Approved February 20, 1989
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Dale Sprague at
Chairperson

3:30 a.m./p.m. on February 15, 19 89 in room 531-n of the Capitol.

All members were present except:

Representative Hoy, excused

Committee staff present: Emalene Correll, Research Department
Bill Edds, Revisor of Statutes
Patti Kruggel, Committee Secretary

Conferees appearing before the committee:

Others present: see attached list

The Chairman called the meeting to order at 3:30 p.m.

A motion was made by Rep. Brown to approve the minutes of February 14, 1989. Rep. Flower seconded. The motion carried.

Harold Riehm, Kansas Association of Osteopathic Medicine, appeared before the Committee to request the introduction of two bills. The first bill request (Attachment 1) would be to amend K.S.A. 40-12a02 (An Act permitting an association or associations of health care providers to establish a professional liability insurance company for certain health care providers.) This bill would preclude a health provider association from requiring membership as a condition to policy issuance.

It was moved by Representative Turnquist that the Committee request the bill. Representative Littlejohn seconded. The motion carried.

Mr. Riehm's second bill request (Attachment 2) is the introduction of a Medical Accident Compensation Act, an approach to resolving the medical malpractice dilemma in Kansas. The Association recognizes the complexity of the bill but asks that the Committee introduce the bill to be considered as a possible interim study.

Representative Campbell made a motion that the Committee introduce the bill. Representative Bryant seconded. The motion carried.

There were no other bill requests and the Committee opened discussion on HB 2181.

HB 2181 -- An Act amending the health care provider insurance availability act; eliminating the expiration date of the plan for equitable apportionment of applicants for professional liability insurance; amending K.S.A. 1987 Supp. 40-3413, as amended by section 124 of chapter 356 of the laws of 1988 and repealing the existing sections.

Emalene Correll, Legislative Research Department, gave a brief overview of HB 2181 stating that it would repeal the proposal resulting in the termination of the Health Care Provider Insurance Availability Plan (HCPIAP).

MINUTES OF THE ~~House~~ COMMITTEE ON ~~Insurance~~,

room ~~531-S~~ Statehouse, at ~~3:30~~ a.m./p.m. on , 19~~89~~

Dick Brock, Insurance Department, testified that HB 2181 pertains to the Insurance Commissioner's Proposal No. 1. The Bill recommends that the statutory "sunset" provisions relating to the HCPIAP be deleted. (Attachment 3.)

There were no others wishing to testify on HB 2181 and the Committee began discussion on HB 2381.

HB 2381 -- An Act relating to continuing care contracts; providing for the regulation of continuing care providers under the administration of the commissioner of insurance; providing penalties for violations; repealing K.S.A. 16-1101, 16-1102, 16-1103, 16- 1104 and 16-1105.

Emalene Correll, Legislative Research Department, briefed the Committee on the bill. She stated that the bill would substitute new law by making some changes and tightening up the existing law.

Dick Brock, Insurance Department, testified on behalf on HB 2381. He explained that the bill reflects the Insurance Commissioner's Proposal No. 11 and that is was developed through a cooperative effort of the Kansas Department of Aging, the Department of Social and Rehabilitation Services, the Department of Health and Environment, the Kansas Association of Homes for the aging, the American Association of Retired Persons to resolve some problems revealed by a change of ownership of a facility providing continuing care, and general concerns of organizations such as the American Association of Retired Persons. (Attachment 4.)

Frank Lawler, American Association of Retired Person, appeared in support of HB 2381 and provided testimony (Attachment 5). Mr. Lawler explained that the proposed legislation was recommended in an effort to find answers to the inadequacies of the existing statute.

Next appearing before the Committee was John Grace, Kansas Association of Homes of the Aging. Mr. Grace provided testimony (Attachment 6)which would amend HB 2381 to combine the filing time of audit and disclosure statements and to extend the filing time for one month from three to four months. Other than this exception, the Association supports the bill.

George Dugger, Department on Aging, testified before the Committee in support of HB 2381as an improvement to our consumer protection laws. Mr. Dugger stated that the Department feels the bill will enable consumers of continuing care services to make better quality decisions about investing significant portions of their life savings. (Attachment 7.)

There were no others wishing to testify on HB 2381 and the hearings were concluded.

The meeting was adjourned at 4:25 p.m.

GUEST LIST

COMMITTEE: Insurance DATE: 2/15/89

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Dick Brown	Topeka	[illegible]
John Grace	"	KS Assoc Home Sp
		Aging
Rod Frey	"	KTLA
Lee Wright	Overland Park	Farmers Ins. Group
[illegible]	[illegible]	[illegible]
[illegible]	Topeka	[illegible]
Floyd Peine	Wichita	SHA & Visitor
[illegible]	Topeka	KS Dept. of Ag.
Frank Lawlor	Leawood, Ks	AARP
Jim Oliver	Topeka	PIA of Ks

KANSAS ASSOCIATION OF OSTEOPATHIC MEDICINE
REQUEST FOR INTRODUCTION OF BILL TO
HOUSE INSURANCE COMMITTEE 02/15/89

Attachment 1

SUGGESTED AMENDMENTS TO K.S.A. 40-12a02 (An Act permitting an association or associations of health care providers to establish a professional liability insurance company for certain health care providers.)

40-12a02. Formation and operation; purpose; assessment plan. (a) except as otherwise provided in this act, the provisions of article 12 of chapter 40 of the Kansas Statutes Annotated shall control the formation and operation of companies organized under this act.

(b) Any association of health care providers domiciled within the state of Kansas which has been in existence for three years or more, may, as provided in this act, form an insurance company for the purpose of issuing contracts of insurance providing liability insurance for health care providers ~~which are members of the association~~, their employees, directors, professional associations and affiliates upon the assessment plan.

(c) Any two or more such associations of health care providers may form an insurance company for the purpose of issuing contracts of insurance providing liability insurance for ~~such association's respective members, the member's employees,~~ health care providers, their employees, directors, professional associations and affiliates upon the assessment plan.

New Section (d). No insurance company formed under provisions of this act may require membership in the association or associations forming the company as a condition of issuing a contract of insurance providing liability insurance for a health care provider. However, nothing in this subsection shall prohibit such insurance company from requiring as a condition of coverage of a nonmember that the nonmember agrees to be subject to reasonable risk management, loss control or other similar programs and conditions to which members are subject. Such conditions may be met through programs provided by the association or associations forming the company or by other associations of Kansas health care providers which have been in existence for three years or more and are domiciled in the State of Kansas.

New Section (e). No insurance company formed under the provisions of this act may assess any surcharge or offer any discount to a health care provider based on whether or not the provider is a member of the professional association or associations forming the company.

Attachment 1

A Medical Accident Compensation System: A Model Act

M. MARTIN HALLEY, M.D., J.D., ROBERT J. FOWKS, J.D., M.B.A.,
F. CALVIN BIGLER, M.D., AND DAVID L. RYAN, J.D., LL.M.

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SPECIAL FEATURE

A Medical Accident Compensation System: A Model Act

M. MARTIN HALLEY, M.D., J.D., ROBERT J. FOWKS, J.D., M.B.A., F. CALVIN BIGLER, M.D., AND DAVID L. RYAN, J.D., LL.M.*

This paper represents the culmination of the authors' long efforts to formulate a means of meeting the liability crisis enveloping the medical profession by establishing a consistent and equitable modus operandi for the management of claims against health care personnel. The paper is presented with a view to making readers acquainted with the alternative compensation approach as outlined by the authors and does not necessarily represent the position of the Kansas Medical Society.

Introduction

History and Development. A model medical accident compensation system, analogous to workers' compensation systems, has been developed by our team of physicians and attorneys. The statute for the model system, consisting of 38 detailed sections, is set forth below. This third-generation document is the result of extensive revision and expansion of a 1985 prototype completed by the Subcommittee on Patient Compensation of the Professional Liability Committee of the Kansas Medical Society. Bryce B. Moore, J.D., a former director of the Kansas workers' compensation agency, authored the prototype.[1]

The model applies workers' compensation principles to health care injuries and eliminates tort terminology such as fault, negligence and damages. Adversarial tort proceedings are avoided, and expeditious claim resolution is provided for an anticipated larger number of health care injuries than compensated under the present system. The compensable event is clearly defined with the assistance of expert review panels. Benefits, based on actual or constructed earnings, are equitably provided for all members of society. A quality control mechanism, integral to the system, is separated from the compensation channels.

The model is flexible: individual provisions can be changed or omitted as desired, or as required by actuarial, political or constitutional considerations. Although based on Kansas law, the statute is adaptable to any jurisdiction. It is universally feasible, since it appears to address all major components of a compensation system, including administration, claim disposition, dispute resolution, definition of the compensable event and the extent of injury, form and amount of compensation, funding, cost, quality control, ongoing evaluation and constitutionality.

Description of the Model System.[2,3] The framework consists of a full-time, three-member state compensation board supported by expert review panels, the state court system, a quality control mechanism and a database section. The Board, assisted by administrative law judges, hears and decides claims and approves settlements for preliminary or final compensation in the form of medical benefits, rehabilitation benefits, personal injury benefits or death benefits. The *expert review panels* consist of up to three qualified providers and necessary consultants. They are convened, at the Board's discretion, to assist in determining the existence and extent of medical injury, the existence of substandard practice, and the relationship of such injury to substandard practice. *State district and appellate courts* hear and determine appeals from Board decisions within the purview of the act. *Quality control* provisions mandate the reporting of all claims and outcomes, as well as database analyses to appropriate agencies and institutions for evaluation and action, and require hospitals and other health care entities to request information from the database. The *database* inputs and processes all data concerning the occurrence, compensation and prevention of health care injuries, assists in quality control, and monitors the effectiveness of the Act.

Comments. This model medical accident com-

*From the Midwest Institute for Health Care and Law, 901 SW Garfield, Topeka, KS 66606.

pensation system appears to address successfully the three major previously unresolved problems of administrative compensation:

1. Definition of the medical injury or compensable event is accomplished through individual case review, thus eliminating the necessity for comprehensive schedules of compensable events. The health care injury is defined as a temporary or permanent impairment, disability or other adverse outcome, caused by substandard health care practice, arising out of the delivery or the failure of delivery of health care to a patient.

2. The cost of an administrative compensation system has been and remains a major concern, since all indications are that such a system will result in a substantial increase in the number of compensated injuries. The increased expenses are offset in part by the greater efficiency of the system, as well as by other cost controls, most of them currently utilized by workers' compensation systems, and frequently proposed as elements of tort reform. These other cost controls are: limitation of total awards, adopting current workers' compensation schedules; reasonable statutes of limitation as presently in effect in Kansas; payment only for medical care, rehabilitation, and economic loss; periodic payments of awards; modification or termination of benefits with changes in a beneficiary's status; offset of other insurance benefits; elimination of joint and several liability; an entry threshold, albeit low; and reasonable structuring of attorney fees. Actuarial evaluation indicates that provider financing is feasible if cost controls are applied. A wider base of financial support would probably be required if cost controls are omitted, or if a broader definition of injury is contemplated.

3. Constitutionality of a medical accident compensation system is another major concern, and cannot be definitely predicted. However, it appears that ultimate determination for such a system should be favorable, since an adequate quid pro quo is rendered through the tradeoff of a substantial increase in the number of paid claims and other benefits in return for the restriction of tort rights, just as is the case in workers' compensation systems, which are constitutional in every state.

Conclusions. The consumer-oriented system detailed in this statute can be expected to minimize substandard health care and health care injuries, and stabilize insurance premiums through more predictable settlements and awards. At the same time, it will insure the payment of limited, prompt, and certain benefits to a larger number of injured patients, many of whom are presently filing no claim or receiving no compensation after experiencing the vagaries of adversarial tort proceedings.[4, 5, 6]

REFERENCES

1. The Kansas Medical Accident Compensation Act. Professional Liability Committee, *Subcommittee on Patient Compensation*, Kansas Medical Society. Halley MM, chair; Bigler FC; Fowks RJ; Moore BB. (Available from the Kansas Medical Society, Topeka, KS, 66612, May 1985.)

2. Halley MM. Malpractice '87: Status and solutions. *Kansas Med* 1987:88:261–64, 294–97.

3. Halley MM. Governors at work: The Committee on Professional Liability. *Bull Am Coll Surg* 1988;73:61–62.

4. Halley MM, Fowks RJ, Bigler FC, Ryan DL. Commentary for a medical accident compensation system: A model act. (Available from the Midwest Institute for Health Care and Law, Topeka, KS. 1987.)

