association
Richard Hite, Trial Attorney
Former Governor John Anderson
Kathleen Sebelius, Kansas Trial Lawyers
Charlotte Gregory, Respiratory Therapist, Wichita
Lynn Johnson, Kansas Trial Lawyers

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

John Meyers, Office of the Governor, testified the Governor has maintained his commitment to find an equitable and sound solution to the complex and multi-faceted problem of medical malpractice. I urge you to substitute a cap on pain and suffering for the present overall cap, and pass out the bill favorably. Copies of his testimony and a newspaper article are attached (See Attachment I).

Ron Smith, Kansas Bar Association, was recognized to introduce Richard Hite, trial attorney.

Mr. Hite testified although the bar is not satisfied with other provisions, he will focus on the most objectionable feature, the overall cap on awards. The cap on economic losses would not produce reduction in insurance premiums. It is not supported by the Reagan administration, American Medical Association, St. Paul Insurance Company, KCCI and 48 states, including Missouri and the Governor. He stated the cap is not justified by rash of runaway verdicts. The bar feels the most important single factor in current premium situation is the actuarially unsound 1976 Act which created the Health Care Stabilization Fund. One-third of premium surcharge of HCSF is for the purpose of catching up. The deficit is still being paid off. There is too much medical malpractice by a small minority, and disciplinary procedures need to be tightened. He said there are too many problems in the tort system; too many claims filed that have no merit. The bar supports the use of screening panels be admissible in evidence. The tort system is never going to be a very popular thing. They hope to eliminate what they believe is an emotional plea and eliminate the cap from the bill.

The chairman requested Mr. Hite to submit an itemized summary of his testimony.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY,

room 313-S, Statehouse, at 10:00 a.m./p.m. on March 26, 1986

House Bill 2661 continued

A copy of Mr. Hite's summary which was turned in later in the day is attached (See Attachment II).

Former Governor John Anderson stated he was asked to appear, he is not a volunteer. He served at the request of Fletcher Bell at an interim study conducted last year. He explained that committee of 26 members spent considerable amount of time studying the factors that go into problems of insurance and medical malpractice. A copy of the report of the citizens committee is attached (See Attachments III). He testified you can't give one segment of our society without taking it from someone else. Trying to fix that problem by fixing a cap is wrong. He said it is wrong to take away from a person who is injured by a medical malpractice case. Jurors just are not going to cap the doctor on the case. The jury just can't bring a verdict against the doctor is one of the human factors that go into our business. He stated peer review will help if tighten up on that. He proposed to do away with the mandate in the law that the jury can't be informed that there is insurance in this case.

Kathleen Sebelius, Kansas Trial Lawyers was recognized to introduce Charlotte Gregory, from Wichita who is a respiratory therapist in a Wichita hospital.

Charlotte Gregory related two cases. A woman in labor had problems from anesthetics that were administered and oxygen supply to the blood stream was cut off which resulted in brain damage. She has $500 thousand in medical bills which insurance covered, but her medical bills could exceed $1 million by the time the case goes to trial. The second incident concerned a man who was in a minor car accident injuring his knee. He had a reaction from drugs given to him to relax. When the nurse checked on him, he had stopped breathing. He is now fed through a tube with no movements of his own. She said they called this chronic vegetative state. Imposing of caps would place victims as this on the welfare role.

Lynn Johnson, representing the Kansas Trial Lawyers, testified the price of malpractice insurance has risen dramatically for Kansas doctors. The price of liability insurance in various professions and industries has risen dramatically in the past few years. There is little evidence in Kansas, or other states, that significant tort reform which limits awards to victims, provides relief from insurance gouging. He stated the KTL enthusiastically support the provisions of House Bill 2661 in the area of peer review. They proposed and endorse a $1 million cap on the liability of the fund. They continue to endorse the surcharge averaging, endorsed by the Interim Committee, but deleted by the House Committee. Mr. Johnson testified they strongly urge detailed insurance data gathering for medical malpractice and other liability insurance. KTLA endorses the proposals regarding an itemized jury verdict. They endorse mandatory settlement conferences. He stated KTLA supports medical malpractice reform aimed at addressing the current insurance crisis. They urge the committee to divide the bill into appropriate sections or to delete the provisions imposing a flat cap of $1 million on all damages. Copies of his testimony and a newspaper article are attached (See Attachments IV).

The meeting adjourned.

A copy of the presentation on medical malpractice by the Kansas Insurance Department is attached (See Attachment V).

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

Copies of the Kansas Trial Lawyers handouts are attached (See Attachments VII).

GUEST LIST

COMMITTEE: SENATE JUDICIARY COMMITTEE

DATE: 3-26-86

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Marta Fisher Linenberger	Topeka	KIMS
[illegible]	Topeka	Guest
[illegible]	Topeka	Kings
Martha J. Hutchison	Topeka	~~KE~~ K Medical Society
John [illegible]	Topeka	Gov. Office
[illegible]	Topeka	KBA
Richard C. Hite	Wichita	KBA
Frank [illegible]	Wymore NE	KTIA
Darlene [illegible]	Herkimer KS	Guest
Frank Feldhausen	Bremen Ks	KTIA
[illegible]	Mission Hills KS	KTLA
Ron Smith	Topeka	KBA
[illegible]	Topeka	KBA
Homer Cowan	Ft Scott	The Western Co's
M. Ingle	Topeka	Gov. Staff
PAT DAVIS	TOPEKA	" "
DIANE DUFFY	LAWRENCE	" "
Steve Jack	Topeka	- -
John Brookens	Westmoreland	Taxpayer
Larry Apps	Topeka	Ks Dental Assoc.
David Hufford	Wichita	Physician
DAREN EPPLEY	TPK	Student
GEOFF HERLEY	TOPEKA, KS	WU LAW
Bradley Post	Wichita	KTLA
Bob [illegible]	Topeka	KTLA

A-VI

GUEST LIST

COMMITTEE: SENATE JUDICIARY COMMITTEE DATE: ______

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Kathleen Sebelius	Topeka	KTLA
Kelle Roesch	Lawrence	KTLA
[illegible]	KC	[illegible]
Charlotte Gregory	Wichita	KTLA
Mark B Hutton	Wichita	KTLA
Donna Smith	Topeka	Ks. Bar Assoc.
Wayne PROBASCO	"	Ks Podiatry Assn
PATRICIA HENSHALL	"	OJA
Lori Callahan	Topeka	Am. Ins. Assn.
J. George	"	Staff
Blake Post	434 S. Topeka, Topeka	KTLA
Larry Buening	Topeka	Healing Arts Bd
Charlene Abbott	Topeka	Bd Healing Arts
Larry Magill	Topeka	Indep Ins. Agents of Ks
Gary Robbins	Topeka	Ks Opt Assn
Sherman A Parks Jr	Topeka	Ks Chiropractic Assn

A VI

3-26-86

STATE OF KANSAS

OFFICE OF THE GOVERNOR
State Capitol
Topeka 66612-1590

John Carlin *Governor*

Testimony to
Senate Judiciary Committee
Regarding House Bill 2661
by John Myers
March 26, 1986

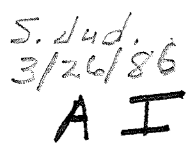
Mr. Chairman and members of the committee, I am John Myers, Director of Policy for Governor Carlin, and I am here to testify on his behalf. Throughout the debate on House Bill 2661, the Governor has maintained his commitment to find an equitable and sound solution to the complex and multi-faceted problem of medical malpractice. The Governor has followed closely the hearings of the Interim Committee on Medical Malpractice, the Bell Commission on Tort Reform and the House Judiciary Committee. The vast majority of recommendations that have emerged from these studies are rational, well-directed proposals which he believes are necessary and will have a positive impact on the Kansas health care environment.

The Governor is particularly encouraged by a number of key provisions in the bill. For one, the proposal to limit the liability of the Health Care Stabilization Fund (HCSF) to $1 million will result in an immediate reduction of the surcharge on doctors' premiums. Further, the requirement that the HCSF merit-rate the surcharge according to the risk presented by each individual doctor will result in a much more equitable approach to risk-pooling.

The mandate on the use of settlement conferences in medical malpractice cases will enhance communication between the parties and help facilitate fair and reasonable compromises without the time and expense of a court trial.

Also, the requirement that all jury verdicts be itemized will hinder what some call "runaway" juries by requiring that juries detail in their verdicts exactly how much money they are awarding for economic and non-economic damages.

The Governor supports all these measures and many others in HB 2661. However, as the primary proponent of the people of Kansas, he does not support an overall cap on the recovery rights of medical malpractice victims. Such a simplistic approach to this complex problem is not a solution but merely a shifting of the burden from one group of victims to another. And further, we are asking those injured to surrender their rights without asking anything in return. In exchange for this cap, we have received <u>no</u> guarantee from the insurance industry that they will lower premiums. We have received <u>no</u> guarantee that health care costs will come down. And more importantly, we have received <u>no</u> guarantee of continued access to quality health care for the citizens of rural Kansas.



However, two things are certain if we pass this cap. First, someone will be injured and require care beyond what $1 million can provide, and they will not be compensated. Second, the liability of those doctors who cause the most severe injuries will be protected by an arbitrary limit.

Recognizing the need to balance the concerns of those seeking to limit liability and those advocating victims' rights, the Governor has suggested a compromise which he believes should satisfy all parties. A significant factor in most jury decisions is compensation for pain and suffering. By applying the cap only to the non-economic portion of a jury award, a victim's medical bills and out-of-pocket costs will be recovered yet doctors' liability will be reasonably limited. Damages that a victim cannot prove cannot be recovered, and the portion of an award that is arbitrarily set (pain and suffering) will be statutorily limited.

Preference for a cap on pain and suffering rather than an across-the-board cap has been widespread throughout the nation and the state. A pain and suffering cap was adopted in Missouri last month and also has been recommended by the American Medical Association and President Reagan's Task Force on Tort Reform. Within the state, the Bell Commission on Tort Reform and the Kansas Chamber of Commerce and Industry both recommended some type of cap but did not recommend a limit on actual or future medical expenses. Clearly, a compromise can be reached if all the parties involved are willing.

In conclusion, the issue of accessible and quality health care will remain high on the public agenda in Kansas no matter what action you take. There currently are many factors contributing to the problem of access to care in rural areas, including prospective reimbursement systems, dwindling population bases and general cost containment measures. Undeniably, medical malpractice insurance premiums also are a factor in a doctor's decision to practice in rural Kansas. But the fact is, a cap on pain and suffering offers the same assurances for reducing premiums as offered by an overall cap. The advantage, however, is that it assures victims of compensation for their actual medical expenses resulting from medical malpractice.

On behalf of Governor Carlin, I urge you to substitute a cap on pain and suffering for the present overall cap, and then pass HB 2661 out favorably.

Malpractice Cap on Actual Damages Is Bad Policy

By Gov. John Carlin

The issue of medical malpractice has taken center stage in Topeka during the past few weeks. When an issue becomes as emotional and political as this one has, the facts are often ignored. I urge everyone to pay attention to the debate, since the results will have a profound effect on all Kansans. Unfortunately, the discussion has disintegrated into a battle between doctors, insurers and lawyers. My goal is not to find a solution merely to satisfy these groups, but instead to find the one that is best for all Kansans.

Carlin

Access to quality medical care and compensation for victims of medical malpractice are two concerns that must be balanced to find an equitable solution to benefit everyone. The rising cost of medical malpractice insurance affects the cost of medical care for everyone. Not only have medical costs skyrocketed, but many doctors, especially those in high-risk specialties, are choosing to limit their practices or retire because they see no alternative.

I do not want Kansas to los doctors because of high insuranc premiums. Nor do I want to se the availability of health car threatened. But in our attempt t avert that threat, we cannot affor to create new problems by car lessly limiting the fundament rights of victims.

