Approved MARCH 22, 1988
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by REPRESENTATIVE DALE SPRAGUE
Chairperson at

3:30 XX a.m./p.m. on MARCH 17, 19 88 in room 531-N of the Capitol.

All members were present except:

Representative Littlejohn, excused

Committee staff present:

Chris Courtwright, Research Department
Bill Edds, Revisor of Statutes Office
Nancy Wolff, Secretary

Conferees appearing before the committee:

Dick Brock, Kansas Insurance Department
John Hannah, Fraternal Congress of America
Senator Mike Johnston
Vicki Thomas, Kansas University Medical Center
Cheryl Dillard, Kaiser Permanente
Jerry Slaughter, Kansas Hospital Association
Tom Bell, CSJ Health Systems

The meeting was called to order by the Chairman.

Hearings were scheduled on House Bill 3056, which relates to the formation, operation and regulation of fraternal benefit societies. It would make certain acts unlawful and would prescribe penalties. The other bill scheduled for hearing was Senate Bill 623 which would make persons engaged in residency training at the University of Kansas Medical Center self-insured by the University for occurrences arising during training.

Dick Brock, Kansas Insurance Department, testified as a proponent to House bill 3056. This was an Insurance Department request for a bill introduced by the House Insurance Committee. He stated that the two main items covered by this legislation are the prior approval on forms of insurance and the licensing and registration of agents.

John Hanna, Fraternal Congress of America, testified in support of House Bill 3056. The amendments proposed by Mr. Hanna have been reviewed and approved by the Kansas Insurance Department. Mr. Hanna distributed amendments to the bill (Exhibit I) for the review of the committee.

There being no opponents to the bill, the hearings on House Bill 3056.

The hearings were then opened on Senate Bill 623.

Senator Mike Johnston, one of the sponsors of Senate Bill 623, testified in support of the bill. He testified that Senate Bill 623 would continue the self-insurance that is currently utilized for interns/residents at KUMC. This "tail coverage" would cover acts while the doctor was an intern/resident at KUMC. He stated that the legislation would make it easier for doctors to stay in Kansas and would make it possible for more doctors to pay into Health Care Stabilization Fund. He requested that the bill be amended to make it effective upon publication in the Kansas Register.

Vicki Thomas, representing the K.U. Medical Center, testified in support of the bill and requested a small cleanup amendment on page 4, line 127 by adding the words "or was engaged" following the word "engaged".

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE,

room 531-N, Statehouse, at 3:30 XX a.m./p.m. on MARCH 17, 1988.

Cheryl Dillard, Kaiser Permanente, also gave testimony in support of Senate Bill 623. (Exhibit II) She also distributed a balloon copy of proposed amendments to the bill. (Exhibit III)

Jerry Slaughter, Kansas Medical Society, testified in support of Senate Bill 623.

Tom Bell, on behalf of CSJ Health Systems of Wichita, presented prepared testimony of Stephen Blaes (Exhibit IV) in support of the legislation.

There being no further conferees, the meeting was adjourned.

VISITORS TO HOUSE INSURANCE COMMITTEE

DATE: March 17, 1988

NAME	REPRESENTING
Ron Calbert	United Transportation Union
Jess W. Taylor	Kansas Fraternal Congress
D W Young	National Fraternal Congress
John P. Hanna	National Fraternal Congress of America
Dick Brock	Ins Dept
Richard Thomas	Ks. Univ. Med. Center
Bob Keagle	Marsh & McLennan, KC Mo.
Wendell Doolittle	Marsh + McLennan, KC Mo
Jeffrey O'Ellis	Kaiser
Cheryl Dillard	Kaiser Permanente
John Peters	Kaiser Permanente
Ron Todd	Ins. Dept.
Marilyn Reed	Kmea
Richard Thomas	KRA

HOUSE INSURANCE COMMITTEE HEARING

ON HOUSE BILL NO. 3056 KANSAS FRATERNAL CODE

March 3, 1988

Mr. Chairman and members of the Committee.

My name is John P. Hanna. I am Consulting Counsel to the National Fraternal Congress of America which represents 100 fraternal benefit societies operating throughout the United states.