5. Halley MM, Fowks RJ, Bigler FC, Ryan DL. Medical malpractice: The administrative compensation alternative. (Available from the Midwest Institute for Health Care and Law, April 1988.)

6. Halley MM, Fowks RJ, Bigler FC, Ryan DL (eds.). Medical malpractice solutions: Systems and proposals for injury compensation. Springfield, IL: Charles C Thomas, to be published in 1989.

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A MEDICAL ACCIDENT COMPENSATION SYSTEM A MODEL ACT*

SECTION 1

NAME AND SCOPE OF THE ACT

A. This Act shall be known as the Medical Accident Compensation Act.

B. A health care provider shall be liable to pay compensation for personal injury or death arising out of the delivery or the failure of delivery of health care to a patient in accordance with the provisions of the Medical Accident Compensation Act.

C. Benefits under this Act shall be exclusive as to any civil action against a health care provider arising out of the delivery or the failure of delivery of health care to a patient.

D. No health care provider, or employee, or associate of such provider shall be liable for any injury for which compensation is recoverable under the Medical Accident Compensation Act, except as otherwise provided in the Act. No health care provider or employee or associate of such provider shall be liable to any third party for any injury or death of a patient or other person which was caused under circumstances creating a legal liability against a third party and for which benefits are recoverable under the Medical Accident Compensation Act.

SECTION 2

THE COMPENSABLE EVENT

A. Medical accident compensation under this Act shall be payable for a personal injury arising out of the delivery or the failure of delivery of health care to a patient. No compensation shall be payable where an injury is caused by the willful refusal of a patient to follow medical advice or where an injury is the result of the willful intention of the patient to injure himself, herself, or another.

(1) *Personal Injury* shall mean the occurrence of a temporary or permanent impairment, disability, or other adverse outcome caused by substandard health care practice.

(2) *Health Care Practice* shall mean all aspects of such activity by providers involving patients, including, but not limited to, diagnosis, treatment, procedures, authorization for care, informing a patient, and prevention or protective health care management.

(3) *Substandard Health Care Practice* shall mean that degree of deviation in the quality of care which would not be acceptable to or utilized by a reasonably competent and reasonably prudent similar health care provider under similar conditions and circumstances.

B. The Medical Accident Compensation Board constituted under Section 16 of this Act shall determine the presence or absence of injury, the presence or absence of substandard practice, and the relationship of such injury to substandard practice. The Board shall additionally determine the extent of such injury for purposes of awarding benefits under this Act.

C. A Board determination may be assisted by the conclusions of an expert review panel appointed under Section 17 of this Act. The Board shall liberally utilize such expert review panels and consider panel conclusions strongly persuasive in determining the presence or absence of injury, the extent of injury, the presence or absence of substandard practice, and the presence or absence of causation of injury by substandard practice.

SECTION 3 *DEFINITIONS*

For purposes of this Act, unless the context requires otherwise, the following words and phrases shall have the meanings respectively ascribed to them herein:

BOARD means the Medical Accident Compensation Board.

BOARD FEE FUND has the meaning set forth in Subsections 5D and 5E of this Act.

COMMISSIONER means the Commissioner of Insurance of this state.

DATABASE has the meaning set forth in Section 36 of this Act.

DIRECTOR means the director of the Medical Accident Compensation Board.

HEALTH CARE PRACTICE has the meaning set forth in Section 2 of this Act.

HEALTH CARE PROVIDER is defined as set forth in K.S.A. 40-4301f, K.S.A. 40-3401g, K.S.A. 60-513d, and amendments thereto. [Cite appropriate state health care provider definitional statutes.]

PANEL means an expert review panel as set forth in Section 17 of this Act.

PATIENT means a person who comes under the health management or medical care of a health care provider for examination, diagnosis, or treatment, or in any other manner, so that a physician-patient relationship or an equivalent provider-patient relationship is established.

*The Act is based on Kansas law. Appropriate state agencies and statutory citations may be substituted for use in other states.

PERSONAL INJURY has the meaning set forth in Section 2 of this Act.

RECOVERY GUARANTEE FUND has the meaning set forth in Section 6 of this Act.

SPENDABLE TAKE-HOME EARNINGS are defined as the claimant's average weekly or monthly take-home earnings in his or her employment or employments for a recent 12-month period, as determined by the Board. Not included in the computation of spendable take-home earnings is the amount withheld for social security contributions, or for federal, state, or local income tax withholding. However, to be included in the spendable take-home income figure are pension plan contributions and the amount of any fringe benefits paid by the employer but discontinued due to a compensable occurrence under this Act.

STANDARD OF REASONABLE CARE for a health provider under this Act shall be defined as that level of care, skill, knowledge, and treatment which is recognized and utilized by reasonably competent and reasonably prudent similar health care providers under similar conditions and circumstances.

STATE'S AVERAGE WEEKLY WAGE means the average weekly wage paid in insured work subject to Employment Security Law, as determined annually by the Secretary of Human Resources as provided in K.S.A. 44-704 and amendments thereto. [Cite appropriate state employment security law.]

SUBSTANDARD HEALTH CARE PRACTICE has the meaning set forth in Section 2 of this Act.

SECTION 4

FUNDING OF COVERAGE

A. A health care provider, as defined in K.S.A. 40-3401 and K.S.A. 60-513d and amendments thereto [cite appropriate state health care provider definitional statutes], shall pay compensation that may be due under this Act in the following manner:

(1) By insuring the payment of such compensation with an insurance carrier authorized to transact this type of insurance in this state; or

(2) By becoming a self-insured or by maintaining a membership in a group-funded self-insurance pool, with the approval of the Commissioner of Insurance. The Commissioner shall be authorized to promulgate such rules and regulations as may be required to regulate sufficiently a self-insurance program or a group-funded self-insurance program.

B. The knowing and intentional failure of a health care provider to secure the payment of compensation as set out in Subsection A shall be a Class C misdemeanor.

C. Where a health care provider has no insurance to secure the payment of compensation that may be awarded under this Act and is otherwise financially unable to pay compensation to the claimant, the claimant may apply to the Insurance Commissioner for payment of compensation that may be due under this Act. If the Insurance Commissioner concludes that the health care provider cannot pay the award and is uninsured, the Insurance Commissioner shall make payment to the claimant from the Recovery Guarantee Fund, which shall be maintained by the Commissioner as set forth in Section 6. A claim may be filed against the Recovery Guarantee Fund prior to determination on the merits where it is the claimant's belief that the health care provider does not have insurance, or may be financially unable to pay compensation, or may for any reason be unavailable for adjudication under the provisions of this Act.

D. The Commissioner of Insurance, acting as administrator of the Recovery Guarantee Fund, shall have a cause of action against the health care provider for the recovery of any amounts paid from the Fund pursuant to this section. Such action shall be filed in the district court in the county in which the compensable event occurred, or where the health care provider is located or can be found.

SECTION 5

ASSESSMENT FOR THE COST OF THE BOARD, THE BOARD FEE FUND

The expense of the administration of the Medical Accident Compensation Board shall be financed in the following manner:

A. The director of the Board shall estimate as soon as practicable after January 1 of each year the expenses necessary for the administration of the Board for the fiscal year beginning July 1 thereafter. Such estimates shall be provided to the legislature, and the legislature shall then determine the amount of administrative expense to be obtained from insurers, self-insureds, and group-funded self-insurance programs under the provisions of this Act.

B. The share of the expense as determined under this section shall be prorated among insurers, self-insureds, and group-funded programs as follows: The director shall determine the total amount of insurance business written or conducted in the immediately preceding calendar year and the relative amount applicable to each insurance carrier, self-insured and group-funded program, through determination of amounts of insurance in force, premiums collected, benefits paid, or other applicable data. The director shall list the data forming the basis for the determination and the amounts so al-

located, and shall provide by regulation for the collection of the proportionate amount of the expense from each carrier, self-insured, and group-funded program.

C. Assessment shall be paid within thirty (30) days of the date the notice is served upon a carrier, self-insured or group-funded self-insurance program. If such amounts are not paid within such period, the director may assess a civil penalty equal to ten percent (10%) of the amount so unpaid for each thirty (30) days the liability remains due and unpaid. Such civil penalties shall be collected as part of the original amount as determined by the director under this section.

(1) If a carrier fails to pay the amounts assessed by the director as provided in this section for a period of more than sixty (60) days from the time notice of such amount is first served to such carrier, the director shall make a verified report to the Commissioner of Insurance, who may suspend or revoke the authorization of such carrier to do business in the state.

(2) If a self-insured fails to pay the amounts assessed by the director as provided in this section for a period of more than sixty (60) days from the time notice of such amount is first served to such self-insured, the self-insured shall forfeit any self-insurance bond and be suspended from being a self-insured.

(3) If any group-funded self-insurance program fails to pay the amounts assessed by the director as provided in this Act for a period of more than (60) days from the time notice of such amount is first served on such group, the group shall forfeit any self-insurance bond and be suspended as a self-insurer.

D. There is hereby created in the state treasury a fund to be called the Board Fee Fund, for the purpose of administering the funds collected under this section. The director shall remit all monies received under the provisions of this section, or as fees, charges, or other receipts to the state treasurer at least monthly. Upon receipt of such remittance, the state treasurer shall deposit the entire amount thereof in the state treasury, credited to the Board Fee Fund, except that five percent (5%) of any such deposit shall be credited to the state General Fund.

E. All expenditures from the Board Fee Fund shall be made in accordance with the appropriate acts upon warrants of the Division of Accounts and Reports issued pursuant to vouchers approved by the director, or by a person or persons designated by the director.

F. The legislature shall provide funds for the operation of the Board from general revenue sources for the Board's first two (2) years of operation. The General Revenue Fund shall be reimbursed by a special assessment on carriers, self-insureds and group-funded insurance programs not later than thirty-six (36) months after the effective date of this Act.

SECTION 6

THE RECOVERY GUARANTEE FUND: PURPOSE, ESTABLISHMENT, FUNDING

A. There is hereby created in the state treasury a fund to be called the Recovery Guarantee Fund. The purpose of this fund is to secure the payment of compensation under circumstances set forth in Subsections 4C and 4D, and to reimburse a provider or an insurer in the event compensation has been paid, but is subsequently reduced or disallowed by hearing or appeal, as set forth in Subsections 20E and 24B.

B. The Recovery Guarantee Fund shall be financed as follows: The Insurance Commissioner, as soon as practicable after January 1 of each year, shall estimate the expenses necessary for the administration of the Fund for the fiscal year beginning July 1 thereafter. The Commissioner shall submit such figure to the Board which shall include this amount in the assessment for the cost of the Board, as provided under Section 5 of this Act.

C. The Board shall transfer the Commissioner's portion of the assessment to the Commissioner upon receipt of these monies. The Commissioner shall remit all such monies received by him from the Board to the State Treasury upon receipt of these monies from the Board. All expenditures from the Recovery Guarantee Fund shall be made in accordance with the appropriate acts upon warrants of the Division of Accounts and Reports issued pursuant to vouchers approved by the Commissioner.

D. All claims against the Recovery Guarantee Fund within the first twenty-four (24) months after the effective date of this Act shall be made to the legislature, which shall provide funds for compensation of each individual claim. Any amount so expended by the legislature shall be reimbursed to the General Fund by a special assessment to be included in the special assessment provided for in Subsection 5F of this Act.

SECTION 7

LIMITATION OF ACTIONS

A. No claim under the act shall be brought more than two (2) years after the date of a compensable occurrence, within the guidelines set out in this sec-

tion. In cases where compensation payments have been suspended, such written claim shall be made within two hundred (200) days after the last payment of compensation.

B. A claim arising out of the rendering or failure to render professional services by a health care provider under this act shall be deemed to have accrued at the time of the occurrence of the act giving rise to the claim, unless the fact of injury is not reasonably ascertainable until some time after the initial act, in which case the period of limitation shall not commence until the fact of injury becomes reasonably ascertainable to the injured party, but in no event shall such claim be commenced more than four (4) years beyond the time of the act giving rise to the claim.

C. Where a claimant is less than eighteen (18) years of age or incapacitated or imprisoned for a term less than such person's natural life, such person shall be entitled to make a claim within one (1) year after the legal disability is removed, except that no claim shall be commenced by or on behalf of any person under disability more than eight (8) years after the time of the compensable occurrence. Notwithstanding the foregoing provision, if a person imprisoned for any term has or reasonably could have had access to facilities for purposes of bringing a claim, such person shall not be deemed to be under legal disability.