AT THE END of the legislativ session last year, I signed a b designed to reduce insurance pr miums. Among the changes, th new law capped the amount a vi tim could be awarded for punitiv damages. Unfortunately, the bi has not resulted in the immedia lowering of premiums as promise by its proponents. Now, a new b is winding its way through the le islative process. It would place total and arbitrary cap on th amount a victim could recover i a medical malpractice case. U der the bill, a victim would not b guaranteed the right to recov actual out-of-pocket expenses fo medical care or lost wages due malpractice by a doctor.

A House Committee recently heard testimony from a victi who will have incurred at least million in medical expenses alo before any judgment in his case rendered. An arbitrarily set lin in the form of a cap would pr vent any provision for future medical care for him. I find it unacceptable to further punish victims by restricting their rights of recovery while rewarding the wrongdoers by protecting the level of their liability.

The addition of the so-called "pinhole" amendment does little or nothing to improve the measure. If the real intent is to allow full recovery of damages for the victim, then we should be honest and remove the cap on actual economic losses. If the "pinhole" does not allow the victim to fully recover economic losses, then all we have done is created another bureaucratic hoop that will frustrate victims in their rightful attempt at recovery of actual losses. It is a poor attempt at a compromise.

GIVEN THE MAGNITUDE of the problem, we should look at our own history to guide us. Here in Kansas during the 1970s, we placed a cap on awards in liability cases involving municipalities. Yet today, communities across Kansas are finding it difficult to obtain liability insurance. Obviously, caps have not worked in this instance, which raises the question of their viability in other areas.

The claim that my opposition to a total restriction of victims' rights is obstructing progress on this issue is absurd. To the contrary, I am seeking a solution that is equitable to all interests involved in this debate. As a result, I support a compromise which will achieve that objective, yet not diminish my main goal to protect the rights of victims.

The amendment I support places a limit of $350,000 per defendant on the amount of damages a victim can be reimbursed for pain and suffering. This compromise, when coupled with the cap on punitive damages, will address those concerned about inflated awards. But it will not prevent victims from recovering their actual costs. Few Kansans would argue with this alternative.

This compromise resembles the new law recently enacted in Missouri. Unlike its counterpart here in Kansas, the Missouri Medical Society supported the limited cap on pain and suffering. In addition, the official recommendation of the American Medical Association is in support of caps on non-economic losses. In Kansas, the state Chamber of Commerce and Industry has studied tort reform and also adopted the position that actual economic losses should not be capped. The Chamber does support a cap on pain and suffering such as I am now recommending.

Even the Kansas Insurance Commissioner's special panel on tort reform rejected the notion of limiting actual damages. The report states, " ... the risk exists that even with (structured settlements), many injured persons may be denied adequate compensation for future medical or custodial costs." The chairman of the panel, former Gov. John Anderson, concurs with my view that a total cap on a victim's right to recover actual costs is bad public policy.

THE CONSENSUS of opinion is clear. Total caps on awards are not the answer. This compromise is the common middle ground. However, the debate over caps has overshadowed other solutions to the medical malpractice dilemma. For the most part, all sides agree there are additional ways to address the problem.

One solution is mandatory settlement conferences. All parties to a malpractice claim would participate, including those ultimately responsible for any award, so awareness of the issues involved would be enhanced and communication between all parties improved.

Another change would be to differentiate between doctors with claims against them and those without. Currently, most insurance carriers do not increase doctor's premiums in proportion to the number of claims paid against them. By increasing premiums according to each doctor's claims history, a more equitable system to determine premiums would be created.

Finally, the internal structure of the Board of Healing Arts has never been clearly defined and, despite an increasing caseload, the current administrator is authorized to work only on a part-time basis. Both factors have adversely affected the board's ability to police the medical profession and investigate malpractice complaints. In addition, various public and private entities should be required to report to the board any knowledge of malpractice claims. The board is a key participant in the malpractice arena, and these changes would enable its members to carry out their responsibilities more effectively.

Addressing the issue of medical malpractice is a tremendous challenge and the severity of the issue warrants a great deal of concern by all Kansans. We cannot justify the abandoning of victims' rights as a remedy to our problems. Instead, we need to implement a number of solutions that together will help reduce the costly burden of malpractice insurance on the medical profession while maintaining the rights of innocent victims to be compensated for their injuries.

-Wichita Eagle Beacon
March 15, 1986

3-26-86

OUTLINE OF REMARKS ON HB 2661
BEFORE SENATE JUDICIARY COMMITTEE
OF
RICHARD C. HITE
LEGISLATIVE CHAIRMAN
KANSAS BAR ASSOCIATION

Although not satisfied with other provisions -- will focus on most objectionable feature -- overall cap on awards.

Cap is <u>inherently unjust</u>

- on one hand grants special privilege
- on other hand denies recovery for actual financial losses to those most severely injured
- breach of fundamental principle of full compensation for loss occasioned by negligence

Cap would <u>not produce significant reduction in premium</u>

- only evidence -- $1,000,000 cap, without pinhole, would reduce premium surcharge to HCSF by 5.3% and overall premium by 2.65%
  - testimony of actuary employed by Kansas Insurance Department

Cap is <u>not supported by</u>

- Reagan administration
- American Medical Association
- St. Paul Insurance Company -- leading insurer
- KCCI
- 48 states, including Missouri
- Governor

Cap is Not Justified by Rash of Runaway Verdicts

- Information from HCSF (See attached letter)
  - 4 verdicts in excess of $1,000,000
    - 1 reversed on appeal
    - 1 still on appeal
    - 1 settled for less than $1,000,000
    - 1 affirmed on appeal - $2,000,000

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A II

Cap is Supported by Medical Society

- many proponents under impression that cap will dramatically reduce premiums
- better to inform those proponents of facts
- rather than make change which is fundamentally wrong

What Is Cause of High Malpractice Premiums?

What Should Be Done About High Premiums?

Most Important Single Factor --

- actuarially unsound 1976 Act
  - inadequate premiums
    - none at all for HCSF 1981, '82, '83
  - caused $25,000,000 deficit or more
  - accounts for approximately 1/3 of premium surcharge

Action Needed

- modify legislation
  - done in 1984
  - impact to be felt after "Catch-Up"

$1,000,000 limit on coverage would produce same premium reduction as cap on awards.

Too Much Medical Malpractice by Small Minority

Action tighten disciplinary procedures

addressed in 1984

addressed in HB 2661

Action merit rating

impose penalty on repeat offenders

also lighten load on others

A II

Problems In Tort System

Too many claims without merit

some irresponsible conduct by attorneys

no yardstick for review of damages awarded

excessive post judgment interest

insufficient use of annuity principles

Cap on Awards Is Not Solution to Any of Those Problems

Solutions are:

use of screening panels (limited)

imposition of sanctions and penalties

itemized jury verdicts

requirement that future damages be reduced to present value

reduction of post judgment interest rate

All Recommended By Bar

All Contained In Proposed Legislation

Despite Criticism Tort System Provides Valuable Service

- establishes standard of conduct
- imposes financial penalties on those who deviate from standards

If Principles Are Seriously Breached Will Lead To Adoption of Administrative Compensation System.

- administrative system would have disastrous results
  - economically
  - from motivational standpoint

A II

STATE OF KANSAS

KANSAS INSURANCE DEPARTMENT

420 S.W. 9th
Topeka 66612-1678 913-296-3071

1-800-432-2484
Consumer Assistance
Division calls only

FLETCHER BELL
Commissioner

January 10, 1986

Mr. Ron Smith
Kansas Bar Association
1200 S.W. Harrison
Topeka, Kansas 66612

Dear Ron:

Enclosed with this letter, please find the pretrial orders in the following cases:

Morris v. Francisco $1,200,000 - REVERSED ON APPEAL
Olsen v. Humana $6,200,000 ACTUAL - ON APPEAL
Walters v. Hitchcock $2,000,000 - AFFIRMED ON APPEAL
Scales v. Wichita Cardiology $1,040,000 - SETTLED FOR $900,000
Wentling v. St. Joseph Medical Center - $768,000

These orders pertain to those cases in which judgments were obtained necessitating an obligation from the Fund in excess of $500,000 per case.

Please note, however, that the plaintiff verdict in Morris v. Francisco was reversed on appeal.

If you have questions concerning this information, please do not hesitate to contact the undersigned. The statement for providing you with this information is attached to this letter.

Very truly yours,

Fletcher Bell
Commissioner of Insurance

Derenda J. Mitchell

Derenda J. Mitchell, Attorney
Health Care Stabilization Fund

DJM:ks
Enclosure
LE/2630

Dick:

These five cases were what we waited 4 months for...

RON

A II

3-26-86

MINORITY REPORT OF KANSAS CITIZENS COMMITTEE

Prefatory Note

The Committee has attempted to suggest solutions for the problems created by the costs of medical malpractice claims, the troubled condition of the Health Care Stabilization Fund (HCSF) and the substantial escalation of medical malpractice insurance premiums. In considering the problems the committee was charged with studying and the recommendations of the majority, it is imperative that two factors be noted and kept in proper prospective.

First, although other matters need to be considered, the fundamental source of the problems considered by the Committee is medical malpractice. Medical malpractice is a deviation from established standards of care which causes injury to an innocent person. The standards are established by members of the medical profession not by lawyers or judges.

If it was found that fire insurance premiums were excessive in a certain region, the most effective action to reduce premiums would be to engage in an aggressive fire prevention program. By the same logic, it is clearly most appropriate that the Citizens Committee has unanimously recommended many steps to improve peer review and strengthen disciplinary procedures in order to eliminate as many acts of malpractice as possible. It is equally appropriate that the committee has recommended many actions intended to reduce

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the liability of the HCSF and improve the handling of medical malpractice claims.

Secondly, it is beyond dispute that a major reason the HCSF is in a precarious financial condition is simply because insufficient premiums have been paid by health care providers in the past. The fund became operative in 1977. Initially the pipeline of claims into the fund was empty and it was known that it would be some time before the pipeline was full. Nevertheless, as the number of claims increased, the premium income of the HCSF remained substantially the same for three years, declined to one-third of the initial amount in the fourth year and disappeared entirely for the fifth, sixth and seventh years. In the fifth, sixth and seven years (1981, 1982 and 1983), the health care providers were receiving unlimited coverage over and above primary limits at no cost. All of this occurred while the rate of inflation for medical services was at an all time high.

The inadequate premiums paid to HCSF had a tremendous role in bringing about the present "crisis." According to information supplied by the Insurance Commissioner, underpayment of premiums accounts for about 24 million dollars of the 31 million dollar deficit that the fund faces.

Particularly because of the two factors which have been noted, those joining in the minority report believe:

1. The highest priority should be given to reducing the incidence of medical malpractice particularly among the very small minority of health care providers who are responsible for multiple meritorious claims.

2. Strong emphasis should be placed on improvement of the actuarial and claims handling aspects of the HCSF.

3. The existing tort system should not be drastically altered by special privilege legislation until every reasonable step has been taken to solve the more direct problems referred to in 1 and 2.

4. The existing tort system should not be drastically altered by special privilege legislation to "make-up" the HCSF deficit attributable to underpayment of premiums in the past.

5. The ultimate impact of legislative enactments in 1984 and 1985, plus the additional legislative action recommended by both the majority and minority will produce a reasonable solution to the problems addressed by the Committee.

Specific Comments and Recommendations

The minority strongly disagrees with the recommendations included in the majority report to place an arbitrary "cap" or limit on the recovery of damages in medical malpractice cases, to make screening panels mandatory and to restrict attorneys' contingent fees.

1. Caps on Awards: The majority proposes a cap of $500,000 on verdicts in medical malpractice cases. The cap would apply to all damages except future medical or custodial care.