[Introductions -]

The National Fraternal Congress of America wholeheartedly endorses House Bill 3056, a part of Insurance Commissioner Fletcher Bell's recommended legislative packages this year. This Bill incorporates the major features of the Revised Fraternal Code adopted by the NFCA in October, 1983 and which has been enacted in thirteen states, including your neighboring state of Nebraska in 1985. This Bill, of course, has been tailored by Commissioner Bell and his staff to meet specific requirements in Kansas.

While there are no NFCA member-societies domiciled in Kansas, there are 32 member-societies licensed and operating in this State with about 122,000 members statewide. A list of those societies having the most members in Kansas are:

EXHIBIT I

AAL

Independent Order of Foresters

Knights of Columbus

Lutheran Brotherhood

Modern Woodmen of America

North American Benefit Association

Royal Neighbors of America

Western Fraternal Life Association

Woodmen of the World Life Insurance Society

Before describing some of the specifics of this Bill, I would like to describe briefly a fraternal benefit benefit society and summarize the reasons why the National Fraternal Congress of America feels that this Bill is important to the citizens of Kansas, to the Insurance Department, and to the membership of fraternals in the state.

Fraternal benefit societies are self-help membership organizations formed by people of common ethnic, religious, or vocational backgrounds, or by people holding similar patriotic or moral beliefs. It is a concept of organization brought to the United States over 100 years ago by our ancestors from abroad. In fact, some of these groups could not get commercial insurance, the railroad workers, for instance, and thus they banded together for common interests.

Fraternal benefit societies operate today in the same manner as they have in the past. Each society brings together, through membership requirements, people of common ethnic, religious or vocational backgrounds, or patriotic or moral beliefs. Each society has such purposes for which it was established, and each society creates and administers programs and activities to carry out those purposes. Each society operates on a lodge or branch system where local members meet regularly to identify and meet the needs of lodge members and their local communities through their programs and activities. They have a representative form of government, and each society is required to provide life, health, or disability insurance benefits to its members.

The volume and substance of self-help activities, charitable and benevolent programs, local lodge and branch meetings, time of volunteers, disaster relief and other programs is very substantial in Kansas, involving millions of dollars, hundreds of thousands of person hours, and thousands of meetings and events.

Why is this revised fraternal code needed?

The laws governing fraternal benefit societies in Kansas were last extensively revised in 1927 with only three amendments to that law since then, plus additions of sections relating to mutualization in 1931 and for conversion to a stock life insurance company in 1959. Provisions relating to insurance of children were added in 1943.

This Bill updates the law into a comprehensive regulatory article for fraternal benefit societies in Kansas.

Fraternal benefit societies have unique organizational and operational features. These include a lodge system, a representative form of government, the concept of membership with certain rights and privileges attached, specific purposes for which each fraternal exists, and programs and activities to carry out those purposes, including insurance and other benefits.

Current Kansas law governing fraternal benefit societies, Article 7 of Chapter 40, includes and requires these unique characteristics. This Bill addresses all of these characteristics in a clear and direct manner, clarifying the definition of a fraternal benefit society and making it easier for the Insurance Department to determine whether or not a fraternal is in compliance with these requirements.

Current Kansas law uses some terms which seem to be confusing or contradictory. This Bill contains a section on definitions to remove any such confusion [Section 4]. The Bill also has been made gender-neutral.

The Bill clarifies provisions regarding juvenile insurance contracts, designation of irrevocable beneficiaries, assignment of insurance contracts, and the use of insurance contracts for third party situations. Current Kansas law either does not address these situations or does so in an incomplete manner. These provisions are important to our members in their personal, financial and tax planning.

The Bill subjects fraternals operating in Kansas to the same examination and reporting requirements with which stock and mutual insurers are required to comply [Section 20]. This gives the Insurance Department a means to monitor the financial solvency of fraternals. Also contained in the Bill is a feature unique to fraternals whereby anytime the financial reserves of a fraternal become impaired, a fraternal has the authority to levy an additional assessment against its members by cash, policy loan, or reduced benefits, until the reserves are restored [Section 12(d)]. This feature alone will prevent a Baldwin-United situation from happening to fraternals.