D. If any person entitled to bring a claim dies during the continuance of any disability specified in Subsection 7C and no determination has been made of the claim accrued to the deceased, any person entitled to claim from, by, or under the deceased, may commence or continue such claim within one (1) year after the decedent's death, but in no event shall such claims be commenced more than eight years beyond the time of the act giving rise to the claim.

E. When a claim accrues against a provider who has departed the state, or has otherwise absconded or concealed himself or herself, the period of limitation shall be tolled while such provider remains out of the state, or while such provider is so absconded or concealed. If after a claim accrues, a provider departs the state, or otherwise absconds or conceals himself or herself, the time of such absence or concealment shall not be computed as any part of the period within which the claim must be brought. This section shall not apply to extend the period of limitation as to any provider whose whereabouts are known and upon whom notice of a claim can reasonably be served.

F. No claim shall be brought against a health care provider to recover for an ionizing radiation injury arising out of the delivery or the failure of delivery of professional services by a provider more than four (4) years from the date of the last occurrence to which the injury is attributed.

SECTION 8

THIRD-PARTY ACTIONS, SUBROGATION, LIENS, ASSIGNMENT

A. When the injury or death for which compensation is payable under this Act was caused under circumstances creating a legal liability against a party other than a provider or any person in association with or in the employ of a provider, the claimant or the claimant's dependents or personal representatives shall have the right to take compensation under the Medical Accident Compensation Act and pursue a remedy by proper action in a court of competent jurisdiction against such other party or person.

B. In the event of recovery from such other party or person by the claimant or by the claimant's dependents or personal representatives by judgment, settlement or otherwise, the provider shall be subrogated to the extent of the compensation and medical aid provided by the provider to the date of such recovery and shall have a lien therefore against such recovery and may intervene in any action to protect and enforce such lien. Whenever any judgment, settlement, or other recovery occurs prior to the completion of compensation or medical benefit payments, the amount of such recovery which is in excess of the benefits paid under this Act to the date of such recovery shall be credited against future payments under this Act. Such actions against the other party, if prosecuted by the claimant, must be instituted within one year from the date of the injury, and if prosecuted by the claimant's dependents or personal representatives of a deceased patient, must be instituted within 18 months from the date of such injury.

C. Failure on the part of the claimant, or the dependents or personal representatives of a deceased patient, to bring such action within the time herein specified shall operate as an assignment to the provider of any cause of action, and such provider may enforce the cause of action in the provider's name or in the name of the patient, dependents, or personal representatives for their benefit as their interest may appear by proper action in any court of competent jurisdiction. The court shall fix the attorney fees which shall be paid proportionately by the provider and the patient.

D. The provider's subrogation interest or credits

against future payments of compensation and medical aid shall be diminished by the percentage of the award attributed to the conduct of a provider, the provider's associates, or those for whom the provider is responsible, other than the injured patient.

E. No subrogation right, lien, or other third-party right, unless expressly provided, shall be recognized under the coverage of this Act.

SECTION 9

OTHER INSURANCE COVERAGE

No insurer or other entity conducting business or governmental functions in this state or otherwise subject to the laws of this state shall deny, reduce, delay, withhold, or otherwise modify coverage under any insurance policy or other benefit plan on grounds that benefits are or may be covered, or have been received, under the provisions of this Act.

SECTION 10

CREDIT FOR DUPLICATE PAYMENTS

A. Any award of benefits under this Act shall be reduced by the amount of any past or future payment or benefit covered by this section which the claimant or any dependents have received or are eligible to receive from any other source on account of the same occurrence that is the basis of the claim against the health care provider under this Act.

B. For purposes of this section, "payment or benefit covered by this section" shall mean:

(1) Medical, disability, or other insurance coverage, workers' compensation, military service benefit plans, employment wage continuation plans, social welfare benefit programs or other benefit plans or programs provided by law.

(2) Life insurance payments not including the first $100,000 of such life insurance benefits, and not including 50% of such life insurance benefits in excess of $100,000.

B. "Payments or benefits covered by this section" shall be reduced by any amounts paid by the claimant to secure the right to such payments or benefits, and shall not include any payments or benefits that are subject to a reasonably founded claim of subrogation, reimbursement, or lien as determined by the Board.

C. The health care provider, or the provider's insurer, shall have a statutory assignment for the recovery of past payments to the claimant by the provider, or the provider's insurer, under this Act as to any corresponding future amounts paid by any other source as to payments arising out of the same occurrence that is the basis of the claim against the provider. The director shall determine the amounts subject to such assignment and shall certify these amounts to the provider, or to the provider's insurance carrier.

SECTION 11

DEATH BENEFITS

A. For a compensable death under this Act, benefits shall be paid, except where otherwise provided, at a weekly rate of 100% of the decedent's spendable weekly take-home earnings, subject to a maximum of 75% of the state's average weekly wage. Benefits for a claimant less than 18 years of age, or a housewife or homemaker, shall be determined on the basis of 75% of the state's average weekly wage, except where constructed spendable take-home earnings result in a lesser amount. Benefits shall be subject to the maximum amounts specified in Section 15, and the minimum amounts specified in Subsection 11B.

B. Where the decedent's actual or constructed spendable take-home earnings result in an amount less than fifty percent (50%) of the state's average weekly wage, benefits shall be paid to eligible survivors under this section in a weekly amount equal to fifty percent (50%) of the state's average weekly wage. Such benefits shall be paid out for a maximum of five hundred twenty (520) weeks, not to exceed a total sum of $100,000.

C. Where for any reason the average weekly take-home earnings of the deceased cannot otherwise be reasonably established, benefits shall be paid as set forth in Subsections 11A or 11B, based on the constructed spendable take-home earnings of the deceased as determined by the Board. Such Board determination of earnings shall take into consideration the age and education of the deceased, prior income from jobs, job skills, and any other factors that will fairly determine what the decedent's spendable take-home earnings would have been or that will result in fair and reasonable compensation.

D. Where the deceased is retired and receiving a pension income and/or social security or compensation for a total or partial disability from a governmental or insurance source, compensation shall be paid to any eligible survivors under this section, in a weekly amount equal to the loss of that income to the survivors. If a retired individual has worked to supplement his or her retirement income, the weekly amount of such spendable take-home earnings shall be included in figuring compensation due under this subsection. Such compensation shall be subject to the maximum amount specified in Section 15 and the minimum amount specified in Subsection 11B.

E. Where a claimant has been previously awarded or paid temporary or permanent benefits for a claim that later comes under this section, any temporary or permanent benefits so paid shall be credited toward any payments under this section.

F. Where the deceased patient is survived by a spouse only, benefits shall be paid to the surviving spouse as set out in Subsections 11A through 11E as applicable. The surviving spouse shall be entitled to benefits until such spouse's death or remarriage. Upon remarriage, the surviving spouse's entitlement shall cease. However, the said spouse shall be entitled to a lump-sum benefit consisting of compensation that would have been paid to the surviving spouse for the next fifty-two (52) weeks from the time of the spouse's remarriage.

G. Where the deceased is survived only by a child or children, the child or children shall be entitled to weekly benefits as set out in Subsections 11A through 11E as applicable, which shall be divided equally among them if there is more than one eligible child. Compensation shall be paid to any eligible child or children until they reach the age of eighteen (18), or until twenty-three (23) years of age if the child is attending an accredited college or university or a vocational or technical school or is incapacitated. Where a child becomes no longer eligible to draw benefits, compensation shall be reapportioned as set out in Subsections 11I and 11J.

H. Where the deceased is survived by a spouse and children, both eligible to receive benefits under this Act, compensation shall be paid as set out in Subsections 11A through 11E as applicable and such benefits shall be paid one-half to the spouse and one-half to the child or children.

I. If the deceased leaves no legal spouse or dependent children eligible for benefits under this section, but leaves other dependents, as defined in K.S.A. 44-508 and amendments thereto [cite appropriate state workers' compensation beneficiary statute], wholly or partially dependent upon the deceased's earnings, such other dependents shall receive weekly compensation as provided in this section until death, remarriage or so long as such other dependents do not receive more than 50% of their support from any other earnings or income or from any other source. The maximum benefits payable to all such other dependents, regardless of the number of such other dependents, shall not exceed a maximum amount of $20,000.

J. The marriage or death of any dependent shall terminate all compensation under this section to such dependent. When any child or legal spouse is no longer eligible for benefits under this section, his or her benefits shall be reapportioned among the surviving legal spouse or dependent children who remain eligible for benefits under this section, but the compensation allowed to dependents other than the surviving legal spouse or dependent children shall not increase or decrease. If the deceased does not leave any dependents who are citizens of or residing at the time of the injury in the United States, the amount of compensation shall not exceed in any case the sum of $750.

K. Where the deceased is under the age of eighteen (18), Subsection 11I above shall not apply. Compensation shall be paid as set out in Subsections 11A, 11B, 11C, or 11E, and in accordance with Section 15, as follows:

(1) Where the parents have jointly provided a home for the child, and the child lived in a home occupied by both parents, benefits shall be paid as provided by this Act, one-half to each parent.

(2) Where the parents are not occupying the same home or are divorced or separated, benefits shall be paid as set out in this Act, one-half to each parent, where the child lived with one parent and the other parent provided support for the child. Where the child lived with one parent and there is no history or pattern of support by the other parent, then benefits shall be paid as set out under this Act only to the parent with whom the child lived. Where the child lived with neither parent, but one or both parents provided support for that child, then benefits shall be paid as set out under this Act either to the one parent, if the one parent was the only one providing support, or one-half to each parent, if both parents provided support to the child.

(3) Where the deceased is under the age of eighteen (18) and survived by a spouse and/or a child or children, benefits shall be paid as set out in Subsections 11A, 11B, 11C or 11E, as applicable, to the spouse and/or children in the manner set out in this section.

L. For the death of an unborn child, compensation shall be paid in an amount to be determined by the parties or the Board, based on an amount that would fairly compensate the parent or parents in accordance with Section 15.

M. Where a compensable death occurs under this Act, the decedent's estate shall be reimbursed as to expense of burial of the deceased, not to exceed an amount of four thousand dollars ($4,000).

N. The following definitions will be used for purposes of this section:

(1) Child:

a. A natural or adopted child of the deceased, except where the relationship has been severed by adoption.

b. A stepchild of the deceased who lives in the decedent's household.

c. Any other child who is actually dependent in whole or part on the deceased and who is related to the deceased by marriage or consanguinity.

(2) Dependent shall be defined as in K.S.A. 44-508, and amendments thereto. [Cite appropriate state statute.]

(3) Spouse or surviving spouse means a person legally married to the deceased according to the laws of this state at the time of the decedent's death.

SECTION 12

COMPENSATION FOR TEMPORARY PERSONAL INJURY

A. Where following a compensable event under this Act, the claimant is temporarily unable to engage totally or partially in his or her usual occupation or engage in activities comparable to those existing prior to the compensable event, compensation shall be paid to the claimant to replace the claimant's actual or constructed spendable take-home earnings. This compensation shall be paid in an amount up to 100% of spendable take-home earnings, as determined by the difference between such earnings prior to the compensable event and the amount of such earnings at the time of the disability, subject to a maximum of 75% of the state's average weekly wage. Benefits for temporary personal injury compensation shall be paid for a maximum of 200 weeks, subject to the provision of Section 15.

B. Where for any reason an earnings figure cannot be reasonably established for purposes of paying temporary compensation as provided in this section, the claimant's compensation benefits shall be determined as in Subsections 13C, 13D, and 13E, based upon reduction in the claimant's health level, upon functional disability to the body as a whole, or upon loss of income-earning ability.

C. Compensation for a temporary personal injury may be modified by agreement of the parties, or by the Board following a hearing upon application of any party as provided in Section 23.

D. If the claimant also has a permanent personal injury arising from the claim that is compensable under this Act, the amount of temporary compensation paid shall be credited against any award for such permanent personal injury.

E. No compensation under this section shall be paid during the first week a claimant is temporarily completely or partially unable to engage in his or her usual occupation. Thereafter, compensation shall be paid as set out in this section. If the claimant is temporarily unable to engage completely or partially in his or her usual occupation for three (3) consecutive weeks, compensation shall then be paid by the health care provider for the first week the claimant is temporarily unable, totally or partially, to engage in his or her usual occupation.