Minority Position: The minority opposes the proposal to place an arbitrary cap on awards for the following reasons:

A. It is inherently unfair.

B. It may be unconstitutional.

C. The effect of a cap on the financial condition of the Health Care Stabilization Fund (HCSF) is problematical

A. A Cap Is Inherently Unfair: The unfairness of the proposed cap is obvious. It would, for example, transfer from the negligent health care provider to the person injured by that negligence the responsibility for replacing future loss of earnings. The cap would apply no matter flagrant the negligence which caused the injury. The cap would apply no matter how great the need for compensation to pay living expenses of the injured party, and in some instances, dependents of the injured party. It is ironic that under the majority proposal the party injured by medical negligence would

be able to pay his doctor and hospital bills but not his landlord or grocer.

The minority believes that a person injured by the negligence of a health care provider should be entitled to recover all reasonable damages arising from the negligence.

B. A Cap Is Probably Unconstitutional: The courts of other states which have enacted caps on medical malpractice verdicts are split as to whether caps are constitutional. In Kansas, however, the prospects that a cap would be found unconstitutional are enhanced by Article 18 of the Bill of the Rights of the Kansas Constitution. Article 18 provides that all persons shall have a remedy "by due course of law" for injuries they suffer.

The proponents of a cap argue that the constitutionality of some legislation which limits the amount of recovery for injuries, such as the Workers' Compensation Act, has been upheld in Kansas. They fail to state that there has always been some "trade-off" involved in those situations. The Workers' Compensation Act, for instance, eliminates any defense of an employer to an employee's claim for injuries arising out of his employment.

There is no trade-off in the majority proposal for a cap on the amount of recovery. The proposal would simply take away an existing right without offering any offsetting benefit and is therefore probably unconstitutional. At the very least, the proposal of the majority, if adopted by the legislature, would leave the

proposed solution to the current problems under a constitutional cloud for a year or two or possibly more.

C. The Effect Of A Cap Is Problematical: The proponents of a cap on medical malpractice verdicts generally leave the impression that there have been many excessive verdicts which establish the need for a cap. They do not offer any data to support their conclusion.

The statistics made available to the Citizens Commission by the Insurance Commissioner indicate that there have been only 12 judgments which exceeded the limits of the primary coverage required by the HCSF Act. Those limits were $100,000 until 1983 and have been $200,000 since then. Of the small number of verdicts in medical malpractice cases which have exceeded one million dollars, most have been settled on a confidential basis during the appeal process. No information has been made available to the Commission which would tend to establish that the final disposition of any of the substantial claims was truly excessive.

It is clear from the statistics that a vast percentage of loss payments made by the HCSF are by settlement prior to trial. Because settlements are made by agreement, it is a fair assumption that there was evidence of malpractice in cases which were settled and that the settlements were not excessive.

Available Alternatives: A number of alternatives to the recommendation of the majority are available and would address the problems created by the projected deficits in the HCSF more fairly and more effectively.

The proposal of the insurance subcommittee to limit the liability of the HCSF to one million dollars is very timely. No state which has a HCFS or the equivalent provides more than one million dollars coverage. Limitation of the liability of the fund rather than the health care provider would be consistent with the practice applicable to all other individuals, businesses and professions in the state. Everyone is required to decide how much insurance coverage is enough and to seek excess insurance in the commercial market, if they want more.

Steps can be taken to determine whether there is a problem with excessive verdicts and to address any problem that does exist after an informed decision is made. The Kansas Bar Association has recommended that courts be directed to require itemization of verdicts in medical malpractice cases. Itemized verdicts would indicate the amount of damages awarded for past and future out-of-pocket expenses, such as medical expenses, loss of income and nonpecuniary losses such as pain and suffering. With that information, the appellate courts could more effectively review verdicts to determine whether they were excessive. The legislature, if necessary, could determine whether additional action is needed.

A III

The Bar Association has proposed legislation which would require the proof of present value of future damages in medical malpractice cases. Adoption of that proposal would mean that a plaintiff would be required to offer evidence discounting the value of money needed 20 years in the future to take into account the earning power of that money during the next 20 years. That proposal combined with the 1985 modification of the collateral source rule in medical malpractice cases only, should have a substantial impact on the amounts of verdicts and consequently the amounts of settlements.

2. Mandatory Screening Panels: The majority report includes a recommendation that the Indiana Plan for mandatory screening panels in medical malpractice cases be adopted with modifications. A major modification would exempt claims in which less than $50,000 was sought from the screening panel process. Otherwise, screening panels would be mandatory and the results would be admissible at trial.

The exemption of cases where the claim is for less than $50,000 from the mandatory screening process is an improvement over the Indiana Plan. The use of screening panels tends to be time-consuming and expensive. In addition, there is some reason to believe that mandatory screening panels paid for by the side that prevails would encourage greater numbers of smaller claims. Small claims of a very questionable nature could be submitted to the

mandatory screening panels simply to determine whether evidence to support the claim could be developed by that means.

The minority believes, however, that screening panels should not be mandatory where experienced counsel have secured the services of competent witnesses to testify that there has been a deviation from accepted standards of medical care prior to filing suit. If such evidence is available, the case is almost certain to be filed regardless of the findings of the screening panel and the screening panel simply becomes another layer of time-consuming expensive bureaucracy.

It is the recommendation of the minority that an attorney should be permitted to file a medical malpractice suit without going through the screening panel process if an affidavit is filed that the attorney has consulted with a physician qualified to render an opinion and that physician has determined the case has merit. After the case is filed, on the motion of the defendant or on the court's own motion, the case could still be referred to a screening panel if the court believed the attorney's affidavit was not well-founded or was not filed in good faith. In cases in which more than $50,000 was sought and plaintiffs' counsel are unwilling or unable to submit the required affidavit, mandatory submission to a screening panel would be required in accordance with the majority's recommendation.

3. <u>Restrictions On Attorneys' Contingent Fees</u>: The majority report recommends that contingent attorneys' fees on

recoveries over $100,000 in medical malpractice cases should be arbitrarily limited to 25 percent. This proposal is not directed to an identified problem.

The problem being considered by the Commission is excessive medical malpractice premiums. All of the studies which have been made have concluded that restrictions on attorneys' fees do not decrease the number of medical malpractice claims or the amount of settlements or judgments in those cases. Consequently, such restrictions do not have an impact on medical malpractice insurance premiums. The studies which reached that conclusions were conducted on behalf of the Rand Corporation, the Pennsylvania Medical Society and Pennsylvania Bar Association acting jointly, and, most importantly, the American Medical Association. The conclusion of the American Medical Association is published in its 1985 final report on medical malpractice. It is discussed in an article in the magazine Medical Economics, which is published by the AMA.

There are medical malpractice cases in which the amount of work, the cost of litigation, the risk that there will not be any recovery on other factors justify contingent fees in excess of 25 percent.

Existing statutes require courts to approve the fees of attorneys in medical malpractice cases. A case by case review of fees is more likely to prevent the rare abuses of the contingent fee

system without creating possible interference with the ability of a deserving plaintiff to secure the services of an attorney.

The foregoing minority report is joined in by the following committee members:

Richard C. Hite

Jerry R. Palmer

Eugene Ralston

Lynn Johnson

John J. Jurcyk

James Buchele

John Anderson, Jr.

Gerald Marlatt

CHAIRMAN'S ADDENDUM

In most, if not all, major problems involving a public policy change, one must weigh the benefits sought against the detrimental changes to be worked. In the case of placing a cap on medical malpractice awards I simply believe that the insurance premium crisis is not of such magnitude that we should violate the long standing principle that under the law all citizens of the state shall be treated with equal protection under the law.

The proposed changes set out in the committee report to fix a cap on recovery will, in my opinion, violate that principle. We are not prepared to abandon our adversarial system of justice and I do not believe the recommended cap on recovery should be allowed to eat away at the system and do greater harm to some Kansas citizens who already have suffered great harm under the health care provider system.

In the final analysis, our state government through its agencies and its legislature should, I believe, address this problem from the standpoint of the public good and from the viewpoint of the individual citizen. In that respect we are met with the doctor-patient relationship. I cannot agree that our so-called insurance premium crisis demands that the victim of malpractice should suffer the brunt of financial

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damage as well as a physical damage in order to correct a premium cost problem to the physician.

Therefore, I must concur with the minority report on the issue of placing a cap on awards.

JOHN ANDERSON, JR.
Chairman of the Committee

3-26 ~~

TESTIMONY
BEFORE THE
SENATE JUDICIARY COMMITTEE
ON
H.B. 2661
MEDICAL MALPRACTICE

Lynn R. Johnson
for the
Kansas Trial Lawyers Association

S. Jud.
3/26/86
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The medical malpractice issue has been very emotional and controversial in Kansas during the past two sessions. The Trial Lawyers Association has participated in the debate and study on this important topic, and briefly we would like to trace that history.

S.B. 110 was introduced in January, 1985, at the request of the Kansas Medical Society. It contained numerous recommendations, mostly in the area of tort reform, with no attention paid to insurance reform or peer review and risk management.

KTLA opposed S.B. 110 on the grounds that the Kansas Legislature had gathered no data to understand the malpractice crisis, and did not have any evidence that the proposed legislation would solve the stated problem. We volunteered to work with a legislative interim committee to resolve the insurance crisis.

Instead, the Legislature greatly narrowed the focus of S.B. 110 and ultimately passed a bill which the Governor signed. The bill allowed evidence of collateral source payments to be introduced in medical malpractice trials, so that the jury could lower awards. In addition, a cap of $3 million or 25% of gross income was placed on punitive damage awards, with 50% going to the victim and 50% of the damages paid back to the Health Care Stabilization Fund. A seven year sunset provision was added to S.B. 110.

The proponents told the Legislature and the Governor that

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S.B. 110 would have a beneficial impact on insurance premiums, and that limitations of punitive damages would provide significant psychological relief for Kansas doctors.

The bill has been found constitutional by one Kansas Federal District Court judge. Two other Federal District judges have declared S.B. 110 to be unconstitutional. An appeal will be made to the Kansas Supreme Court for ultimate determination. Clearly, there has been no insurance relief for Kansas doctors.

There was a major one-topic interim study on medical malpractice this summer. We participated in that discussion, attending the hearings, providing witnesses to discuss laws in other states and ultimately offering a list of recommendations to the Interim Committee.

Our investigation and work in this area yielded the following conclusions:

- The price of malpractice insurance has risen dramatically for Kansas doctors. In some cases, a continued rise in rates will result in a reduction of medical care for Kansas citizens.
- The price of liability insurance in various professions and industries has risen dramatically in the past few years. In some cases, insurance is not available at any price.
- Little data is available from liability insurance

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companies on the claims history and premiums collected. According to the Insurance Commissioner's data, St. Paul collected $18.5 million from health care providers between 1980 and 1984, and paid $6.1 million in losses.

During the same five years, Medical Protective collected $12.1 million and paid $5 million in losses.

Similar data is not available about other lines of liability insurance in terms of claims paid and premiums collected. In medical malpractice, primary carriers have a cap, a total liability limit of $200,000.

- There are significant rises in the surcharge rates, used to purchase excess insurance by Kansas doctors. The increases are due, in large part, to the non-collection of premiums of 3 years, and inadequate surcharges for earlier years.

- There is little evidence in Kansas, or other states, that significant tort reform, which limits awards to victims, provides relief from insurance gouging.

  * Kansas does not have joint and several liability. Our insurance consumers do not receive discounted rates.

  * Kansas has a $500,000 cap on governmental liability. Kansas cities, townships and schoolboards have not experienced any rate relief.

  * Kansas primary insurance carriers, in medical malpractice, have a cap of $200,00. Doctor's rates for primary

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coverage continue to soar.

* Kansas is one of the few states with a cap on wrongful death recovery. The insurance consumer has received no benefit.