The Bill also contains provisions subjecting fraternals to the same consumer protection provisions that apply to stock and mutual insurers, such as agent's licensing, policy form filing, minimum valuation and financial standards and mandated benefits in insurance contracts, and, for the first time, specifically requires that fraternal certificates be filed with and approved by the Insurance Commissioner, and within one year to meet the standard provision requirements for life, accident and health insurance policies. Fraternals and their field representatives would be subject to the unfair trade practices act, Article 24, the same as now.

Present law does not require fraternal agents to be licensed. This Bill would require all full-time fraternal agents to be licensed the same as for insurance company agents, but regular salaried officers, employees or members who do not engage in the business of soliciting insurance and receive no commissions would be exempted, as would part-time agents as defined. No examination should be required of any person acting as a fraternal agent prior to enactment of this bill, and we recommend and urge an amendment to New Section 25(a), as follows:

page 16, line 31 - delete the period after "situated" and add ", except that no examination shall be required of a person who is an agent of a society immediately prior to the effective date of this act, but this exception shall apply only for the particular kind of insurance for which such person was acting as agent."

The Bill continues present law to subject fraternals to the same investment laws that apply to stock or mutual insurers. The Bill authorizes fraternals to issue, with prior approval of the insurance department, new types of interest-sensitive or variable insurance products [Section 15(c)]. Current Kansas law does not provide for what is called separate account authority. It is needed, however, so that fraternals will be authorized to provide the types of insurance products of value to their members and perhaps of significance to the future of the insurance industry.

In conclusion, this Bill substantially revises the body of law governing fraternals in a modern, up-to-date approach. It restates the rights and responsibilities of members of fraternal societies. It improves the regulatory process for fraternals so that the Insurance Department can do a thorough job of regulating. It affirmatively retains and clarifies the unique characteristics of fraternals so that you can be assured that frater-

nals will live up to their necessary role in our society. It continues certain limitations and requirements of operations and products, i.e., no group insurance, membership qualifications, and other structural features that I have mentioned.

As a practical matter, this Bill does not substantially increase or broaden the authority of fraternals, or give them any special treatment that they do not have under present law, except for internal separate account authority, and the authority to issue new forms of life, accident and health insurance as they are developed. The Bill does considerably strengthen the authority of the Insurance Department in the regulation of fraternals.

Our experience in other states has been that the insurance companies and the life and health underwriter groups in each state have had no objection to this revised fraternal code.

On behalf of the National Fraternal Congress of America, I thank you for this opportunity to explain this revised Fraternal Code for Kansas. We urge you to vote favorably on House Bill 3056, and will gladly respond to any questions you may have.

National Fraternal Congress of America
1300 Iroquois Drive
Naperville, Illinois 60540
(312) 355-6633

KAISER PERMANENTE

TESTIMONY OF KAISER PERMANENTE
BEFORE KANSAS HOUSE COMMITTEE ON INSURANCE
SENATE BILL 623

MARCH 17, 1988

Mr. Chairman, I am Cheryl Dillard, Government Relations Manager for Kaiser Permanente in Kansas City. Kaiser Permanente is the largest and most experienced health maintenance organization in the country, with over 5 million members in 16 states and the District of Columbia. In Kansas City, Kaiser Permanente has 17,000 members. I am appearing before the Committee today to propose an amendment to Senate Bill 623.

The amendment we are proposing would change the section of the Kansas Insurance Code which addresses self-insurance for health care providers and would grant the Commissioner the authority to recognize the financial strength of groups of providers for the purpose of self-insuring, without jeopardizing contribution levels for the Health Care Stabilization Fund. We believe the amendment we have recommended for your consideration will give the Insurance Commissioner the authority to administer this section of the law in a more realistic manner.