SECTION 13

COMPENSATION FOR PERMANENT PERSONAL INJURY

Where following a compensable claim under this Act, a permanent personal injury is determined to exist, compensation shall be due as follows:

A. A figure expressed as a percent shall be determined, which figure represents a percentage of loss of the claimant's income-earning ability due to the permanent personal injury. Further, a percentage shall be determined representing either the overall reduction in the claimant's health level or a functional disability to the body as a whole due to the permanent personal injury. The percentage and method set forth in Subsections 13B, 13C and 13D that gives the claimant the highest weekly benefit shall be used.

B. If the percentage to be used for compensation is based on loss of income-earning ability, this percentage shall be multiplied by the claimant's actual or constructed spendable take-home earnings as defined under this Act. This figure shall be subject to a maximum of 75% of the state's average weekly wage. The resulting figure shall represent the claimant's weekly benefit rate.

C. If the percentage of the overall reduction in the claimant's health level or functional disability to the body as a whole is used as the percentage to calculate compensation, this percentage shall be multiplied by a figure equal to 75% of the state's average weekly wage. The resultant figure shall then be the weekly benefit rate.

D. Where the claimant is less than 18 years of age, or was a housewife or homemaker, compensation may be awarded as follows:

(1) If permanent total disability exists due to the personal injury, compensation may be awarded in a weekly amount not to exceed 75% of the state's average weekly wage.

(2) If permanent partial disability, impairment, or other adverse outcome exists due to the personal injury, compensation may be awarded as set forth in Subsection 13C, as to the overall reduction of the claimant's health level or functional disability of the body as a whole, or as set forth in Subsection 13E, based on loss of income-earning ability, in an amount not to exceed 75% of the state's average weekly wage.

E. If the permanent total or partial disability, impairment, or other adverse outcome cannot be fairly or readily compensated under the methods set out in Subsections 13A, 13B, 13C, and 13D, an estimate may be made of the claimant's loss of income-earning ability. This estimate shall consider the age and education of the claimant, prior income from jobs, job skills, and any other factors that would fairly determine what the claimant's spendable take-home earnings would have been if he or she had been employed or receiving a salary at the time of the compensable occurrence, or that will result in fair and reasonable compensation. The Board may then arrive at a weekly dollar amount that is believed to compensate the claimant fairly. This weekly dollar amount shall not exceed a maximum equal to 75% of the state's average weekly wage.

F. Where a determination of permanent total disability is made, compensation is payable as set forth above, but not to exceed the maximum limitations of Section 15. Otherwise, compensation shall be limited to 520 weeks under Subsections 13A through 13E, not to exceed the maximum limitations of Section 15.

SECTION 14

MEDICAL BENEFITS

In the event of a compensable claim, the claimant shall be entitled to all medical benefits that may be reasonably necessary for treatment, cure, relief, or other care of the personal injury or its consequences, as follows:

A. Medical benefits shall include the services of a physician or physicians, and such medical, surgical and hospital treatment, including nursing, home nursing care, custodial care and services, medicines, medical and surgical supplies, ambulance, crutches and apparatuses, and other items that may be necessary for treatment, cure, relief, or care.

B. The claimant or the claimant's dependents shall be entitled to reimbursement for any transportation costs reasonably incurred in obtaining the other benefits provided under this section. Reimbursement for transportation costs shall be at the rate prescribed for the compensation of state officers and employees under K.S.A. 1980 Supp. 75-3203a and amendments thereto. [Cite appropriate state travel reimbursement statute.] Other costs shall include reasonable amounts for meals and overnight lodging required for purposes of evaluation or treatment at medical facilities.

C. The claimant or the claimant's dependents shall be entitled to reimbursement from the provider or the provider's insurance carrier for medical expenses otherwise provided in this section in the event that such expenses have been incurred and paid prior to an award of benefits under this Act, and to the extent that these expenses have not been paid by other insurance and are not otherwise reimbursable by other insurance coverage.

D. Any health care provider, medical supply establishment, surgical supply establishment or ambulance service who accepts the terms of the Medical Accident Compensation Act by providing services or material thereunder shall be bound by the fees approved by the Board, and no claimant awarded benefits under the Act, or dependent of a claimant awarded such benefits, shall be liable for any charges above the amounts approved by the Board.

E. In the event that a provider or provider's insurance carrier refuses or neglects to provide reasonably the benefits to which a claimant is entitled under this section, the claimant may provide the same for himself or herself, and the provider or the insurance carrier shall be liable for such expenses, subject to the regulations adopted by the Board.

F. The health care provider, or the provider's representative, shall designate who provides the benefits set out under this section, except where the services or materials have already been provided, or are in the process of being provided prior to an award of benefits under this Act. If the services of a physician or physicians or other facilities furnished as above provided are not satisfactory to the claimant, the director may authorize the appointment of one or more other physicians or the utilization of other facilities, subject to the limitations set forth in this section and the regulations adopted by the Board.

G. The claimant may seek medical care or consultation without the approval of the provider, the provider's representative, the director, or the Board. However, the provider or the provider's insurance carrier shall only be required to pay a maximum of $350 for such unapproved fees and charges incurred after the filing of a claim under this Act, and relating to examination, diagnosis and treatment.

H. All fees, expenses, transportation costs and charges under this section, except unapproved fees and charges as set out in Subsection 14G, shall be subject to regulation by the director and approval by the Board, and shall be limited to such as are fair and reasonable. The director shall have jurisdiction to hear and determine all disputes as to medical benefits, expenses, costs, or charges and interest due thereon.

SECTION 15

PROVIDER MAXIMUM LIABILITY FOR PERSONAL INJURY COMPENSATION

Notwithstanding any provision of the Medical Accident Compensation Act to the contrary, the maximum benefits payable by a provider, not including medical benefits under Section 14, rehabilitation benefits under Section 26, or burial expenses under Subsection 11M, shall not exceed the following:

A. Death benefits to any or all dependents by the provider shall not exceed a total amount of $200,000. When such total amount has been paid, the liability of the provider under this Act for any further compensation to dependents shall cease, other than to minor children of the deceased. However, the payment of compensation under this section to any minor child of the deceased shall continue for the period of the child's minority at the weekly rate in effect when the provider's liability otherwise terminated under this section, and shall not be subject to termination under this section until such child becomes 18 years of age, or until 23 years of age if the child is attending an accredited college or university or vocational school, or is incapacitated.

B. Permanent total disability benefit payments, including payments or amounts due for any prior temporary total disability and permanent partial or temporary partial personal injury, shall not exceed $125,000 for a personal injury or any aggravation thereof.

C. Temporary total disability benefit payments, including payments or amounts due for any prior permanent total disability, and permanent partial or temporary partial personal injury, shall not exceed $100,000 for a personal injury or any aggravation thereof.

D. Benefit payments for a permanent or temporary partial impairment, disability, or other adverse outcome, including payments or amounts due for any prior permanent total or temporary total disability, and permanent partial or temporary partial personal injury, shall not exceed $100,000 for a personal injury or any aggravation thereof.

SECTION 16

THE MEDICAL ACCIDENT COMPENSATION BOARD

A. There is hereby established within the Department of Human Resources a division known as the Medical Accident Compensation Board. The Board shall be administered, under the supervision of the Secretary of Human Resources, by the director of the Medical Accident Compensation Board, who shall be the chief administrative officer of the Board.

B. The Medical Accident Compensation Board shall consist of three (3) members: a director and two (2) associate directors. The director shall be an attorney licensed to practice law in this state. One associate director shall be a physician licensed under the Healing Arts Act. [Cite applicable licensing authority.] The other associate director shall be neither an attorney nor a health care provider and shall receive no income from a health care source. If the last described associate director is married, the same requirements regarding profession and income shall apply to his or her spouse. The Board may hire a permanent secretary and other clerical assistants or staff, and shall purchase or rent equipment as needed to conduct the affairs of the Board. The Board, in hearing claims, shall sit as a three (3) member Board or can sit as a two (2) member Board if a member must disqualify himself or herself from serving on a particular case or is otherwise unable to participate. All decisions by the Board must be made by the agreement of at least two (2) of the Board members. The Board is authorized to establish rules and regulations to carry out the provisions of this Act.

C. The director shall be the chief administrative officer of the Board, and shall be appointed by the Secretary of Human Resources, subject to approval by the Governor. The term of office for the director shall be four (4) years. In case of vacancy in the office of director, the Secretary of Human Resources shall, within thirty (30) days of such vacancy, and with approval of the Governor, appoint a successor to fill the vacancy for the unexpired term. The director shall be in the unclassified service under the Civil Service Act of this state and shall receive an annual salary set by the Secretary of Human Resources, subject to the approval of the Governor. The director shall devote full time to the duties of the office and shall not engage in the private practice of law or hold other employment during his or her term of office.

D. The director of the Medical Accident Compensation Board, subject to the approval of the Secretary of Human Resources, shall appoint the two associate directors, who shall be members of the Board, and who shall serve at will. In case of vacancy in the office of associate director, the director shall, within thirty (30) days of such vacancy, and subject to approval of the Secretary of Human Resources, appoint a successor to fill the vacancy. Associate directors shall be in the unclassified service under the Civil Service Act and shall receive an annual salary set by the Secretary of Human Re-

sources, subject to the approval of the Governor. The associate directors shall have such powers, duties, and functions as are assigned to them by the director or are prescribed by law. The associate directors shall devote full time to the duties of their offices, and shall not engage in private practice or hold other employment during their terms of office.

E. The director of the Medical Accident Compensation Board may appoint, with the approval of the Secretary of Human Resources, one or more administrative law judges, who shall be attorneys admitted to the practice of law in this state, and who shall have such powers, duties, and functions as are assigned to them by the director or are prescribed by law. The administrative law judges shall be in the classified service, shall devote full time to the duties of their offices, and shall not engage in the private practice of law during their terms of office.

F. Each appointee shall be subject to either dismissal or suspension of up to thirty (30) days for any of the following:

(1) Failure to conduct oneself in a manner appropriate to the appointee's professional capacity;

(2) Failure to perform duties as required by the Medical Accident Compensation Act; or

(3) Any reason set out for dismissal or suspension in the Civil Service Act of this state or rules and regulations adopted pursuant thereto.

G. No appointee shall be appointed, dismissed or suspended on account of race or sex, or for political or religious beliefs.

SECTION 17

EXPERT REVIEW PANEL

A. An Expert Review Panel may be appointed by the director to assist in the determination of any claim and shall submit a written report containing its findings and conclusions to the Board. Appointment of the Panel shall be completed within twenty (20) days after a claim is filed with the Board. The Panel shall submit its report to the Board twenty (20) days after such appointment, unless an extension of time, not to exceed thirty (30) days, has been authorized by the director of the Board. The report shall be available to the parties at least twenty (20) days prior to the Board hearing. The contents of the report shall include conclusions concerning the presence or absence of injury, the extent of injury, the presence or absence of substandard practice, and the presence or absence of a causal relationship between the injury and substandard practice. The Panel shall terminate following a Board decision on the claim. However, the Panel may be reconvened at the discretion of the Board for reconsideration of a claim or other post-decision proceedings.

B. The membership of the Panel shall consist of a chairman, who shall be a member of the Board or an administrative law judge employed by the Board, and up to three health care providers who shall be currently active in their respective fields. The chairman of the Panel shall have an administrative function only, and shall not vote on panel conclusions. Physician and surgeon voting members of the Panel shall be currently certified by applicable specialty boards. Voting Panel members shall also have devoted at least 50% of their professional time to active clinical practice in the appropriate specialty during the five years immediately preceding appointment, or to its instruction at a medical school, or to a combination of active clinical practice and instruction. The state agency which licenses, registers, certifies, or is responsible for the practice of any group of health care providers shall maintain and make available to the Board a current list of health care providers who are eligible to serve on a Panel. Eligible health care providers shall serve upon request, but no individual may be required to serve more than once in each quarter. Three consecutive refusals to serve shall be reported by the Board to the appropriate licensing agency, and shall be considered unprofessional conduct unless adequately explained. At the Board's discretion, qualified non-resident providers satisfying the above criteria in another state may be appointed to an Expert Review Panel, or may serve as consultants to such Panels.