There is no question that doctors' insurance rates are high, in many cases too high. Doctors are victims of insurance spirals, similar to other professions, day care centers, truck drivers and governmental units. The following proposals, which we made during the Interim Committee, are aimed at lowering insurance rates and making the current system more fair and equitable. Many of these proposals are contained within S.B. 2661, and we strongly urge Committee support for these reform measures.

I. PEER REVIEW AND RISK MANAGEMENT.

The Kansas medical profession and the Board of Healing Arts has not done a good job with peer review. We enthusiastically support the provisions of H.B. 2661 in this area. For the first time in Kansas the long standing conspiracy of silence would be broken and incompetent and frequently negligent physicians would be reported and hopefully disciplined.

A September 11, 1985 Closed Claims Report from the Kansas Insurance Depament (partial chart in the Interim Report) shows the following:

* between 1976 and 1985, 36 doctors had 3 or more claims;

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* these doctors totalled 144 claims; and,

* the total amount paid was $6,473,692 or $175,000 per doctor. This is primary coverage money, not Fund dollars.

During the same period:

* 16,043 providers covered by Fund.

* total of 1,691 providers had been sued (almost 10%).

* 68 doctors, .4%, were responsible for at least 30% of the claims (240/855 claims). The Insurance Commissioner's Office has not supplied to the Interim or other legislative committees the full cost of those claims.

* Kansas hospitals do not currently have risk management programs. They are mandated by H.B. 2661 and should have a very positive inpact on eliminating medical negligence.

II. INSURANCE REFORM.

Kansas doctors are forced, by law, to purchase too much insurance. While some highly paid, highly specialized doctors need and can afford to purchase umbrella coverage, most Kansas doctors are forced to overbuy coverage.

KTLA proposed and endorses a $1 million cap on the liability of the Fund. This rids the system of the supposed deep pocket and should have a significant beneficial impact on doctors' premiums. Currently, excess insurance is somewhat difficult to purchase, but the Fund actuaries told the Interim Committee that the availability problem should be solved within

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12 months.

Kansas doctors should be rated for insurance according to claims experience. This will additionally penalize frequently negligent providers, while providing some tangible relief to careful doctors.

KTLA continues to endorse the surcharge averaging, endorsed by the Interim Committee, but deleted by the House Committee. If the goal is to make the insurance system more fair, and to reduce the premium burden on the high risk specialists, this is a reasonable approach.

Currently, an OB-GYN insured by St. Paul pays $20,052 per year, while her colleague, insured by Medical Protective pays $12,267. When a surcharge is added, the St. Paul doctors pays a total of $42,109; the Medical Protective OB pays $25,761.

The averaging proposal would not change primary rates, but would charge a flat rate for the surcharge among specialty groups. Under the above examples, St. Paul's doctor would pay $37,827.50 and the Medical Protective doctor would pay, $30,042.50. As this example indicates, some coverage would be increased, but the unfair burden on those doctors who carry higher primary coverage, would be reduced.

We strongly urge detailed insurance data gathering for medical malpractice and other liability insurance. A sample statute from Oklahoma is enclosed.

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III. TORT REFORM.

KTLA endorses the proposals regarding an itemized jury verdict. This will allow the trial judge and subsequent data gatherers to obtain some hard facts about awards and the relation to medical bills and costs.

We endorse mandatory settlement conferences. This mechanism will enable cases to be expedited and for appropriate settlement offers to be made and discussed.

While KTLA does not support the mandatory 3-doctor screening panel in H.B. 2661, we endorse methods which screen out potentially frivolous suits.

- Additional use of the current frivolous lawsuit statute where penalites are assessed against the plaintiff and the attorney.
- Affadavit of experts filed in malpractice cases. If no expert is available, the screening process would be automatic. These provisions would force questionable cases out of the process while not causing additional expense and delay for legitimate causes of action. NOTE: After 8 years, Nebraska recently abolished the mandatory screening panel as costly and unworkable. Both doctors and lawyers agreed that it should be discontinued.

While there are significant areas of agreement, and numerous bills that we endorsed during the Interim process, we feel that there is a glaring flaw in H.B. 2661. Prior to institut-

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ing the numerous changes listed above, which will have a significant impact on doctors premiums, the Kansas Legislature should not impose an arbitrary cap on awards to seriously injured victims. This is potently unfair and probably unconstitutional. There is no guarantee that the cap will produce any tangible results beyond other provisions.

* $1 million cap on Fund will have some actuarial impact, on the Fund, as a $1 million cap imposed by Legislature.

* Primary insurers (St. Paul and Medical Protective) offered no guarantees if Kansas becomes the 4th state in the nation with a cap on economic awards. The St. Paul moratorium on doctors' insurance is in effect for all states, even those with caps.

* "Pinhole provision" is an admission that some victims will not be able to cover expenses with the arbitrary limit. Yet there is no guarantee that expenses will be paid.

* Kansas Medical Society is isolated in recommending cap on economic loss. This concept has been rejected by:

American Medical Association
President Reagan's Task Force on Tort Reform
Kansas Chamber of Commerce
Fletcher Bell's Citizens Committee
AARP of Kansas
Kansas Bar Association
Victims Coalition of Kansas
Kansas Trial Lawyers Association
People's Medical Society

CONCLUSION.

KTLA supports medical malpractice reform aimed at address-

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ing the current insurance crisis. We urge the Committee to divide H.B. 2661 into appropriate sections or to delete the provisions imposing a flat cap of $1 million on all damages. Other provisions of this important bill will have a significant effect on insurance premiums. It is unfair to shift the burden for catastrophic losses totally to the families and guardians of innocent victims.

The insurance crisis must be solved to ensure available affordable liability coverage for doctors and other professions and industries in Kansas. This harsh proposal should not be considered unless all other options have failed.

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3-26-81

PRESENTATION ON

MEDICAL MALPRACTICE

BY

KANSAS INSURANCE DEPARTMENT

BEFORE SENATE JUDICIARY COMMITTEE

MARCH 25, 1986

S. Jud.
3/26/86
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INTRODUCTION - RON TODD, INSURANCE DEPARTMENT REPRESENTING THE COMMISSIONER OF INSURANCE.

I DON'T HAVE TO TELL YOU WE HAVE A PROBLEM WITH MEDICAL MALPRACTICE INSURANCE IN THIS COUNTRY. IT IS NOT A CONTRIVED PROBLEM. IT IS A REAL PROBLEM DEMANDING OUR MOST HONEST AND THOUGHTFUL CONSIDERATION. AND, IT IS A PROBLEM WHICH SINCERE, DEDICATED CITIZENS AND PUBLIC SERVANTS HAVE ADDRESSED AS MEMBERS OF THE CITIZENS COMMITTEE WHO WERE APPOINTED BY THE INSURANCE COMMISSIONER AND AS MEMBERS OF THE SPECIAL LEGISLATIVE COMMITTEE WHO STUDIED THIS PROBLEM LAST SUMMER, WHOSE RECOMMENDATIONS ARE NOW BEFORE YOU, AND BY THE HOUSE OF REPRESENTATIONS WHO HAVE VOTED TO ENACT HOUSE BILL 2661.

A DECADE AGO THE MEDICAL MALPRACTICE PROBLEM FIRST BECAME A SERIOUS CONCERN IN THE UNITED STATES. INSURANCE COMPANIES WHO WERE WRITING PROFESSIONAL LIABILITY INSURANCE LOOKED AT THEIR STATISTICS AND SAW THAT A SERIOUS PROBLEM

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WAS DEVELOPING. THE NUMBER OF MEDICAL MALPRACTICE CLAIMS WERE INCREASING DRAMATICALLY AND THE DOLLAR AMOUNT OF THOSE CLAIMS WAS ALSO INCREASING AT AN ALARMING RATE.

PROFESSIONAL LIABILITY INSURANCE COMPANIES WERE INCREASING THEIR RATES AND MANY WITHDREW FROM KANSAS. MANY OF US REMEMBER THOSE YEARS VERY WELL. IT WAS CLEAR IN THE MID 1970'S THAT WE NEEDED TO ACT OR HEALTH CARE PROVIDERS WOULD BE LEFT WITH NO PROFESSIONAL LIABILITY INSURANCE. THIS WOULD HAVE BEEN A DISASTER FOR HEALTH CARE PROVIDERS AND FOR PERSONS INJURED BY MEDICAL MALPRACTICE AS WELL.

THE COMMISSIONER APPOINTED A COMMITTEE IN THE MID 1970'S TO ADDRESS THE "AVAILABILITY PROBLEM" WHICH IS WHAT WE WERE FACED WITH AT THAT TIME. NOT UNLIKE THIS YEAR, THAT COMMITTEE'S RECOMMENDATIONS WERE TRANSMITTED TO A SPECIAL INTERIM COMMITTEE AND, AS IT TURNED OUT, WERE

OBVIOUSLY HELPFUL TO THE LEGISLATURE IN ARRIVING AT THE PACKAGE OF LAWS ENACTED BY THE 1976 LEGISLATURE.

TO INSURE THAT INSURANCE REMAINED AVAILABLE AND THAT INJURED PARTIES WERE PROTECTED, THE 1976 LEGISLATURE REQUIRED THAT ALL ACTIVE KANSAS HEALTH CARE PROVIDERS ACQUIRE AND MAINTAIN PROFESSIONAL LIABILITY INSURANCE. SECONDLY, THE LEGISLATURE ESTABLISHED A HEALTH CARE STABILIZATION FUND TO ACT AS AN EXCESS INSURANCE CARRIER FOR ALL ACTIVE KANSAS HEALTH CARE PROVIDERS. THE CONCEPT AT THAT TIME WAS THAT THE PRIVATE INSURANCE MARKET WOULD PROVIDE BASIC INSURANCE COVERAGE OF $100,000/$300,000 TO PROVIDERS WHILE THE HCSF COVERED LIABILITY ABOVE THOSE AMOUNTS. ADMINISTRATION OF THE HCSF WAS VESTED IN THE INSURANCE DEPARTMENT AND HAS REMAINED THERE. WITH MORE THAN 10 YEARS OF ADMINISTRATION, WE HAVE ACCUMULATED A GREAT DEAL OF EXPERIENCE.

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THE 1976 LEGISLATURE ALSO CREATED A JOINT UNDERWRITING ASSOCIATION OFFICIALLY TITLED THE HEALTH CARE PROVIDERS INSURANCE AVAILABILITY PLAN. THIS PLAN WAS ESTABLISHED TO PROVIDE THE BASE INSURANCE COVERAGE OF $100,000/$300,000 IF A PROVIDER WAS UNABLE TO OBTAIN THIS PRIMARY INSURANCE COVERAGE FROM THE PRIVATE MARKETS.

THE PLAN IS ADMINISTERED BY WESTERN INSURANCE COMPANY AS AN INDEPENDENT CONTRACTOR UNDER THE SUPERVISION OF THE BOARD OF GOVERNORS OF THE PLAN.

IF I CAN BACK UP JUST A LITTLE BIT, I WANT TO REMIND YOU THAT, AS I SAID EARLIER, THE SUBJECT ADDRESSED BY THE LEGISLATURE IN 1976 WAS THE "AVAILABILITY" OF MEDICAL MALPRACTICE INSURANCE AND THE 1976 LEGISLATION DID WHAT IT WAS INTENDED TO DO. HEALTH PROVIDERS IN KANSAS HAVE PROFESSIONAL LIABILITY INSURANCE AVAILABLE.