Currently, Kansas insurance law defines a long list of health care providers. Among them are physicians, health maintenance organizations and professional corporations made up of physicians. When a health care provider's annual premium for basic liability coverage meets or exceeds $100,000, existing law permits that health care provider to self-insure with the approval of the Commissioner. Self-insurance means that the provider can look to his/her or their own resources to cover those claims arising out of liability actions against the individual provider, the health maintenance organization or the group. The law specifies that providers meeting that financial threshold are eligible to apply to the Commissioner for a certificate of self-insurance. Financial and administrative conditions must be met before a certificate can be issued. In addition, the provision of the law dealing with self-insurance is quite specific that those providers who are granted a certificate of self-insurance by the Commissioner must still meet their individual responsibilities to pay the premium surcharge into the state's Health Care Stabilization Fund. Current law requires that each individual health care provider, health maintenance organization or individuals within a group of providers must meet the financial threshold of $100,000 in premium costs before being permitted to apply for a certificate.

EXHIBIT II

The amendment we propose would authorize the Commissioner, under certain defined circumstances, to recognize from a logical group of providers an aggregated annual premium of $100,000 for the purpose of qualifying for a certificate of self-insurance. That group of providers, as referenced in the amendment, would be a health maintenance organization and any group of providers who practice as a group to provide physician services for enrollees of the health maintenance organization. That collective group of health care providers would still be required to apply to the Commissioner for a certificate of self-insurance, would need to carry basic liability coverage for each individual provider and would be required to pay the applicable surcharge for each provider to the Health Care Stabilization Fund.

We suggest that this amendment would permit logical groupings of health care providers, such as HMOs and the group of physicians who provide physician services for the HMO, to rely on their own financial strength for liability coverage while, at the same time, continuing to make the appropriate individual contributions to the Stabilization Fund.

I'd be pleased to answer any questions that you may have about our proposed amendment.

Session of 1988

SENATE BILL No. 623

By Senators Johnston, Anderson, Feleciano, Karr, Martin, Mulich, Norvell, Parrish, Steineger, Strick and Warren

2-10

AN ACT relating to insurance; concerning liability of the health care stabilization fund for and self-insurance of occurrences arising during residency training; amending K.S.A. 40-3414 and K.S.A. 1987 Supp. 40-3403 and repealing the existing sections.

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

Section 1. K.S.A. 1987 Supp. 40-3403 is hereby amended to read as follows: 40-3403. (a) For the purpose of paying damages for personal injury or death arising out of the rendering of or the failure to render professional services by a health care provider, self-insurer or inactive health care provider subsequent to the time that such health care provider or self-insurer has qualified for coverage under the provisions of this act, there is hereby established the health care stabilization fund. The fund shall be held in trust in a segregated fund in the state treasury. The commissioner shall administer the fund or contract for the administration of the fund with an insurance company authorized to do business in this state.

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

(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

EXHIBIT III

(D) prepare and publish, on or before October 1 of each year, a summary of the fund's activity during the preceding fiscal year, including but not limited to the amount collected from surcharges, the highest and lowest surcharges assessed, the amount paid from the fund, the number of judgments paid from the fund, the number of settlements paid from the fund and the amount in the fund at the end of the fiscal year.

(2) The board shall consist of 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) two members appointed from the public at large who 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; (G) one member who is a licensed professional nurse authorized to practice as a registered nurse anesthetist; and (H) one member of another category of health care providers. Meetings shall be called by the chairperson or by a written notice signed by three members of the board. The board, in addition to other duties imposed by this act, shall study and evaluate the operation of the fund and make such recommendations to the legislature as may be appropriate to ensure the viability of the fund.

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

(c) Subject to subsections (d), (e), (f), (i) and (k), the fund shall be liable to pay: (1) Any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable resident health care providers or resident self-insurers for any

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

in the administration of the fund; (10) return of any unearned surcharge; (11) reasonable and necessary expenses for attorney fees and other costs incurred in defending a person engaged *or who was engaged* in residency training from claims for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider; (12) any amount due from a judgment or settlement for an injury or death arising out of the rendering of or failure to render professional services by a person engaged in residency training; (13) amounts authorized by the court pursuant to K.S.A. 1986 Supp. 60-3411 and amendments thereto; and (14) reasonable and necessary expenses for the development and promotion of risk management education programs.