C. The Expert Review Panel may convene in any desired location, may exchange information by correspondence, or may conduct meetings by telephone conference calls. The panel shall consider all available material, including but not limited to medical records, contentions of the parties, examinations or reports of X-rays, test results, and treatises. The Panel shall make its report in writing to the Board, and such report shall include concurring or dissenting opinions.

D. No Panel member or consultant, having acted in good faith, without malice, and within the scope of his or her official capacity, shall be subject to subpoena or other process for any matter arising out of or related to participation in the panel. No member or consultant of the Panel, having acted in good faith, without malice, and within the scope of his or her official capacity, shall be subject to a civil action for damages as a result of any such matter. Upon request of the Panel member or consultant,

the Board shall provide for the defense of any civil action or proceeding against a panel member or consultant in his or her official or individual capacity or both, on account of an act or omission in the scope of his or her service on the Panel. Any civil judgment or other award against a Panel member or consultant, in his or her official or individual capacity, or both, arising out of an act or omission in the scope of service on a Panel, shall be paid by the Board.

E. Reimbursement of Panel members shall be at the rate of $250 per day, for time spent in panel deliberations. All other expenses, including research time, office overhead, travel, meals, and lodgings, shall be authorized by the Board in a reasonable manner. Reimbursement for out-of-state experts or consultants shall be provided through reasonable schedules established by the Board. The final costs of each Panel shall be assessed to the provider within thirty (30) days following Board decision for the claim under consideration.

SECTION 18

PROCEDURE FOR CLAIMS AGAINST A HEALTH CARE PROVIDER, SETTLEMENT

A. A claim for compensation under this Act shall be made in writing by the claimant or the claimant's representative to a health care provider within the time limitations set out in this Act. The claim shall be served upon the provider or his duly authorized agent by registered or certified mail, within the time limitations set forth herein. The written claim need not take a specific form, but the communication must clearly show the intent to collect compensation; the time, place and particulars of the alleged injury; and the name and address of the person injured. Failure to make such a written claim shall bar any claim against a provider. The Medical Accident Compensation Board shall maintain a claimant advisory section and shall, upon request, provide information and assistance in claim initiation and development.

B. Within twenty (20) days after receipt of a written claim, the provider shall so notify the Medical Accident Compensation Board. Within thirty (30) days after receipt of a written claim, the provider or the provider's representative shall meet with the claimant or the claimant's representative for purposes of resolving the claim. Within sixty (60) days following the initial meeting between the claimant or the claimant's representatives and the provider or the provider's representatives, the parties shall attempt to reach agreement in regard to disposition of the claim. After this sixty (60) day period, either party may file a written application with the Board for a hearing.

C. When an application is made to the Board for a hearing, the matter shall be scheduled for hearing within twenty (20) days after such application is received, unless an Expert Review Panel has been appointed. If a Panel has been appointed, the hearing shall be scheduled within thirty (30) days after the panel report has been submitted. The matter shall be assigned to a member of the Board or to an administrative law judge. An extension of the foregoing time limits may be granted for good cause or upon agreement of the parties.

D. An agreement for settlement may occur at any stage of the proceedings. The provider or the provider's representative shall submit a detailed written report of such settlement to the Board within twenty (20) days of such settlement.

SECTION 19

MEDICAL EXAMINATIONS

A. After a claim for compensation is made under this Act, either party may request that the claimant undergo a medical examination. The Board may authorize and require an examination based on a request by either party, or on the Board's own motion. If an examination is required, the claimant shall submit to the examination by one or more reputable physicians at a reasonable time and place. A report of the examination shall be rendered to the Board within fifteen (15) days. Subsequent examinations may be similarly required and authorized, but the claimant shall not be required to submit to more than two (2) examinations in any one month, except by special order of the director. The claimant, upon request, shall be entitled to have physicians of the claimant's choice participate in such examinations.

B. A claimant so submitting to an examination, and the provider or the provider's insurer, shall be entitled to a copy of the report and shall, upon request, be entitled to receive and shall have delivered to them a copy of the report within fifteen (15) days after such examination. The reports received by the Board or by any party shall be identical.

C. The claimant shall not be required to submit to an examination outside the town or city in which he or she is a resident, until sufficient funds have been furnished to pay for transportation to and from the place of examination. Funds for transportation costs shall be provided at the rate prescribed for compensation of state officers and employees. Additionally a reasonable sum for board and lodging for each day or part thereof the claimant is required

to be away from his or her residence shall be provided.

D. The claimant shall not be liable for any fees or charges of any physician selected under the provisions of this section.

E. Except as otherwise provided, there shall be no disqualification or privilege preventing the furnishing of reports by or the testimony of any physician who actually makes an examination or treats an injured claimant under the coverage of this Act.

F. If the claimant refuses to submit to an examination as herein provided, or if the claimant or his or her physician or surgeon unnecessarily obstructs such an examination, the claimant's right to compensation under this Act shall be suspended until such examination takes place. If a claimant refuses to submit to an examination while any proceedings are pending under this Act, such proceedings shall be dismissed upon a showing of continued refusal.

SECTION 20

PRELIMINARY HEARING, PRELIMINARY MEDICAL COMPENSATION, PRELIMINARY TEMPORARY DISABILITY COMPENSATION

A. An application for preliminary hearing may be filed by either party after a claim against a provider is filed, or such preliminary hearing may be initiated by the Board. A preliminary hearing may be held to expedite or clarify a claim, to determine whether medical treatment was or should be furnished, to provide temporary compensation or rehabilitation benefits, or for any other reason at the discretion of the Board. The Board shall give at least seven days' written notice by mail to the parties of the date and location for the preliminary hearing. Such preliminary hearings shall be informal and shall be held by a Board member or by an administrative law judge in any county designated by the Board or by the administrative law judge. The Board member or administrative law judge shall exercise such powers as are provided for the conduct of full hearings on claims under this Act.

B. The Board member or administrative law judge, upon a preliminary finding that the injury to the claimant is compensable and in accordance with the facts presented at such preliminary hearing, may make a preliminary award of medical compensation and/or may make a preliminary award of partial or total temporary disability compensation. Such medical or personal injury compensation shall be provided pending the conclusion of a full hearing on the claim.

C. The decision in a preliminary hearing shall be rendered within five (5) days of the conclusion of the hearing. No findings or awards from a preliminary hearing shall be appealable by any party, and the same shall not be binding in a full hearing on the claim, but shall be subject to reconsideration.

D. The amount of preliminary compensation paid under this section shall be credited against any other subsequent award for a temporary or permanent personal injury.

E. If compensation has been paid by the provider or the provider's insurance carrier pursuant to a preliminary award entered under this section, and the amount of compensation so awarded is then reduced or totally disallowed upon a full hearing on the claim, the provider and the insurance carrier shall, subject to final appeal, be reimbursed from the Recovery Guarantee Fund established in Section 6 of this Act. Reimbursement shall include all amounts of compensation paid which are in excess of the amounts of compensation that the claimant is entitled to, as determined in the full hearing on the claim and any subsequent appeal. The director shall determine the amount of compensation paid by the provider and the insurance carrier which is to be reimbursed under this subsection, and the director shall certify to the Insurance Commissioner the amount so determined. Upon receipt of such certification, the Commissioner shall cause payment to be made to the provider or to the provider's insurance carrier.

SECTION 21

HEARINGS OF THE BOARD

A. Hearings of the Board shall be informal in nature and not subject to the rules of civil procedure or evidence. Common law doctrines or statutory provisions outside this Act shall not apply as a basis of defense for the health care provider. The health care provider, however, may raise the defenses of intentional injury by the patient or failure of the patient to follow a recommended course of reasonable treatment or self-care.

B. The Board shall give at least seven days' written notice by mail to the parties of the date and location for the hearing. The notice shall include a copy of any preliminary hearing order entered in the matter. The Board shall give the parties reasonable opportunity to be heard and to present evidence, and shall insure an expeditious hearing. The Board shall have the power to administer oaths, certify official acts, issue subpoenas and otherwise compel the attendance of witnesses and the production of documents at hearings as either party may

request. Testimony may be presented to the Board through witnesses called by either the health care provider or the claimant or the claimant's representative. All testimony shall be under oath. On agreement of the parties, evidence may be submitted by transcribed depositions or by depositions made through video recordings. The Board shall cause the hearing to be recorded at the Board's expense. The Board is not required, at its expense, to prepare a transcript, unless required to do so by a provision of law. Any party, at the party's expense and subject to such reasonable conditions as the Board may establish, may cause a person other than the Board to prepare a transcript from the Board's record, or cause additional recordings to be made during the hearing. When both parties have completely submitted their case, the Board shall take the matter under advisement and render a decision within thirty (30) days. A decision by the Board shall be in writing and shall state the grounds for approval, denial, or modification of the claim and the award to be entered.

C. If a Board decision is not entered within thirty (30) days following complete submission by both parties, any party to the action may notify the director that an award is not entered, or the director may proceed on the director's own motion, and the director shall enter an award forthwith based on evidence in the record.

D. Hearings shall be held in a location that can be agreed upon by the Board and the parties. If agreement cannot be so reached, the director shall designate a location not more than one hundred (100) miles from the location where the facts leading to the claim under this Act occurred.

SECTION 22

REVIEW, REHEARING, COURT APPEAL

A. Within ten (10) days after final action by the Board, a party may, in writing, petition the Board for a rehearing. The request for rehearing shall be approved or denied by the director or a designated associate director within ten (10) days after receipt of such written request. A rehearing by the Board shall take place within twenty (20) days of approval. All acts, findings, awards, decisions, rulings or modifications of findings or awards made by the Board shall be subject to review. The filing of a request for review shall not be a prerequisite to an appeal to the district court.

B. The decisions, findings, awards, or rulings of the Board may be appealed by any party to the proceedings to the district court of the county where the claim occurred, upon questions of law and fact as presented and shown by a transcript of the proceeding before the Board. On such appeal, the district court shall have jurisdiction to determine if the Board made a correct finding under the purview of this Act. The district court may grant or deny compensation, or may increase or diminish any award made by the Board.

C. An appeal to the district court may be taken and perfected by filing a written notice of appeal with the Board within twenty (20) days following the date of the Board's final action on the claim. The Board shall forward the appeal to the district court along with the Board's record of the claim. The record shall consist of a certified copy of all documents expressing the Board's actions regarding the claim, other documents identified by the Board as having been considered by it and used as a basis for its action, and any other material required by the court. The court may require or permit subsequent corrections or additions to the record.

D. Such appeal shall have precedence over all other hearings before the court except those of like character, and shall be decided within sixty (60) days after submission.

E. The appealing party shall notify the Board when judgment is issued by the court. If judgment is not issued within sixty (60) days of submission, the appealing party shall notify the Board to that effect. The director shall advise the judge to whom the case was submitted that 60 days have elapsed since submission of the case and request that a decision be rendered. If no decision is forthcoming within thirty (30) days of such request by the director, the director shall advise the supreme court justice having jurisdiction over such judge, regarding the appeal and the failure to render a decision as required by this section.

F. Any party to the proceedings may appeal from any findings or order of the district court to the appellate courts on questions of law. Such appeal shall be perfected within twenty (20) days from the date of the entry of judgment by the district court. The appealing party shall notify the Board when a case has been submitted to the appellate court and when judgment is issued by that court. Appeals pursuant to this Act shall be prosecuted in like manner as other appeals in civil cases, and shall take precedence over other cases except those of a like character.

SECTION 23

MODIFICATION OF AWARDS

A. Any award, either by the Board or through the agreement of the parties, shall be subject to

modification during the period the award is being paid. Modification may be upon agreement of the parties or through an application to the Board. In modification by agreement of the parties, the provider or the provider's representative shall submit a detailed written report of such agreement to the Board within 20 days of such agreement. A lump sum award is not subject to modification under this section.

B. In a case where death results and benefits are being paid to eligible survivors, any party may apply to have the payments reapportioned or to terminate benefits, as the facts may warrant.

C. Where weekly benefits are being paid for a temporary or for a permanent personal injury, the parties may seek a modification of the award. Considerations for modification shall include any change in the physical condition of the claimant, change in the employability status of the claimant, or any other reason as determined by the Board.

D. The Board may dismiss an application for modification if the facts so warrant. The effective date of modification of an award where compensation is being paid for the death of a patient shall be a date fixed by agreement of the parties or determined by the Board following a hearing.

E. A hearing for modification shall be held upon the application of any party. Such hearing shall occur after at least 20 days' notice by registered mail to all parties, and shall provide opportunity for the parties to present all material and relevant evidence.