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WE HAVE A PROBLEM TODAY BUT IT IS NOT ONE OF AVAILABILITY. THE COST MAY BE PROHIBITIVELY HIGH, BUT THE INSURANCE IS AVAILABLE TO THEM. IF ALL PRIVATE INSURANCE COMPANIES WITHDRAW FROM KANSAS, PROVIDERS WILL STILL BE ABLE TO OBTAIN INSURANCE THROUGH THE JUA, AND THE HEALTH CARE STABILIZATION FUND WILL CONTINUE TO PROVIDE EXCESS COVERAGE FOR ALL ACTIVE KANSAS PROVIDERS. TODAY, OUR PROBLEM ISN'T "AVAILABILITY" -- OUR PROBLEM IS COST.

THE HEALTH CARE STABILIZATION FUND IS A NONPROFIT ENTITY. IT EMPLOYS SOME OF THE BEST DEFENSE FIRMS IN THE STATE TO REPRESENT PROVIDERS WHO ARE SUED FOR MALPRACTICE. IT ATTEMPTS TO SETTLE CASES THAT SHOULD BE SETTLED, AND TO TRY CASES THAT SHOULD BE TRIED. BUT IN THE END THE PAYMENTS MADE FROM THE HCSF TO PAY AWARDS AND JUDGMENTS MUST BE PASSED ON TO THE PROVIDERS. THERE IS NO GOVERNMENT MONEY IN THE HCSF. ALL THE MONEY TO FUND THE HCSF IS PROVIDED BY THE PHYSICIANS, HOSPITALS, PHARMACISTS,

PODIATRISTS, OPTOMETRISTS, PHYSICAL THERAPISTS AND OTHER PROVIDERS COVERED BY THE ACT.

IT IS HARD TO IMAGINE NOW THAT AT THE TIME THE 1976 ACT WAS ENACTED THERE HAD NEVER BEEN A MEDICAL MALPRACTICE JUDGEMENT IN KANSAS FOR $500,000. LET ME ASSURE YOU THAT THIS IS NO LONGER THE CASE.

IN 1984, THE LEGISLATURE TOOK SOME REMEDIAL ACTION TO HELP PROTECT THE HCSF FROM ESCALATING COSTS. A CAP OF $3,000,000 WAS PLACED ON FUND COVERAGE. PREVIOUSLY, THE FUND HAD UNLIMITED LIABILITY. PRIMARY INSURANCE LIMITS WERE INCREASED FROM $100,000/$300,000 TO $200,000/$600,000. THE LEGISLATURE ALSO ACTED TO PLACE THE HCSF ON A MORE TRADITIONAL INSURANCE ACCRUAL BASIS INSTEAD OF THE "CASH" BASIS ESTABLISHED IN 1976.

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SPECIFICALLY, IN 1976, THE LAW PREVENTED THE HCSF FROM ASSESSING A SURCHARGE IF THE HCSF HAD ASSETS IN EXCESS OF $10,000,000. THE FUND ALSO ASSESSED PROVIDERS ONLY ENOUGH TO PAY FOR CLAIMS PAID FROM THE FUND. THE LAW DID NOT PROVIDE A MEANS TO RESERVE FOR FUTURE LIABILITIES AND TO DO SO ON AN ACTUARIALLY SOUND BASIS. IN 1984, THE FUND WAS PERMITTED TO ACCUMULATE SUFFICIENT SURCHARGES TO PAY ANTICIPATED FUTURE OBLIGATIONS AND THE $10,000,000 CEILING WAS REMOVED.

IN 1985, THE LEGISLATURE AGAIN ADDRESSED THE MEDICAL MALPRACTICE PROBLEM. SOME LIMITATIONS WERE PLACED ON PUNITIVE DAMAGE AWARDS IN MEDICAL MALPRACTICE CASES. THE 1985 ACT ALSO PERMITTED EVIDENCE OF COLLATERAL SOURCES TO BE GIVEN TO THE JURY FOR THEIR CONSIDERATION. IF ANOTHER SOURCE HAD ALREADY PAID PART OR ALL OF THE CLAIMANT'S BILLS, THE JURY WAS ALLOWED TO BE TOLD ABOUT THESE PAYMENTS.

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TODAY, OUR MEDICAL MALPRACTICE COMPENSATION SYSTEM IS UNDER CONSIDERABLE STRESS. INSURANCE PREMIUMS AND SURCHARGES HAVE ESCALATED TO SUCH AN EXTENT THAT IT IS AFFECTING HEALTH CARE IN THIS STATE. SOME PHYSICIANS ARE WITHDRAWING FROM HIGH RISK AREAS OF MEDICINE, SOME ARE RETIRING EARLY, SOME I AM TOLD ARE MOVING TO OTHER STATES. IN RURAL AREAS, A PHYSICIAN WHO DELIVERS ONLY A FEW BABIES EACH YEAR IS UNABLE TO CHARGE ENOUGH TO COVER THE ADDITIONAL COSTS PHYSICIANS MUST PAY FOR INSURANCE TO COVER OBSTETRICS. THE RESULTS ARE UNFORTUNATE. RURAL PHYSICIANS MAY STOP DELIVERING BABIES AND LIMIT THEIR PRACTICES TO LESS RISKY AREAS.

FOR WHATEVER REASONS, THE TRENDS IN MEDICAL MALPRACTICE ARE CLEAR. THE NUMBER OF CLAIMS CONTINUES TO INCREASE. ONE HUNDRED (100) CLAIMS WERE FILED AGAINST THE HCSF IN FISCAL YEAR 1981, 124 IN 1982, 156 IN 1983, 179 IN 1984 AND 230 IN FISCAL YEAR 1985.

THE DOLLAR VALUE OF AWARDS AGAINST THE HCSF HAS ALSO CONTINUED TO ESCALATE. THE FUND HAD PAID CLAIMS AGAINST IT OF $1.7 MILLION IN 1981; $3 MILLION IN 1982; $6.5 MILLION IN 1983; $10.4 MILLION IN 1984 AND $13.1 IN 1985.

WE SEE NOTHING IN THESE OR ANY OTHER AVAILABLE STATISTICS THAT IS ENCOURAGING. WE HAVE NO EVIDENCE TO SUGGEST THAT THESE INCREASES WILL BE REVERSED ANYTIME SOON, UNLESS LEGISLATION IS ENACTED TO CORRECT THE PROBLEMS.

IN JANUARY OF 1985, WE BECAME SO CONCERNED ABOUT THE MEDICAL MALPRACTICE PROBLEM THAT THE COMMISSIONER APPOINTED A CITIZENS COMMITTEE TO REVIEW THE TORT SYSTEM AND MAKE RECOMMENDATIONS. HE APPOINTED THIS COMMITTEE IN ORDER TO RENEW A DIALOGUE BETWEEN HEALTH CARE PROVIDERS AND TRIAL LAWYERS THAT HAD VIRTUALLY ENDED BY EARLY 1985. THE CITIZENS COMMITTEE INCLUDED A NUMBER OF LAWYERS, AMONG THEM THREE DISTINGUISHED LAWYERS WHO NORMALLY REPRESENT INJURED

PERSONS IN MALPRACTICE ACTIONS, PROMINENT PHYSICIANS, OTHER HEALTH CARE PROVIDERS, REPRESENTATIVES OF THE INSURANCE INDUSTRY, AND A NUMBER OF PUBLIC MEMBERS. THE COMMITTEE HAD REPRESENTATIVES FROM LABOR, THE AMERICAN ASSOCIATION OF RETIRED PERSONS, A UNIVERSITY PROFESSOR, A LIBRARIAN, AND BUSINESS LEADERS. WE EXPECTED THE COMMITTEE TO DISCUSS THE MALPRACTICE ISSUE ENERGETICALLY AND IN DEPTH. WE BELIEVE THEY DID JUST THAT, AND WE BELIEVE THE STATE OF KANSAS OWES A CONSIDERABLE DEBT TO THE 25 MEMBERS OF THE COMMITTEE WHO MET EACH MONTH FOR NEARLY ONE YEAR ON A VOLUNTARY BASIS WITHOUT PAY.

THE FINAL DRAFT OF THE WRITTEN REPORT OF THE COMMITTEE WHICH HAS BEEN PROVIDED TO EACH OF YOU IS EXTENSIVE AND CONTAINS MOST OF THE FACTS AND STATISTICS NEEDED TO UNDERSTAND THE KANSAS PROBLEM.

AS YOU PROBABLY KNOW, THE INTERIM COMMITTEE OF THE LEGISLATURE REVIEWED THE PRELIMINARY RECOMMENDATIONS OF THE CITIZENS COMMITTEE AND ADOPTED MANY OF THE SAME RECOMMENDATIONS. THAT IS A TRIBUTE TO THE HARD WORK OF THE COMMITTEE, BUT I THINK IT IS ONLY FAIR TO NOTE THAT MEMBERS OF THE INTERIM COMMITTEE WORKED JUST AS HARD IN REACHING THEIR DECISIONS.

LET ME COMMENT ABOUT THE GENERAL DIRECTION THE CITIZENS COMMITTEE, THE INTERIM COMMITTEE OF THE LEGISLATURE, AND THE HOUSE OF REPRESENTATIVES HAVE TAKEN TO SOLVE THE MEDICAL MALPRACTICE PROBLEM.

1. ALL BELIEVE THAT MEDICAL MALPRACTICE PRESENTS A UNIQUE SET OF PROBLEMS THAT DESERVE TO BE ADDRESSED SEPARATELY FROM LIABILITY PROBLEMS FACING OTHER MEMBERS OF THE INSURANCE BUYING PUBLIC.

2. ALL SEE THE SOLUTIONS TO MEDICAL MALPRACTICE AS REQUIRING A PACKAGE OF CHANGES. TO REDUCE MEDICAL MALPRACTICE COSTS, HOUSE BILL 2661 CONTAINS CAPS ON AWARDS AND SCREENING PANELS TO ELIMINATE UNMERITORIOUS CASES AND TO ENCOURAGE EARLY SETTLEMENT OF VALID CASES. THE THIRD RECOMMENDATION INVOLVES ENFORCING STRICTER PROCEDURES TO ELIMINATE MEDICAL MALPRACTICE FROM THE SYSTEM AND TO CONTROL INCOMPETENT PROVIDERS.

I BELIEVE IT IS CRUCIAL TO RETAIN THIS ENTIRE PACKAGE. THE DETAILS MAY BE ALTERED BUT I THINK A PROPERLY DESIGNED CAP IS AN INTEGRAL PART OF THE PACKAGE AND MUST BE INCLUDED AS PART OF ANY SOLUTION.

3. I MENTION CAPS BECAUSE CAPS HAVE BEEN THE MOST CONTROVERSIAL ISSUE. THE GOVERNOR HAS ALREADY

SUGGESTED THAT HE CANNOT SUPPORT A BILL THAT CONTAINS A CAP. I HOPE HE WILL KEEP AN OPEN MIND ON THIS ISSUE UNTIL HE UNDERSTANDS HOW THE PROPOSED CAP WILL WORK. A PROPER CAP WILL REASONABLY ACCOMMODATE BOTH PRESENT <u>AND</u> FUTURE MEDICAL AND/OR CUSTODIAL EXPENSES OF INJURED PERSONS. THEREFORE, WE CAN HAVE A CAP WITHOUT HARM TO THE WELL-BEING OF INJURED PATIENTS. THE INJURED PATIENT MAY NOT RECEIVE EVERYTHING HE NOW GETS UNDER THE TORT SYSTEM AND HE MAY NOT RECEIVE HIS COMPENSATION IN THE SAME FORM, BUT WE BELIEVE HIS NEEDS WILL BE REASONABLY ACCOMMODATED.

IT IS BECOMING INCREASINGLY CLEAR THAT THE VAST MAJORITY OF KANSAS CITIZENS RECOGNIZE THE NEED FOR CAPS. THE INSTITUTE FOR PUBLIC POLICY AND BUSINESS RESEARCH OF THE UNIVERSITY OF KANSAS IN ITS SECOND ANNUAL PUBLIC OPINION SURVEY OF KANSAS (1986), FOUND THAT 73.8% OF THE KANSAS CITIZENS

SUPPORT A LIMIT ON THE AMOUNT OF DAMAGES THAT CAN BE AWARDED IN ANY MEDICAL MALPRACTICE CASE.