(d) All amounts for which the fund is liable pursuant to subsection (c) shall be paid promptly and in full except that, in any case arising out of a cause of action which accrued before July 1, 1986, if the amount for which the fund is liable is $300,000 or more, it shall be paid, by installment payments of $300,000 or 10% of the amount of the judgment including interest thereon, whichever is greater, per fiscal year, the first installment to be paid within 60 days after the fund becomes liable and each subsequent installment to be paid annually on the same date of the year the first installment was paid, until the claim has been paid in full. Any 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 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) Except as provided by K.S.A. 1986 Supp. 60-3411 and amendments thereto, the fund shall not be liable to pay in excess of $1,000,000 pursuant to any one judgment or settlement for any party 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.

(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.

(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 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, 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.

(j) (1) Upon the payment of moneys from the health care stabilization fund pursuant to subsection (c)(11), the commis-

sioner shall certify to the director of accounts and reports the amount of such payment, and the director of accounts and reports shall transfer an amount equal to the amount certified from the state general fund to the health care stabilization fund.

(2) Upon the payment of moneys from the health care stabilization fund pursuant to subsection (c)(12), the commissioner shall certify to the director of accounts and reports the amount of such payment which is equal to the basic coverage liability of self-insurers, and the director of accounts and reports shall transfer an amount equal to the amount certified from the state general fund to the health care stabilization fund.

(k) Notwithstanding any other provision of the health care provider insurance availability act, no psychiatric hospital licensed under K.S.A. 75-3307b and amendments thereto shall be assessed a premium surcharge or be entitled to coverage under the fund if such hospital has not paid any premium surcharge pursuant to K.S.A. 40-3404 and amendments thereto prior to January 1, 1988.

Sec. 2. K.S.A. 40-3414 is hereby amended to read as follows: 40-3414. (a) Any health care provider ~~whose~~ annual insurance premium is or would be $100,000 or more for basic coverage calculated in accordance with rating procedures approved by the commissioner pursuant to K.S.A. 40-3413 and amendments thereto, may qualify as a self-insurer by obtaining a certificate of self-insurance from the commissioner. Upon application of any such health care provider, on a form prescribed by the commissioner, the commissioner may issue a certificate of self-insurance if the commissioner is satisfied that the applicant is possessed and will continue to be possessed of ability to pay any judgment for which liability exists equal to the amount of basic coverage required of a health care provider obtained against such applicant arising from the applicant's rendering of professional services as a health care provider. In making such determination the commissioner shall consider (1) the financial condition of the applicant, (2) the procedures adopted and followed by the applicant to process and handle claims and potential claims, (3) the amount and liquidity of assets reserved for the settlement of

or any health care system organized and existing under the laws of this state which owns and operates two or more medical care facilities licensed by the department of health and environment whose aggregate

or health care system

(hospitals)

claims or potential claims and (4) any other relevant factors. The certificate of self-insurance may contain reasonable conditions prescribed by the commissioner. Upon not less than five days' notice and a hearing pursuant to such notice, the commissioner may cancel a certificate of self-insurance upon reasonable grounds therefor. Failure to pay any judgment for which the self-insurer is liable arising from the self-insurer's rendering of professional services as a health care provider, the failure to comply with any provision of this act or the failure to comply with any conditions contained in the certificate of self-insurance shall be reasonable grounds for the cancellation of such certificate of self-insurance. The provisions of this subsection shall not apply to the Kansas soldiers' home or to any person who is a self-insurer pursuant to subsection (d) or (e).

(b) Any health care provider ~~who~~ holds a certificate of self-insurance shall pay the applicable surcharge set forth in subsection (c) of K.S.A. 40-3402 and amendments thereto.

(c) The Kansas soldiers' home shall be a self-insurer and shall pay the applicable surcharge set forth in subsection (c) of K.S.A. 40-3402 and amendments thereto.

(d) A person engaged in residency training shall be self-insured by the university of Kansas medical center *for occurrences arising during such training*, and such person shall be deemed a self-insurer for the purposes of the health care provider insurance stabilization act. The university of Kansas medical center shall pay the applicable surcharge set forth in subsection (c) of K.S.A. 40-3402 and amendments thereto on behalf of such person. Such self-insurance shall be applicable to a person engaged in residency training only when such person is engaged in medical activities which do not include extracurricular, extra-institutional medical service for which such person receives extra compensation and which have not been approved by the dean of the school of medicine and the executive vice-chancellor of the university of Kansas medical center.