F. The effective date of modification for a previously entered award for medical or for temporary or permanent personal injury compensation shall be agreed upon by the parties or fixed by the Board, but shall not be earlier than the date the application for modification was filed by either party.

SECTION 24

AWARDS OF COMPENSATION: WHEN DUE, DISALLOWANCE ON APPEAL, REPORTING

A. When the Board awards compensation, at the expiration of twenty (20) days, all past-due compensation awarded to the claimant shall become immediately due. Where an appeal is perfected to the district court, only compensation that is due for the ten (10) weeks next preceding the date of the Board's award shall be payable to the claimant along with any payments due under the award since the date of the award. When the district court enters a decision awarding compensation, all past-due compensation from the date of the occurrence shall be payable to the claimant. The award shall continue to be paid during any appeal to the appellate court.

B. If compensation has been paid during the pendency of an appeal to the district court or to the appellate courts and the amount of compensation awarded by the Board or the district court is reduced or totally disallowed by the decision on the appeal, the provider and the provider's insurance carrier, except as otherwise provided in this Act, shall be reimbursed from the Recovery Guarantee Fund established under Section 6 for all amounts so paid which are in excess of the amount of compensation to which the patient is entitled as determined by the final decision on appeal. The director shall determine the amount of compensation paid by the provider or insurance carrier to be reimbursed under this subsection, and the director shall certify to the Commissioner of Insurance the amount so determined. Upon receipt of such certification, the Commissioner of Insurance shall cause payment to be made to the provider or the insurance carrier in accordance therewith.

C. All awards made by the Board, all settlements and all modifications of awards or settlements, the result of any appeal, or any other outcome, shall be reported by the Board to the Commissioner of Insurance, and shall also be recorded in the database of the Board.

SECTION 25

LUMP-SUM SETTLEMENT OF AWARDS

A. The claimant and the health care provider may enter into an agreement for a lump-sum settlement under this Act. Such a settlement agreement, if reached, must be by consent of both parties and the approval of the Board.

B. The Board, at its discretion, may order a lump-sum award instead of weekly payments when an award is for a total sum of $10,000 or less.

SECTION 26

REHABILITATION

The primary purpose of the Medical Accident Compensation Act shall be to restore to the injured patient the ability to perform work, to earn income, or to otherwise return to activities or potentials comparable to those existing prior to the compensable event. To this end, it is provided as follows:

A. The director shall appoint, subject to the approval of the Secretary of the Department of Human Resources, a specialist in medical, physical, and vocational rehabilitation, who shall be referred to as the rehabilitation administrator.

B. The rehabilitation administrator shall be appointed to a full-time position by the director, with the approval of the Secretary, to be in the classified

service under the state Civil Service Act.

C. The rehabilitation administrator shall: (a) continuously study the problems of physical and vocational rehabilitation; (b) investigate and maintain a directory of rehabilitation facilities, public or private, in this state or in other states; and (c) be fully knowledgeable regarding the eligibility requirements of all state, federal, and other public medical, physical, and vocational rehabilitation facilities and benefits, subject to the requirements set forth in K.S.A. 44-510g and amendments thereto. [Cite appropriate workers' compensation rehabilitation statute.]

D. A claimant otherwise qualifying for benefits under this Act, and not precluded by age or physical condition, shall be entitled to such prompt medical and physical rehabilitation services as may be reasonably necessary to restore to such claimant the ability to perform work, to earn income, or to otherwise return to comparable gainful or satisfactory activities or potentials.

E. The director, upon the director's own motion or upon application of any party, may refer the claimant to a qualified public or private agency or facility for evaluation and for a report of the practicability of, need for, and kind of service, treatment, training or rehabilitation which is or may be necessary and appropriate. The costs of such evaluation and report shall be at the expense of the provider.

F. Within 50 days after such referral, the report shall be submitted to and reviewed by the rehabilitation administrator, copies shall be furnished to each party, and conferences shall be scheduled as necessary. Within 20 days after the initial review of the report, copies of the report, together with the rehabilitation administrator's recommendations and any revisions of or objections to the rehabilitation plan, shall be delivered to each party, to the director, and to the assigned Board member or administrative law judge. Within 10 days after receipt of such report, any party may request a hearing before the director on any matter contained in the report or any such recommendations or revisions.

G. After affording the parties an opportunity to be heard and present evidence, the Board:

(1) may order that any treatment, or medical and physical rehabilitation, or vocational rehabilitation as recommended in the report or as the Board may deem necessary, be provided at the expense of the provider;

(2) may order the provider to pay temporary total or temporary partial personal injury benefits computed as provided in Section 12 during the period of rehabilitation evaluation. Temporary total or temporary partial personal injury benefits paid solely because of involvement in the rehabilitation evaluation process shall not be payable for more than 70 days from the date of the evaluation, except such compensation may be continued by the Board for an additional period of not more than 30 days if circumstances outside the control of the claimant prevent completion of the evaluation or the formulation of the rehabilitation plan;

(3) may direct the claimant to the appropriate federal, state, or other public facility or agency where such services will or may be provided at no cost to the provider, except as otherwise provided in this section, or, upon the request of the provider, to a qualified rehabilitation service program provided directly by the provider; and

(4) may order, if the claimant is not eligible for such state, federal, or other public facility or agency or where such services are not available within a reasonable time, that such services be provided at the expense of the provider by any qualified private agency or facility in this state or contiguous to this state or by a qualified rehabilitation service program provided directly by the provider.

H. Vocational rehabilitation, re-education or training under this section shall be provided at the expense of the provider, and shall not extend for a period of more than 36 weeks, except that in extremely unusual cases, after a hearing and the presentation of evidence, the Board may extend the period for an additional 36 weeks. The provider shall have the right to appeal to the district court any such extension of the initial 36-week period, within the time and in the manner provided in Section 22 of this Act, and any such order shall be stayed until the district court has determined the appeal. There shall be no right of appeal from a judgment of the district court sustaining or overruling any such special order of the director.

I. Where vocational rehabilitation, re-education or training is to be furnished at the expense of the provider under this section, the reasonable costs of board, lodging and travel, not to exceed $3,500 for any 36-week period, shall be paid by the provider, except that in unusual cases, after a hearing and the presentation of evidence, the Board may require that the provider pay an additional amount of not more than $2,000.

J. The provider shall pay temporary total disability compensation during any period of rehabilitation, computed as provided in Section 12 of the Act, but the provider shall receive credit for any weekly, monthly, or other monetary payments made

to the claimant or to the claimant's family by any state, federal, or other public agency, exclusive of any such payments for the board, lodging and travel expenses of the patient. Subject to a maximum 26 weeks, the number of weeks during which temporary total disability is paid during rehabilitation under this section shall not be deducted from the maximum compensation as provided under Section 15 of this Act.

K. If an eligible claimant refuses, without good cause, to undertake the rehabilitation, educational, or training program or refuses to be evaluated under the provisions of this section, and the refusal is not due to the claimant's physical or mental ability to do so, the Board may suspend the payment of any disability compensation until the claimant consents to undertake such program or to be so evaluated. The Board may reduce the personal injury compensation otherwise payable if any such refusal persists for a period in excess of 90 days, except that compensation for permanent personal injury shall not be reduced to less than that payable under Section 13 of this Act.

L. At such a time as any medical, physical, or vocational rehabilitation, re-education or training has been completed under this section, the provider may file an application with the Board seeking modification of any award. Upon at least 20 days' notice by registered mail to all parties, the Board shall set the application for hearing and presentation of evidence. The Board may make an initial award, or modify any existing award, to reflect such personal injury as exists at the conclusion of such rehabilitation. Any new award, or modification of an existing award, shall be subject to the other relevant provisions of this Act.

SECTION 27

PENALTY FOR FAILURE TO PAY COMPENSATION

Where the Board enters an award, compensation shall be payable as set out under this Act. If compensation is not paid as required by the Act following an award by the Board or by judgment of the district court or the appellate courts, the health care provider shall be subject to a penalty as follows:

A. For any week where personal injury compensation is not paid, the claimant shall be entitled to a penalty amount equal to 100% of the weekly compensation that has not been paid. If medical compensation is not paid as required by this Act, the Board may enter a penalty against the health care provider or the provider's insurance carrier in an amount not to exceed $50 a week for each unpaid medical bill.

B. To seek a penalty, a claimant shall file an application for penalty with the Board at any time following a date where compensation is due and not paid. A copy of the application for penalty shall be sent to the health care provider by certified mail. If within ten (10) days, the health care provider does not pay compensation as sought in the application, the Board shall set the matter down for hearing to determine whether a penalty should be assessed.

C. It shall be a defense at any hearing where a penalty is sought that benefits were not due in an amount under the award as claimed and/or the health care provider paid any compensation due within the ten-day period following receipt of the application for penalty.

SECTION 28

JOINT RESPONDENTS

A. More than one individual health care provider may be named as a respondent by the claimant or impleaded as a co-respondent by another health care provider who was previously designated the respondent.

B. When a claim with more than one health care provider as respondents is heard by the Board, the Board may find that the award should be paid by only one of the providers.

C. If the Board determines that more than one health care provider should pay compensation, the Board may apportion compensation as the evidence warrants among the named respondents.

D. The Board, in its discretion, may enter an award jointly against the respondent health care providers so that compensation can be awarded without delay. The Board then may hear evidence and order reimbursement accordingly.

SECTION 29

PAYMENTS NOT ASSIGNABLE

No claim under this Act, or award entered, shall be assignable or subject to levy, execution, attachment, garnishment, or any other remedy or procedure for the recovery or collection of debt, except as provided in Section 33. This exemption cannot be waived.

SECTION 30

DEPOSITIONS

The director or any party to a proceeding before the Board may take the deposition of witnesses residing within or without the state in the manner prescribed by law for like depositions in civil actions in courts of general jurisdiction.

SECTION 31

WITNESS FEES

Each witness who appears before the Board in

response to a subpoena shall receive the same fee and mileage as is provided for witnesses summoned to appear in civil cases in courts of general jurisdiction. The Board shall tax and apportion the costs of such witness fees.

SECTION 32

DESIGNATION OF REPORTERS

The Board shall maintain a list of qualified certified shorthand reporter firms in the state and choose a firm located in the locality of the hearing. The firm so selected shall not be selected again until other firms on the list have been given an opportunity to report the hearings of the Board.

SECTION 33

ATTORNEY FEES

A. No claim of any attorney with respect to any and all proceedings for an initial or original claim for compensation under this Act, whether secured by agreement, order, award, or judgment in any court, shall exceed a reasonable amount for such services or 25% of the amount of compensation paid, whichever is less, in addition to actual expenses incurred, and subject to the other provisions of this section. Except as hereinafter provided, in death cases, total disability, and other personal injury cases, the amount of attorney fees shall not exceed 25% of the sum which would be due under this Act for 415 weeks of permanent total disability based upon the claimant's actual or constructed spendable take-home earnings prior to the compensable event, and subject to the maximum weekly benefits provided in Section 13.

B. All attorney fees relative to the initial or original claim for compensation shall be fixed pursuant to a written contract between the attorney and the claimant or the claimant's dependents, and which shall be filed with the Board and which shall be subject to approval by the Board in accordance with this section. The Board shall review all such contracts and the fees claimed, and shall approve such contracts and fees only if both are in accordance with all provisions of this section. Any claims for attorney fees approved by the Board and not in excess of the limits provided in this section shall be enforceable as a lien on the compensation due or to become due. The Board shall specifically and individually review the reasonableness of each claim of an attorney in each case of settlement or lump-sum payment.

C. No attorney fees shall be charged in respect to compensation for medical benefits or expenses, except where an allowance is made for proposed or future treatment or care as a part of a compromise settlement.

D. No attorney fees shall be charged in connection with any temporary total injury compensation unless the payment of such compensation in the proper amount is refused, or unless such compensation is obtained or reinstated by the efforts of the attorney, whether by agreement, settlement, award, or judgment.

E. Where in any claim there is no dispute as to any of the material issues prior to representation of the claimant or claimants by an attorney, or where the amount to be paid for compensation does not exceed the offer made to the claimant or claimants by the provider prior to representation by an attorney, the fees to any such attorney shall not exceed either the sum of $250 or a reasonable fee for the time actually spent by the attorney, whichever is greater, as determined by the Board, exclusive of reasonable attorney fees for any representation by such attorney in reference to any necessary probate proceedings.