4. WHY HAS A CAP BEEN RECOMMENDED?

BACK IN THE MID 1970'S WHEN KANSAS WAS WORKING TO SOLVE THE INSURANCE AVAILABILITY PROBLEM A FEW STATES ATTEMPTED TO GO BEYOND THE AVAILABILITY OF INSURANCE TO SOLVE THE ROOT CAUSE OF THE PROBLEM. TWO OF THESE STATES WERE INDIANA AND NEBRASKA. BOTH OF THESE STATES ENACTED A $500,000 CAP ON MEDICAL MALPRACTICE AWARDS. BOTH STATES HAVE SURVIVED THE LAST DECADE WITH VIRTUALLY NO MAJOR MEDICAL MALPRACTICE PROBLEMS. INSURANCE PREMIUMS AND SURCHARGES IN INDIANA ARE SIGNIFICANTLY LOWER THAN OUR RATES IN KANSAS. THE SITUATION IN NEBRASKA WAS SO GOOD THAT THAT STATE HAS RECENTLY INCREASED THEIR CAP TO $1,000,000.

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AFTER 10 YEARS OF EXPERIENCE, THE CAPS APPEAR TO HAVE WORKED.

5. HOW DO CAPS WORK?

TO UNDERSTAND CAPS, YOU MUST UNDERSTAND HOW MEDICAL MALPRACTICE CASES WORK TODAY. NEARLY 1/3 OF ALL OF THE MONEY INCURRED BY THE HCSF IS PAID ON TRAGIC CASES FOR BRAIN DAMAGED BABIES. THESE BABIES REQUIRE EXTENSIVE MEDICAL AND CUSTODIAL CARE. NO ONE DEALING WITH THESE CASES CAN HELP BUT BE DEEPLY MOVED BY THESE TRAGEDIES. SOMETIMES THESE TRAGEDIES OCCUR THROUGH NO FAULT OF MEDICINE. SOMETIMES THEY ARE PREVENTABLE BY ANY HUMAN MEANS. SOMETIMES THEY ARE THE RESULT OF MISTAKES MADE BEFORE AND DURING DELIVERY. WE ARE CONCERNED ABOUT THE FUTURE MEDICAL AND CUSTODIAL EXPENSES FOR ALL OF THESE BABIES. HOWEVER, MEDICAL MALPRACTICE ONLY EXISTS, WHEN THE

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BRAIN DAMAGE IS THE RESULT OF A PROVIDER'S NEGLIGENCE.

TODAY WE ARE ABLE TO PROVIDE FOR FUTURE MEDICAL AND CUSTODIAL CARE WITH THE USE OF STRUCTURED SETTLEMENTS. THIS MEANS THAT WE COMPUTE THE AMOUNT OF MONEY NEEDED IN THE FUTURE AND PAY AN ANNUITY COMPANY TO GUARANTEE PAYMENT OF THESE FUTURE EXPENSES. THE ANNUITY COMPANY WILL GENERALLY ONLY CHARGE A FRACTION OF THESE EXPENSES. IT IS NOT UNCOMMON, FOR EXAMPLE, FOR AN ANNUITY TO BE OBTAINED TO PAY 5 OR 6 MILLION DOLLARS OF FUTURE EXPENSES AT A COST OF FAR LESS THAN $500,000. THIS IS POSSIBLE BECAUSE THE ANNUITY COMPANY TAKES INTO CONSIDERATION THE TIME VALUE OF MONEY AND MORTALITY FACTORS.

UNFORTUNATELY, JURIES DO NOT PRESENTLY HAVE THE ABILITY TO PAY ESTABLISHED SUMS EACH YEAR FOR THE LIFE OF THE BABY. THEY MUST AWARD A <u>LUMP</u> SUM. THEIR CALCULATION OF

THE AMOUNT NEEDED IS PURE GUESSWORK AND THEREIN LIES A SIGNIFICANT PART OF THE PROBLEM.

WE USE STRUCTURED SETTLEMENTS EXTENSIVELY. TODAY, HOWEVER, THEY ARE ONLY AVAILABLE WITH THE AGREEMENT OF THE PARTIES. THERE IS NO PROCEDURE FOR COURTS TO ALLOW PAYMENT FOR LIFE, WITH PAYMENTS TO STOP UPON THE DEATH OF THE INJURED PARTY.

IT IS ESSENTIAL IN CONSIDERING CAPS THAT YOU UNDERSTAND THAT A 1,000,000 CAP DOES NOT NECESSARILY MEAN THAT NO MORE THAN $1,000,000 OF DAMAGES WILL BE PAID.

WE STRONGLY AND SINCERELY BELIEVE THAT WITH THE CONTINUED USE OF STRUCTURED SETTLEMENTS AND THE USE OF STRUCTURED AWARDS AND JUDGMENTS WE CAN FUND REASONABLE AND NECESSARY DAMAGES IN CASES ARISING NOW OR IN THE FORESEEABLE FUTURE.

THE HOUSE JUDICIARY COMMITTEE, TO MAKE CERTAIN THAT NOT EVEN A REMOTE CHANCE EXISTS FOR A SHORTFALL OF MEDICAL EXPENSES AND RELATED EXPENSES, CREATED A "PINHOLE" EXCEPTION TO THE CAP. THIS "PINHOLE" WILL PERMIT THE BOARD OF GOVERNORS OF THE HCSF TO PAY EXPENSES ABOVE THE CAP IN CERTAIN SPECIFIED CASES.

WHILE, AS I HAVE STATED, THE $1,000,000 CAP WILL ALMOST CERTAINLY PROVIDE FOR ALL REASONABLE DAMAGES, IS THE CAP, ALONE, ENOUGH TO HELP CONTROL INCREASING PREMIUMS? THE ANSWER IS NO. OTHER ELEMENTS OF THIS SUMMER'S WORK ARE NEEDED, NOT THE LEAST OF WHICH IS REINFORCEMENT OF THE EFFORTS TO DETECT AND DISCIPLINE HEALTH CARE PROVIDERS WHO NEED ATTENTION AND THE MANDATORY USE OF STRUCTURED AWARDS AND JUDGMENTS.

ALSO, WE HAVE THE EXPERIENCE OF INDIANA AND NEBRASKA TO SUGGEST THAT A $500,000 TOTAL CAP WORKS. THE CITIZENS

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COMMITTEE AND THE INTERIM COMMITTEE WERE APPARENTLY CONCERNED THAT A $500,000 CAP MIGHT NOT MEET ALL REASONABLE EXPENSES. SOME, INCLUDING COMMISSIONER BELL, FEEL MORE COMFORTABLE WITH A $1,000,000 CAP. BUT, THE IMPORTANT CONSIDERATION IS THAT WE BELIEVE REASONABLE DAMAGES INCURRED AS A RESULT OF MEDICAL MALPRACTICE WILL BE PAID.

AT THIS POINT, IT IS APPROPRIATE TO COMMENT BRIEFLY ON WHAT EFFECT THE PROPOSED CAP ON AWARDS MAY HAVE ON FUTURE RATES AND SURCHARGES.

DURING THE INTERIM COMMITTEE MEETINGS THE ACTUARIES PROVIDED A LIST OF DIFFERENT RESULTS BASED UPON A NUMBER OF POSSIBLE CAPS. OF COURSE, THE FIRST YEAR BENEFITS WILL BE MINOR SINCE MANY CASES WILL REMAIN IN THE PIPELINE FOR MANY YEARS. HOWEVER, WHEN THESE CASES ARE ELIMINATED, THE ACTUARIES ESTIMATE HCSF SURCHARGE REDUCTIONS OF ONE-HALF FOR A $500,000 CAP AND APPROXIMATELY 21% FOR A $500,000

CAP WITH $1,000,000 CAP ON FUTURE MEDICALS. THE ACTUARIES HAVE ADVISE US THAT A CAP OF $1,000,000 - WITHOUT REGARD TO THE "PINHOLD" SHOULD RESULT IN AN EVENTUAL SURCHARGE SAVINGS OF BETWEEN 30 TO 40 PERCENT WITH A FIRST YEAR SAVINGS BETWEEN 8 TO 12 PERCENT.

WE DO KNOW THAT INDIANA HAS A $500,000 OVERALL CAP AND A NEUROSURGEON IN INDIANA, AT THE TIME OF THE CITIZENS COMMITTEE, PAID A BASE PREMIUM OF $8,544 WITH A SURCHARGE OF APPROXIMATELY 75% OR $6,408 FOR A TOTAL OF $14,952. IN KANSAS A NEUROSURGEON PAYS $12,267 WITH A SURCHARGE OF 110% OR $13,493 FOR A TOTAL OF $25,760. IF KANSAS IMPOSED A $500,000 CAP ONE MIGHT EXPECT THE PREMIUM AND SURCHARGE TO BE THE SAME AS INDIANA. WITH A $1,000,000 CAP AND THE "PINHOLD" PROVISION THE PREMIUM AND SURCHARGE WILL BE HIGHER.

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WE SHOULD MENTION THAT QUESTIONS WERE RAISED AS TO WHY A CAP ON AWARDS IS NECESSARY AT $1,000,000 IF THE PAYMENTS FROM THE HCSF CAN BE CAPPED AT $1,000,000, A PROVISION WHICH IS ALSO CONTAINED IN THE PROPOSAL BEFORE YOU. THESE TWO POINTS ARE OF IMPORTANCE BECAUSE OF THEIR RELATIONSHIP TO BOTH THE 1976 AND 1984 LEGISLATIVE BACKGROUND. FIRST, IF ONLY THE HCSF PAYMENTS ARE CAPPED, IT DOES NOT AFFECT <u>TOTAL</u> AWARDS AGAINST THE PROVIDER. THEREFORE, IT CREATES MUCH THE SAME AVAILABILITY PROBLEM THAT EXISTED IN THE 1970's WHERE ESPECIALLY HIGH RISK PROVIDERS WOULD STILL NEED HIGHER LIMITS OF INSURANCE WHICH ARE NOT GENERALLY AVAILABLE IN THE INSURANCE MARKET, AND TO THE EXTENT IT IS AVAILABLE, IS VERY EXPENSIVE.

IN ALL HONESTY, WE CANNOT GUARANTEE A $1,000,000 CAP WITH THE "PINHOLE" WILL BE SUFFICIENT TO CONTROL PREMIUMS. HOWEVER, WE HAVE ADMINISTERED THE HCSF FOR THE PAST 10 YEARS AND BASED UPON OUR EXPERIENCE, WE THINK A ONE

MILLION DOLLAR CAP TOGETHER WITH OTHER RECOMMENDATIONS OF THE INTERIM COMMITTEE WILL WORK TO STABILIZE AND EVENTUALLY REDUCE PREMIUMS.

YOU MUST BEAR IN MIND, HOWEVER, THAT THERE ARE HUNDREDS OF MEDICAL MALPRACTICE CASES ALREADY IN THE SYSTEM AND THEY MAY NOT BE SUBJECT TO A CAP PASSED BY THIS LEGISLATURE. IT WILL TAKE FIVE TO SEVEN YEARS FOR THESE CASES TO WORK THROUGH THE SYSTEM. HOWEVER, EVEN IMMEDIATELY, CAPS WILL HELP CHANGE THE ATMOSPHERE IN KANSAS AND IN TIME SHOULD PROVIDE A REASONABLE SOLUTION FOR OUR MEDICAL MALPRACTICE PROBLEM.

SEVERAL ISSUES THAT FREQUENTLY AROSE DURING PAST DELIBERATIONS DESERVE COMMENT AT THIS TIME.