(e) (1) A person engaged in a postgraduate training program approved by the state board of healing arts at a medical care facility or mental health center in this state may be self-insured

such

or health care system that (hospitals)

by such medical care facility or mental health center in accordance with this subsection (e) and in accordance with such terms and conditions of eligibility therefor as may be specified by the medical care facility or mental health center and approved by the commissioner. A person self-insured under this subsection (e) by a medical care facility or mental health center shall be deemed a self-insurer for purposes of the health care provider insurance availability act. Upon application by a medical care facility or mental health center, on a form prescribed by the commissioner, the commissioner may authorize such medical care facility or mental health center to self-insure persons engaged in postgraduate training programs approved by the state board of healing arts at such medical care facility or mental health center if the commissioner is satisfied that the medical care facility or mental health center is possessed and will continue to be possessed of ability to pay any judgment for which liability exists equal to the amount of basic coverage required of a health care provider obtained against a person engaged in such a postgraduate training program and arising from such person's rendering of or failure to render professional services as a health care provider.

(2) In making such determination the commissioner shall consider (A) the financial condition of the medical care facility or mental health center, (B) the procedures adopted by the medical care facility or mental health center to process and handle claims and potential claims, (C) the amount and liquidity of assets reserved for the settlement of claims or potential claims by the medical care facility or mental health center and (D) any other factors the commissioner deems relevant. The commissioner may specify such conditions for the approval of an application as the commissioner deems necessary. Upon approval of an application, the commissioner shall issue a certificate of self-insurance to each person engaged in such postgraduate training program at the medical care facility or mental health center who is self-insured by such medical care facility or mental health center.

(3) Upon not less than five days' notice and a hearing pursuant to such notice, the commissioner may cancel, upon reason-

0304 able grounds therefor, a certificate of self-insurance issued pur-
0305 suant to this subsection (e) or the authority of a medical care
0306 facility or mental health center to self-insure persons engaged in
0307 such postgraduate training programs at the medical care facility
0308 or mental health center. Failure of a person engaged in such
0309 postgraduate training program to comply with the terms and
0310 conditions of eligibility to be self-insured by the medical care
0311 facility or mental health center, the failure of a medical care
0312 facility or mental health center to pay any judgment for which
0313 such medical care facility or mental health center is liable as
0314 self-insurer of such person, the failure to comply with any pro-
0315 visions of the health care provider insurance availability act or
0316 the failure to comply with any conditions for approval of the
0317 application or any conditions contained in the certificate of
0318 self-insurance shall be reasonable grounds for cancellation of
0319 such certificate of self-insurance or the authority of a medical
0320 care facility or mental health center to self-insure such persons.
0321 (4) A medical care facility or mental health center authorized
0322 to self-insure persons engaged in such postgraduate training
0323 programs shall pay the applicable surcharge set forth in subsec-
0324 tion (c) of K.S.A. 40-3402 and amendments thereto on behalf of
0325 such persons.
0326 (5) As used in this subsection (e), "medical care facility" does
0327 not include the university of Kansas medical center.
0328 Sec. 3. K.S.A. 40-3414 and K.S.A. 1987 Supp. 40-3403 are
0329 hereby repealed.
0330 Sec. 4. This act shall take effect and be in force from and
0331 after its publication in the statute book.