F. All attorney fees for representation of a claimant or the claimant's dependents shall be only recoverable from compensation actually paid to such claimant or dependents, except as specifically provided otherwise in Subsections G and H.

G. In the event that an attorney renders services to a claimant or the claimant's dependents, subsequent to the ultimate disposition of the initial and original claim, and in connection with an application for review or modification, a hearing for vocational rehabilitation, a hearing for additional medical benefits, or otherwise, such attorney shall be entitled to reasonable attorney fees for such services, in addition to attorney fees received or which the attorney is entitled to receive by contract in connection with the original claim. Such attorney fees shall be awarded by the Board on the basis of the reasonable and customary charges in the locality for such services and not on a contingent fee basis. If the services rendered under this subsection by an attorney result in an additional award of compensation, the attorney fees shall be paid from such amounts of compensation. If such services involve no additional award of compensation, the Board shall fix the proper amount of such attorney fees, in accordance with this subsection, and such fees shall be paid by the provider.

H. All disputes regarding attorney fees shall be heard and determined by the Board, after reasonable notice to all interested parties and attorneys.

I. An attorney found to be in violation of any provision of this section after reasonable notice and hearing before the Board, shall be required to make restitution of any excess fees paid.

SECTION 34

BURDEN OF PROOF

The burden of proof shall be on the claimant to establish a compensable claim under this Act. That burden shall be met where the claimant establishes by a preponderance of the evidence presented to the Board that the claim is compensable. Where this Act provides any affirmative defenses for the health care provider, the burden of proof shall be on the health care provider to establish by preponderance of the evidence that the affirmative defenses shall apply.

SECTION 35

GUARANTEE OR ASSURANCE OF RESULTS, CONSENT TO HEALTH CARE, INFORMED CONSENT

Any claim by a patient against a health care provider on the grounds of guarantee or other assurance of results, or for failure to obtain consent or for failure to inform the patient adequately, shall be subject to the following:

A. A written statement or declaration which may be a part of a standardized document, clearly disclaiming a guarantee or other assurance of results, signed by the patient or a representative, and witnessed, shall be a valid disclaimer of such guarantee or other assurance of results.

B. Written statements or declarations which may be included in a standardized form or document, containing subjects detailed below, or other subjects requiring consent, signed by the patient or a representative, and witnessed, shall create presumptions for the purposes stated.

(1) A written statement or declaration designating a specific provider and the provider's assistants, stating that the patient consents to the proposed treatment or procedure and/or that the patient requests that the proposed treatment or procedure be carried out, shall be presumed to be a valid consent for such treatment or procedure.

(2) A written statement or declaration which acknowledges the possible occurrence of unforeseen conditions during the course of an operation which might necessitate an extension of the initial procedure or a different procedure than covered under the original consent, and which authorizes or requests the provider or the provider's designated assistants or consultants to perform such procedure or procedures as are in their judgment necessary and desirable, shall be presumed to be a valid consent for extension of the initial operation or for a different procedure under such circumstances.

(3) A written statement or declaration which permits the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for this service, and which permits such anesthetics without exceptions or with specifically stated exceptions, shall be presumed to be a valid consent for the administration of an anesthetic not excluded.

(4) A written statement or declaration which permits the transfusion of blood and/or its products, and which acknowledges explanation of the risk and benefits of receiving or not receiving such transfusions shall be presumed to be a valid consent and shall create the presumption that the patient was properly informed relative to such transfusions.

(5) A written statement or declaration which authorizes the study and retention or disposal of tissue or parts which may be removed during an operation or procedure, or the use of removed tissue or parts in reconstructive and other procedures on other patients, shall be presumed to be a valid consent for such purposes.

C. A written declaration, properly signed and witnessed, shall create the presumption that the patient was properly informed. This declaration shall acknowledge that the patient has been advised of the following and shall conclude as indicated: (1) the nature of the illness or disorder, (2) the nature and purpose of the proposed treatment or procedure, (3) possible alternative methods of treatment or alternative procedures, (4) the risks and hazards and anticipated outcomes of the recommended and the alternative treatments or procedures, (5) the possibility of failure of the proposed treatment or procedures, (6) the possibility of complications of the proposed treatment or procedures, including the possibility of adverse outcomes such as death or serious bodily harm, and (7) that the patient has no further questions and desires no further information.

D. No recovery shall be allowed against any health care provider on the grounds that health care was rendered without the consent of the patient or that the patient was not properly informed, where,

(1) The action of the health care provider in obtaining the consent of the patient or in informing the patient was in accordance with the standard of care as defined in this Act.

(2) The health care provider reasonably believed that emergency circumstances and implied consent existed, and that the patient's life or health would be jeopardized by attempts to comply with otherwise standard procedures for obtaining consent and for informing the patient.

(3) The health care provider was precluded from complying with otherwise standard procedures for

obtaining consent and for informing the patient by the patient's physical or mental condition, including the presence of critical illness, unconsciousness, or coma.

E. No recovery shall be allowed against any health care provider on the grounds that the patient was not properly informed, where,

(1) The patient had, or reasonably should have had, from the information provided or from other sources, a sufficient understanding of the procedures and risks involved in the proposed treatment or course of health care.

(2) A reasonable person, under all surrounding circumstances, would have undergone such treatment or procedure had he or she been advised by the health care provider as in paragraph 1 above.

(3) The patient stated prior to receiving treatment or health care services that he or she did not wish to be informed or would accept the treatment or medical services regardless of the risk.

(4) The health care provider, after considering all the attendant facts and circumstances, used reasonable discretion as to the manner and extent to which the risks were disclosed, and reasonably believed that additional disclosures could be expected to alarm the patient unduly, and have a substantial adverse effect on the patient's condition.

F. No recovery shall be allowed against any health care provider where a claim is otherwise barred by K.S.A. 65-2891, 65-2891a, 65-2892, or 65-2892a. [Cite applicable state immunity statutes for emergency care and for treatment or examination of minors.] Where any action against a health care provider is allowed by the above statutes, such recovery shall be limited to the recovery allowed a claimant by this Act.

G. Nothing in this section shall be interpreted to authorize non-emergency health care for incompetent patients, except as otherwise provided by law.

SECTION 36

DATABASE: COMPILATION, ANALYSIS, AND PUBLICATION OF STATISTICS

A. The Board shall establish a separate department to design, develop, and maintain a Database, for purposes of monitoring the effectiveness of this Act, quality control, and study of the problems concerned with the prevention, occurrence, and compensation of health care injuries. This department shall compile and publish in-depth and ongoing statistical material and analyses concerning the coverage under this Act, in the form of regular or special reports to governmental agencies under the provisions of this Act, and to other interested entities, as authorized by law or as deemed appropriate by the Board.

B. The Database shall input and process all data relevant to health care injury compensation, including, but not limited to, injuries, claims, patients, providers, insurers, Board actions, expert review panels, settlements, compensation awards, appeals, and quality control. Analysis shall include, but not be limited to, the following: the type of health care injuries resulting in claims under the Act; the segments of the health care industry where injuries or claims originate; the effectiveness of this Act in awarding fair and expeditious compensation; the purposes for which compensation is being paid; potential methods for minimizing health care injuries, including the effectiveness of present or planned preventive measures; the costs of compensation for injury; the relative utilization of the premium dollar for administrative costs, other system costs, and for the payment of benefits.

C. The Database shall regularly obtain and input relevant data available under Title IV or the Omnibus Health Bill, 42 U.S.C. 11101–52 (Health Care Quality Improvement Act of 1986 and amendments thereto) from the Secretary of Health and Human Services, or from the clearinghouse or databank implemented pursuant to this authority.

D. Provider licensing agencies and the Commissioner of Insurance shall regularly and on special request supply relevant data to the Database. The Medical Accident Compensation Board shall determine the data to be required to accomplish the purposes of this section.

E. Providers, insurance carriers, self-insureds, and group self-insureds shall promptly supply the Board with all data the Board shall require. Failure to comply promptly with requests for such data by the Board shall be reported as delinquent to the appropriate provider licensing authority or to the Commissioner of Insurance. Such delinquency shall be subject to a penalty of one hundred dollars ($100) per day, commencing on the day the request is determined to be delinquent by the provider licensing authority or by the Commissioner.

SECTION 37

QUALITY CONTROL

The provision of health care is essential to the well-being of the citizens of this state, as is the maintenance of an acceptable quality of health care. This Act provides for the accomplishment of these goals by combining provisions for a reasonable means to compensate patients for risks related to the delivery of care by licensed health care providers

with an effective mechanism for monitoring the quality of care and minimizing health care injuries, as follows:

A. The Medical Accident Compensation Board shall submit monthly reports and annual summaries of all claims, settlements, decisions, awards, or other information deemed relevant by the Board, to the health care provider licensing or disciplinary authorities of the state, and to the Commissioner of Insurance. Special reports and information from the database shall be provided on request and as deemed appropriate by the Board, to these agencies, or to other interested parties, including, but not limited to, those concerned with risk management, patient safety, quality assurance, or public or professional education.

B. Hospitals and similar health care facilities shall request information from the Database relative to medical staff members every two years and relative to all new staff applications. These institutions may also request information relative to any practitioner with current or prospective affiliation. The Medical Accident Compensation Board, on its own motion, may supply information to health care providers, and may recommend appropriate action.

C. Health care provider licensing or disciplinary authorities shall evaluate and take appropriate action in consideration of this information, to inform, educate, or sanction providers. The Commissioner of Insurance shall evaluate the information and shall determine the desirability of co-insurance, experience rating, changes in underwriting requirements, or other action. These agencies shall submit monthly reports of action taken and other relevant data, including information obtained as a result of provider reporting requirements, to the Medical Accident Compensation Board, for inclusion in the Database.

D. Nothing in this section shall limit any provider licensing, disciplinary, or other agencies of this state in the performance of their duties, including the authority to require a peer review committee to report any disciplinary action or recommendation of such committee; or to transfer records of such committee's proceedings; or actions to restrict or revoke the license, registration, certification or other authorization to practice of a health care provider; or to terminate the liability of a state health care liability insurance fund for all claims against a specific health care provider for damages for death or personal injury pursuant to other state law.

SECTION 38

EFFECTIVE DATE OF THE ACT

The effective date of this Act shall be ——. Where any claim arises against a health care provider that is compensable under this Act after this date, any recovery against the health care provider shall be subject to the provisions of this Act.

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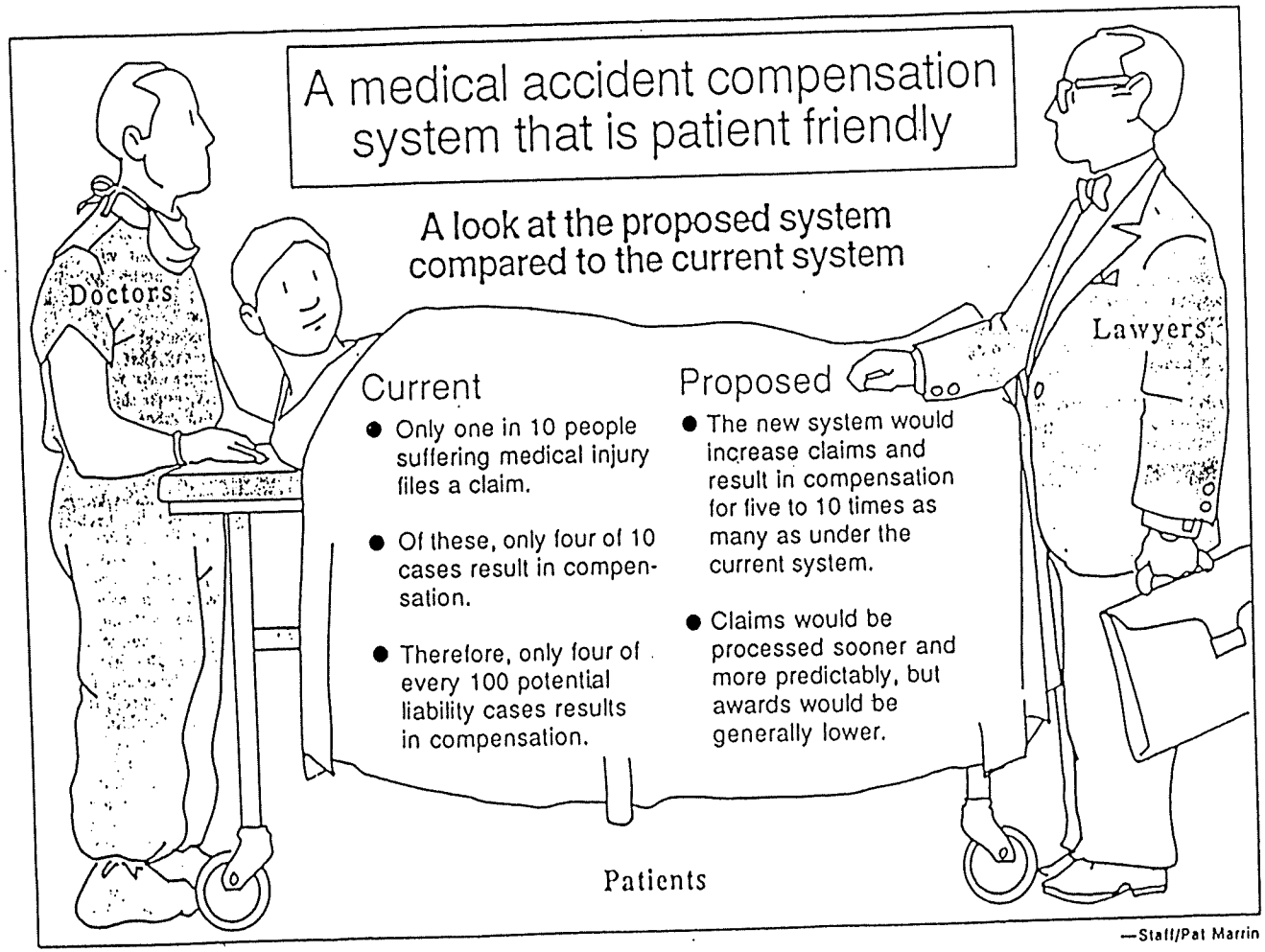
Kansans propose overhaul of malpractice system