1. HIGH INSURANCE RATES ARE ESPECIALLY DIFFICULT FOR RURAL PHYSICIANS WHO PAY THE SAME TOTAL PREMIUMS

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AS URBAN PHYSICIANS BUT GENERALLY HAVE FEWER PATIENTS OVER WHICH TO SPREAD THE COST. A LARGE CONCERN IS THAT SUCH RURAL DOCTORS HAVE OR WILL STOP DELIVERING BABIES, FOR EXAMPLE, TO ACHIEVE A LOWER RATING, QUIT ENTIRELY OR RETIRE MUCH EARLIER IN AREAS WHERE THE PUBLIC HAS NO OTHER ACCESS TO LOCAL SERVICES.

BECAUSE OF MANY PROBLEMS TO ANY SOLUTION PROPOSED, THE BILL BEFORE YOU DOES NOT PROPOSE ANY DIFFERENT RATING BASE FOR RURAL DOCTORS. THIS IS BECAUSE OF DIFFICULTY IN APPLYING A SEPARATE RATING CLASSIFICATION TO SUCH DOCTORS BECAUSE THE ACTUARIAL RATING BASE IS NOT LARGE ENOUGH. IN ADDITION, RURAL PHYSICIANS TODAY DO NOT SEEM IMMUNE FROM HAVING THE SAME STANDARD OF CARE APPLIED TO THEIR ACTIVITIES AS IS APPLIED TO URBAN PHYSICIANS, ESPECIALLY WHEN SUCH CASES ARE

REMOVED TO FEDERAL COURTS. CONSEQUENTLY, IT IS BELIEVED THAT AN OVERALL STABILIZATION OF RATES BROUGHT ABOUT BY THE CONCEPT INCORPORATED IN THE INTERIM LEGISLATIVE COMMITTEE'S PACKAGE AND NOW INCLUDED IN HOUSE BILL 2661, WOULD BE THE BEST IMMEDIATE ANSWER TO THIS SITUATION.

2. IN ANY DISCUSSION OF MEDICAL MALPRACTICE CLAIMS, ONE ISSUE ALWAYS RAISED IS THAT THERE WOULD NOT BE A SIGNIFICANT PROBLEM IF INCOMPETENT PROVIDERS WERE ELIMINATED FROM PRACTICE. WE FEEL THE BILL BEFORE YOU DOES CONTAIN REASONABLE CHANGES THAT ENCOMPASS THE MANY ISSUES RAISED BEFORE BOTH THE INTERIM LEGISLATIVE COMMITTEE AND THE CITIZENS COMMITTEE. HOWEVER, WE WISH TO STRESS THAT THE BILL <u>ALONE</u> WILL NOT ELIMINATE THE MEDICAL MALPRACTICE INSURANCE PROBLEM AND BOTH AFOREMENTIONED COMMITTEES RECOGNIZED THIS BY THEIR

RECOMMENDATION OF A "PACKAGE" OF CHANGES. THE FACT THAT SOME PROVIDERS HAVE MULTIPLE INSURANCE CLAIMS IS NOT UNUSUAL. FOR EXAMPLE, HOSPITALS AND OTHER PROVIDERS IN HIGH RISK CATEGORIES WILL HAVE MORE EXPOSURE TO CLAIMS BECAUSE OF THE VERY NATURE OF THE SERVICES INVOLVED. ALSO, IF A PARTICULAR PROCEDURE RESULTS IN INSURANCE CLAIMS, FURTHER CLAIMS WILL RESULT EVEN IF SUCH PROCEDURE IS NO LONGER FOLLOWED IF IT WERE GENERALLY USED A NUMBER OF TIMES. WE ALL HOPE CONTINUED EFFORTS TO REDUCE "MALPRACTICE" ARE SUCCESSFUL BUT THESE EFFORTS ALONE WILL NOT ELIMINATE INSURANCE CLAIMS.

3. A NUMBER OF OTHER ISSUES WERE PRESENTED TO AND DISCUSSED BY BOTH THE INTERIM COMMITTEE AND THE CITIZENS COMMITTEE AND ADDRESSED, AS WELL, BY THE BILL BEFORE YOU NOW. THESE ISSUES INCLUDE: INFORMATION TO BE FURNISHED TO THE BOARD OF

HEALING ARTS; PAST HCSF SURCHARGES; RATE SUBSTANTIATION FURNISHED TO THE INSURANCE DEPARTMENT BY INSURERS; AND, LOSS EXPERIENCE FURNISHED TO THE INTERIM COMMITTEE.

ONE FINAL ISSUE THAT WE FEEL IS VERY IMPORTANT TO THE CURRENT CLIMATE SURROUNDING MEDICAL MALPRACTICE INSURANCE IS ITS RELATIONSHIP, IF ANY, TO OTHER LIABILITY INSURANCE MARKET PROBLEMS NOW EXISTING IN KANSAS AND ELSEWHERE. AS I AM SURE YOU ARE WELL AWARE, THE AVAILABILITY AND AFFORDABILITY OF MANY KINDS OF LIABILITY INSURANCE POLICIES IS NOW CAUSING CONSIDERABLE TURMOIL AMONG AFFECTED CONSUMERS, INSURANCE REGULATORS, LEGISLATORS, AND THE INSURANCE INDUSTRY ITSELF THROUGHOUT THE UNITED STATES. IN GENERAL, THE UNDERWRITING LOSSES SUSTAINED BY THE ENTIRE PROPERTY AND CASUALTY INSURANCE INDUSTRY IN THE UNITED STATES THE PAST SEVERAL YEARS (OVER 3.8 BILLION IN 1984) HAS CAUSED MOST OF THOSE COMPANIES TO:

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(1) GENERALLY RAISE RATES ON MOST COMMERCIAL INSURANCE RISKS THEY ARE OFFERING TO RENEW;

(2) CANCEL OR NONRENEW MANY RISKS IN ORDER TO REDUCE THEIR VOLUME OF BUSINESS BECAUSE OF DRASTIC REDUCTION IN ACCEPTABLE SURPLUS TO PREMIUMS WRITTEN RATIOS; AND

(3) NONRENEW RISKS FELT TO BE IN THE MOST HAZARDOUS LOSS CATEGORIES.

THE MOST CITED REASONS FOR THESE PROBLEMS ARE:

(1) RECENT REDUCTIONS IN INVESTMENT INCOME OF THE INSURANCE COMPANIES CAUSED BY DECLINES IN INTEREST RATES;

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(2) UNAVAILABILITY OF REINSURANCE NECESSARY FOR THE POLICY LIMITS AND NUMBER OF POLICIES WRITTEN IN PAST YEARS; AND

(3) INCREASING UNPREDICTABILITY OF LIABILITY INSURANCE LOSSES AND THE AMOUNTS OF SUCH LOSSES.

WHAT I HAVE JUST DESCRIBED IS NOT ONLY A PROBLEM IN KANSAS, BUT NATIONWIDE, AND HAS EVEN RESULTED IN A MUCH LARGER NUMBER OF INSURERS BECOMING INSOLVENT. THERE ARE MANY THINGS THAT ARE BEING DONE BY THE INDUSTRY AND INSURANCE REGULATORS TO ADDRESS THESE PROBLEMS, AND SOME ACTION BY THE VARIOUS STATE LEGISLATURES MAY BE NECESSARY. THIS SITUATION HAS RESULTED IN THE QUESTION BEING RAISED THAT ANY CHANGES IN OUR MEDICAL MALPRACTICE INSURANCE STATUTES SHOULD BE DELAYED UNTIL THE ENTIRETY OF THE LIABILITY INSURANCE ISSUES CAN BE ADDRESSED. FOR THIS REASON, WE BELIEVE IT IS IMPERATIVE TO POINT OUT THAT

THERE ARE SIGNIFICANT DIFFERENCES BETWEEN THE PROBLEM AREAS DESCRIBED THAT MAKE CONTINUED CONSIDERATION OF MEDICAL MALPRACTICE PROBLEMS ESSENTIAL. SOME OF THESE ARE:

(1) THE SOCIAL AND ECONOMIC ISSUE OF AVAILABILITY OF HEALTH CARE THROUGHOUT THE STATE IS DIRECTLY CONNECTED TO THE MEDICAL MALPRACTICE INSURANCE ISSUE AND DIRECTLY AFFECT ALL KANSANS;

(2) PRESENT LAWS THAT REQUIRE HEALTH CARE PROVIDERS TO PURCHASE PROFESSIONAL LIABILITY INSURANCE;

(3) MEDICAL MALPRACTICE INSURANCE RATES AND PREMIUMS HAVE BEEN CONSTANTLY INCREASING OVER RECENT YEARS, WHILE OTHER TYPES OF LIABILITY INSURANCE RATES (EXCEPT PRODUCT LIABILITY) WERE GENERALLY STABILIZED OR REDUCED DURING THE LAST FIVE YEARS; AND

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4) MEDICAL MALPRACTICE INSURANCE IS MORE SUSCEPTIBLE TO STATEWIDE ACTIONS AND SOLUTIONS THAN MANY OF THE OTHER LIABILITY SITUATIONS (SUCH AS PRODUCTS LIABILITY) BECAUSE MOST OF THE LIABILITY OCCURRENCES ARE WITHIN THE STATE.

I RECOMMEND THE ADOPTION OF HOUSE BILL 2661.

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3-26-86

TULSA WORLD
THURSDAY
MARCH 6, 1986

Bill Seeks Information From Insurance Firms

By John Greiner

State senators Wednesday passed a bill that, its author claims, would end a "conspiracy of silence among the insurance industry" concerning financial data affecting insurance rates in Oklahoma.

The Unfair Claims Settlement Practices Act, which passed 39-3, would require insurance companies to report 10 years worth of financial information, including premiums collected and amounts paid out in claims for professional liability and personal injury and wrongful death cases.

The act will "put a ray of sunshine on the insurance industry," Sen. Stratton Taylor, D-Claremore, said of Senate Bill 561.

The bill apparently stems from the skirmish between professional associations and lawyers over HB 1892, a House bill aimed at limiting the size of damage lawsuit awards.

Jack Burns, executive director of the Oklahoma Trial Lawyers Association, described Taylor's bill as a joint venture by the senator and the attorney group.

Taylor said his bill is a response to insurance companies that he said irresponsibly raise rates or cancel insurance policies without justification.

The Legislature needs facts from the insurance industry before it can deal with legislation limiting court awards, Taylor said.

Taylor's bill also would require insurance companies to report the number of judgments or settlements that required them to make payments of over $250,000 for non-economic losses for each of the previous 10 years.

Taylor's bill also would create a re-insurance entity that would guarantee liability insurance for individuals or businesses that have difficulty getting liability insurance coverage, Taylor said.

The bill also has provisions to reduce the number of frivolous lawsuits, Taylor said.

Under the proposal, if a judge determines that a plaintiff filed a lawsuit frivolously, the judge could require the plaintiff to pay the defendant's attorney fees.

Also, if an insurance company refused to pay a legitimate claim and forced an insurer to go to court to get his money, the judge could require the insurance company to pay the plaintiff's attorney fees.