(f) for the purposes of subsection (a) "health care provider" may include each health care provider in any group of health care providers who practice as a group to provide physician services only for a health maintenance organization, any professional corporations, partnerships or not-for-profit corporations formed by such group and the health maintenance organization itself. The premiums for each such provider, health maintenance organization and group corporation or partnership may be aggregated for the purpose of being eligible for and subject to the statutory requirements for self-insurance as set forth in K.S.A. 40-3414. (HMOs)

(g) The provisions of subsection (f) of this section and the provisions of subsection (a), relating to health care systems, shall not affect the responsibility of individual health care providers as defined in subsection (f) of K.S.A. 40-3401 or organizations whose premiums are aggregated for purposes of being eligible for self-insurance from individually meeting the requirements imposed by K.S.A. 40-3402 with respect to the ability to respond to injury or damages to the extent specified therein and K.S.A. 40-3404 with respect to the payment of the Health Care Stabilization Fund surcharge. (hospitals & HMOs)

Health System of Wichita

March 17, 1988

BEFORE THE HOUSE INSURANCE COMMITTEE
OF THE KANSAS STATE LEGISLATURE

Written Testimony of Stephen M. Blaes

Relative to Senate Bill 623 and Senate Bill 689

Mr. Chairperson and members of the Committee. I am Stephen Blaes, Chairman of the Board and Senior Counsel of the CSJ Health System of Wichita. Our Health System operates 14 acute care general hospitals and retirement centers in four states. Of these, the System owns and operates 7 hospitals in our State of Kansas:

St. Joseph Hospital, Concordia;

St. Mary's Health Center, Emporia;

Halstead Hospital, Halstead;

The Saint Mary Hospital, Manhattan;

Mt. Carmel Medical Center, Pittsburg;

St. John's Hospital, Salina; and

St. Joseph Medical Center, Wichita.

We are appearing before you today with a special request to amend Senate Bill 623 to include the language of what is presently identified as Senate Bill 689.

We view the provisions of Senate Bill 689 as an important opportunity to assure appropriate liability

EXHIBIT IV

insurance for our hospitals in Kansas while, at the same time, permitting us to do greater service for our patients. I am referring to a self-insurance strategy relating to hospital professional liability exposure for our Kansas hospitals.

Only one of our hospitals, St. Joseph Medical Center of Wichita, qualifies to self-insure professional liability under the Health Care Provider Insurance Act, K.S.A. §40-3401, et seq. It has self-insured this risk since the passage of the Act and has enjoyed an excellent record and substantial savings. In fact, we have carefully measured our professional liability experience throughout the System, and have found that our hospitals have excellent records of quality care and effective risk management, resulting in much lower malpractice settlements, awards and costs of defense on a comparative basis.

If all our Kansas hospitals could participate as a group in a qualified self-insurance program, we could provide excellent protection at substantial savings as compared to traditional insurance costs available in the prevailing market -- savings which would be passed along to benefit Kansas citizens through more cost effective, quality enhanced healthcare services.

In order to qualify our hospitals in Kansas for the self-insurance option, we propose that the CSJ Health System, as the owner and controlling entity, and acting in the institutions' collective behalf, be qualified as a self-insurer. The aggregate annual insurance premiums of all our hospitals would far exceed the statutory minimum of $100,000 as the qualifying floor for self-insurance. The statutes would impose upon the System and its member hospitals the responsibility to conform our self-insurance funding program to all of the standards and requirements of the Commissioner of Insurance, a mandate with which we heartily concur.

We believe we can accomplish this result through the revision of the relevant and governing statute as it pertains to qualification for the self-insurance option. We offer for the Committee's consideration and endorsement the legislative initiative introduced as Senate Bill 689 -- and ask that it be amended into Senate Bill 623 which is before you today. It is designed to amend §40-3414 to qualify a Health Care System, organized and existing under the laws of the State of Kansas and owning or controlling and operating two or more licensed medical facilities, to act in behalf of its member facilities in accomplishing a cost effective, yet fiscally conservative, self-insurance program.

We have discussed these strategies with the Office of the Commissioner of Insurance. We will continue to coordinate this matter with the Commissioner and will conform our self-insurance funding protocols and levels to the Commissioner's requirements.

In behalf of the CSJ Health System -- and, in particular, in behalf of our hospitals in Kansas, their executives, Boards of Trustees, and professional staffs -- we want to express our thanks for your accommodation of our appearance before you today; to ask your support of the legislation we propose; and to assure you of our cooperation with the Office of the Commissioner of Insurance in implementing a fiscally conservative self-insurance program.

In our judgment, this legislation will be very helpful to our hospitals and will enable us to do a better job for the Kansas citizens we serve.

Thank you.