S. Jud.
3/26/86
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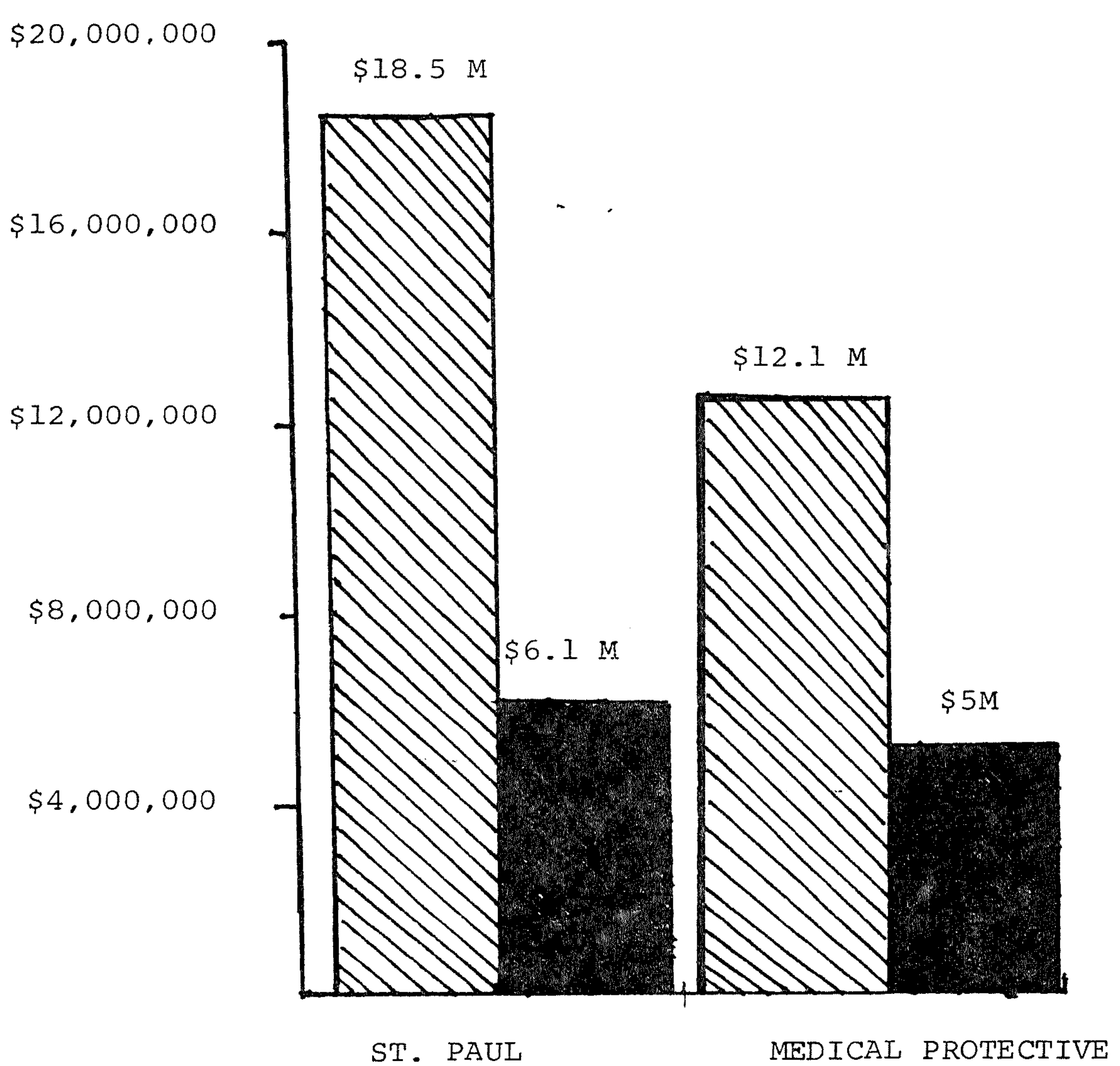
KANSAS PREMIUMS
(1980- 1984)



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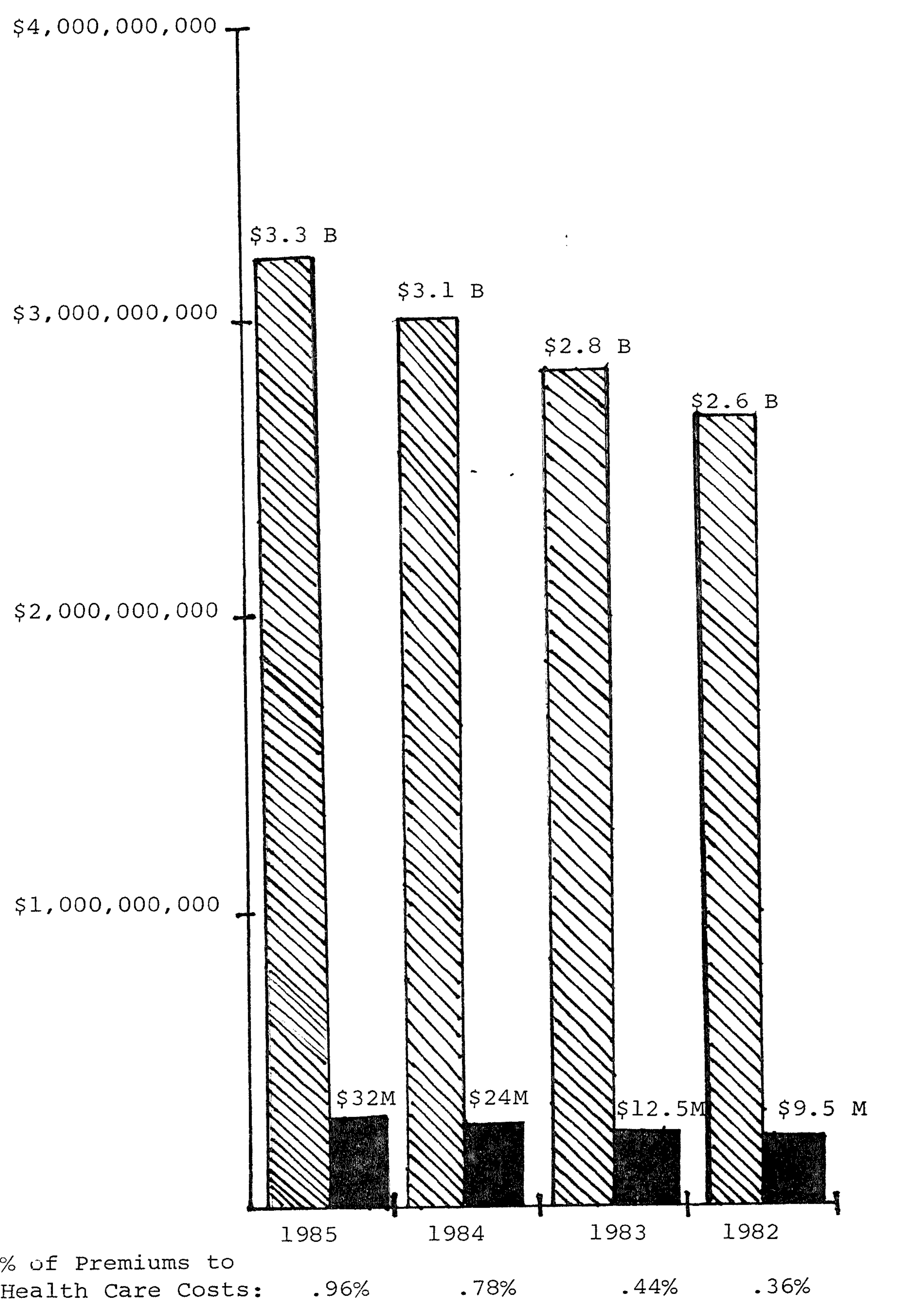
PREMIUM INFORMATION



......Total Malpractice Premiums Paid by Health Care Providers.

......Total Personal Health Care Costs in Kansas.

The above statistics show that malpractice premiums in Kansas represen <u>less than 1%</u> of the total health care costs in Kansas. For three year (1981,1982, 1983), doctors in Kansas paid <u>no surcharge</u> for Fund insurance.

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KANSAS

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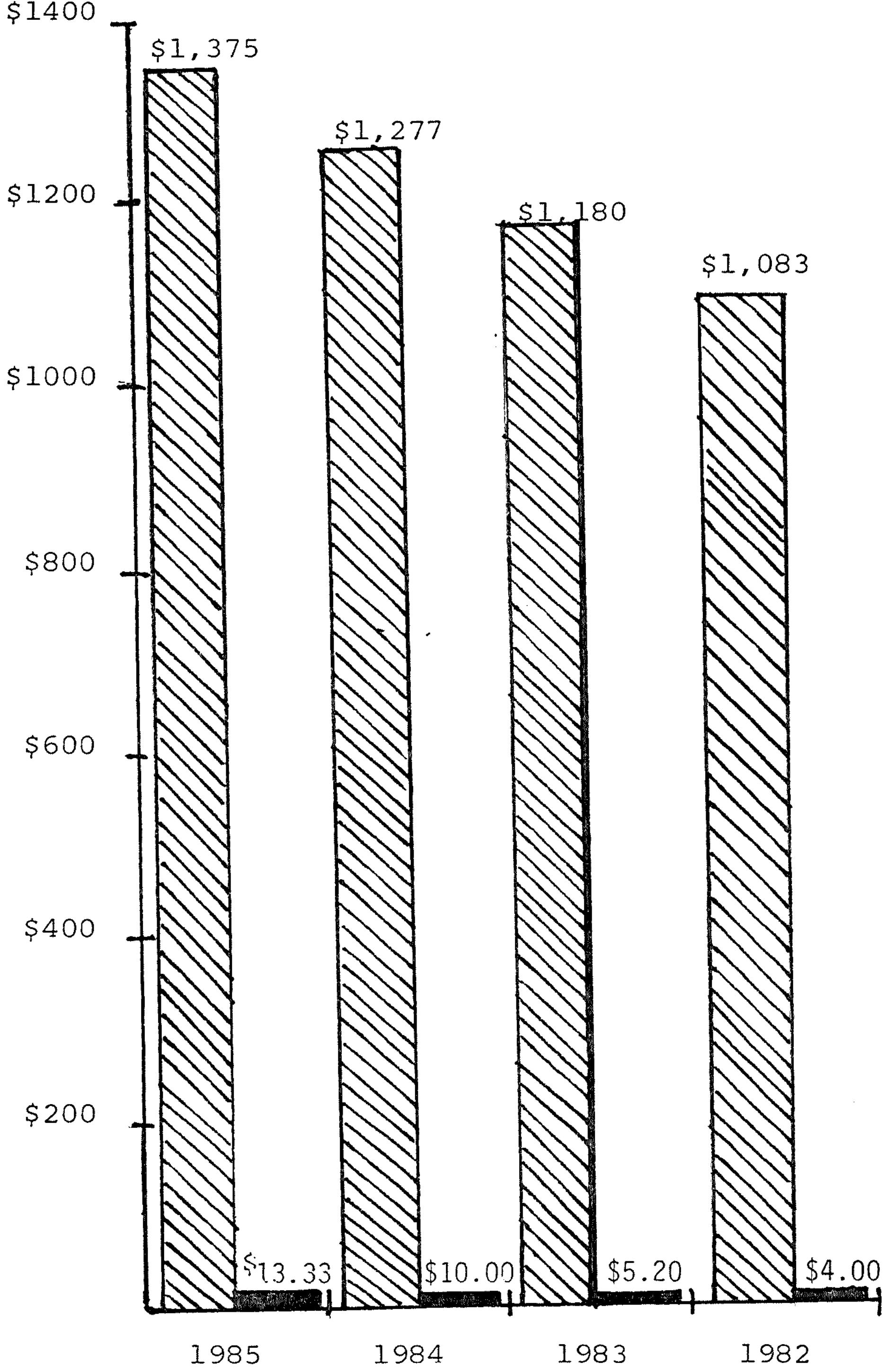
Per Capita Expenditures.



......Per Capita Health Care Expenditures in Kansas.

......Per Capita Share of Malpractice Premiums.

This graph shows the amount, per person, spent on health care in Kansas. Then the total amount of the health care premiums are divided among the citizens in Kansas. If malpractice were abolished and every dollar was returned to the citizens of Kansas, in 1985 citizens would get a total of $13.33, in exchange for losing their legal rights.

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