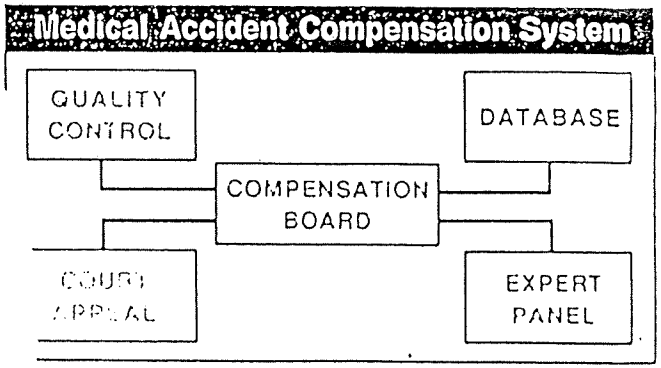
The plan's authors are these doctors and lawyers:

Dr. M. Martin Halley, a Topeka cardiovascular and thoracic surgeon who also has a law degree.

Robert J. Fowks, professor of law emeritus of Washburn University and a specialist in workers' compensation.

David L. Ryan, professor of law at Washburn University and a specialist in constitutional law.

Dr. F. Calvin Bigler, a Garden City surgeon and past president of the Kansas Medical Society.



The heart of the proposed system is a three-member compensation board. An attorney would be its director. The other two members would be a physician and a person who is neither an attorney nor a health-care provider.

Here's a look at the Kansans' plan

The Kansans' proposed medical accident compensation model act is comprised of 38 detailed sections. Here's a brief look at the model:

Framework of the system is a full-time, three-member state medical accident compensation board supported by expert review panels, the state court system, a quality control mechanism and a database section.

Providers must notify the medical accident compensation board of written claims filed against them. Representatives of the patients and providers will attempt to reach agreement over the claim. If agreement isn't reached, the claimant may file a written application with the board for a hearing.

The board, assisted by administrative law judges, hears and decides claims and approves settlements for preliminary or final compensation in the form of medical, rehabilitation, personal injury or death benefits. The board's director is an attorney; the other two members are a physician and a person who is neither an attorney nor a health-care provider.

The expert review panels consist of up to three qualified providers and necessary consultants. They are convened, at the board's discretion, usually in complex cases to help determine the existence and extent of medical injury, the existence of substandard practice and the relationship of such injury to substandard practice.

State district and appellate courts hear and determine appeals from board decisions within the purview of the act. No new evidence can be introduced — the court must make its decision based on the record.

Quality control provisions mandate the reporting of all claims and outcomes, as well as database analyses, to appropriate agencies and institutions for evaluation and action, and require hospitals and other health-care facilities to request information from the database.

The database inputs and processes all data concerning the occurrence, compensation, and prevention of health-care injuries, assists in quality control, and monitors the effectiveness of the law.

The authors say this model answers three major previously unresolved problems of administrative compensation:

- The definition of the medical injury or compensable event is accomplished through individual case review, thus eliminating the necessity for comprehensive schedules. The health-care injury is defined as a temporary or permanent impairment, disability or other adverse outcome caused by substandard health-care practice.
- The cost of an administrative compensation system is a major concern, because indications are that such a system will result in many more compensated injuries. The increased expenses are offset partly by the greater efficiency of the system, as well as by other cost controls, most of them currently used by workers' compensation systems, and frequently proposed as elements of tort reform.

These other cost controls include limitation of total awards, adopting current workers' compensation schedules; reasonable statutes of limitations as are in force in Kansas; payment only for medical care, rehabilitation and economic loss; periodic payments of awards; modification or termination of benefits with changes in a beneficiary's status; offset of other insurance benefits; elimination of joint and several liability, and reasonable structuring of attorney fees.

Actuarial evaluation indicates that provider financing is feasible if cost controls are applied. A wider base of financial support would probably be required if cost controls are omitted, or if a broader definition of injury is contemplated.

- Another major concern is the constitutionality of a medical accident compensation system. This can't be definitely predicted, the authors said.

But it appears that ultimate determination for such a system should be favorable because an adequate quid pro quo is rendered through the trade off of a substantial increase in the number of paid claims and other benefits in return for the restriction of tort rights, they said. That's the case in workers' compensation systems, which are constitutional in every state, the authors said.

New plan applies principles of workers' compensation

By VICKIE GRIFFITH HAWVER

Four Kansans have crafted a new medical malpractice injury compensation model which they hope can cure the ills inflicted by the traditional tort-based malpractice system.

Year after year, the medical malpractice system provides the basis for bloody battles in the Kansas Legislature, and in other legislatures, as doctors and trial lawyers fight over proposed changes to the tort system.

Trial lawyers say they want to protect the rights of medical malpractice victims. Most doctors are rich and can afford malpractice insurance, the lawyers contend.

The doctors counter that the lawyers are out to cash in on big-buck settlements. The cost of malpractice premiums is approaching a crisis, driving doctors out of business and limiting the public's access to health care, the doctors claim.

Lost in the fray, say these four Kansans with a new plan, are the health-care consumers who are injured while undergoing medical treatment.

Only 10 percent of people who have suffered medical injury file claims in the current system, studies have shown, said Topeka cardiovascular and thoracic surgeon M. Martin Halley. Only 40 percent of the filed cases result in compensation for the victim, he said.

That means that only 4 percent of potential liability claims get compensation," said the physician, who also has a law degree.

Halley, two Washburn University School of Law professors and a Garden City surgeon have spent three years devising a plan called a medical accident compensation system. The four will detail that plan in a book they are editing and will publish in the spring.

The Kansans' model applies workers' compensation principles to health-care injuries and eliminates tort terminology such as fault, negligence, damages and jury.

"Adversarial tort proceedings are avoided, and expeditious claim resolution is provided tor an anticipated larger number of health-care injuries than compensated under the present system," the authors write. "The compensable event is clearly defined with the assistance of expert review panels.

"Benefits, based on actual or constructed earnings, are equitably provided for all members of society. A quality control mechanism, integral to the system, is separated from the compensation channels."

Said Halley, "More people would be compensated, but at a lower level. There won't be the big 'lottery' wins from medical malpractice cases, which very few people actually get anyway. But more people would be compensated — and more quickly and predictably."

Halley estimates that five to 10 times more medical injury victims would be compensated under the proposed system.

The current medical malpractice court-based procedure "is a cancer in the system slowly destroying the system," Halley said. "To get rid of it, we need radical therapy ... something better than a Band-Aid."

The proposed system likely won't be marketed to Kansas lawmakers in the 1989 Legislature. The Kansas Medical Society — the doctors' lobbyist group in the state — still has tort reform measures it wants to try to get passed.

Attorneys — specifically those few dozen in the state for whom big malpractice cases are lucrative — also aren't expected to jump on the bandwagon for the plan.

The plan's authors expected as much, given the controversy that surrounds malpractice. They say they're committed to championing a more equitable, consumer-based compensation system. They think their plan eventually will prove to be the answer for Kansas and other states.

Besides Halley, the writers of the plan are:

- Robert J. Fowks, distinguished professor of law emeritus of Washburn University, whose specialty areas include workers' compensation.
- Dr. F. Calvin Bigler, a Garden City surgeon and past president of the Kansas Medical Society, past president of the Kansas Chapter of American College of Surgeons and a current governor-at-large for Kansas for the surgeons college.
- David L. Ryan, distinguished professor of law at Washburn University and a specialist in constitutional law.

About a year ago, the four formed the Midwest Institute for Health Care and Law. It is headquartered in Halley's surgical group-practice offices in the Medical Park/Robert Cotton Building at 901 S.W. Garfield. The institute was formed because of the men's interest in solutions to malpractice problems.

The model act which the four men devised is the result of extensive revision and expansion of a 1985 prototype prepared by the Kansas Medical Society's Professional Liability Committee. The medical society employed Bryce B. Moore, a former director of Kansas Workers' Compensation, to write the prototype.

The book the four will publish is "Medical Malpractice Solutions — Systems and Proposals for Injury Compensation."

In an introduction to the book, the four editors say that medical malpractice claims were rare before the 20th Century, even though such liability existed since ancient times. The incidence of claims swelled by the 1970s, and national attention focused on the problem.

"Nearly two decades later, we do know more about the problem, but opinions still differ widely as to its precise definition, as well as its solution. The problem is admittedly complex and is ultimately societal in scope, since an irreducible minimum of health-care injuries will continue to be an unavoidable hazard to patients — an unfortunate by-product of modern health care," the editors say in their introduction.

The four editors have contributed a section on their plan plus chapters on other topics to the book. Writers from this country and abroad also contributed chapters about medical injury compensation systems.

The purpose of the book is to examine proposals and long-term solutions. The book has five parts:

- The first part looks at the fundamental role of the tort system.
- The second is a historical perspective of the various experiences of tort reform and areas which continue to be a major thrust in state legislatures.
- The third evaluates existing programs and proposals for revision or replacement of the tort system, presented when possible by a major contributor of the original concept.
- The fourth part presents the authors' model medical accident compensation system, which applies workers' compensation principles to health-care injuries and which eliminates tort concepts and tort terminology.
- The book concludes with an evaluation of the constitutionality of compensation systems.

The author-editors cite three options in dealing with the medical malpractice compensation problem:

- Retain the traditional tort system, based on fault, for compensation of injuries and deterrence of substandard conduct.
- Replace the tort system with a compensation system that is pure no-fault at the extreme.
- Or devise a system containing features of both the tort and compensation system — such as the model medical accident compensation system based on workers' compensation principles.

Workers' compensation — an industrial solution to injuries in the workplace — is a system under which the employer provides compensation for on-the-job injuries through insurance. In largely administrative proceedings, the injured worker agrees to accept damages based on fixed formulas, in return for not having to prove that his or her injury was caused by the negligence or fault of the employer.

Under the workers' compensation system, workers trade generally lower — but guaranteed — benefits in return for not having to prove an employer was at fault, the key being that both worker and employer "give up" some rights by mutual agreement.

The editor-authors say their model defines the compensable medical injury as an impairment, disability, or other adverse outcome caused by substandard health-care practice, arising out of the delivery or the failure of delivery of health care to a patient.

"It provides unlimited medical and chronic care benefits, specified rehabilitation benefits, and burial expenses. Personal injury and death benefits are based on the patient's actual or constructed earnings, which are limited by the state's average weekly wage and subject to maximum coverage as provided in present workers' compensation statutes," Halley said.

"The model is flexible, in that individual provisions can be changed if desired or for actuarial reasons. Although based on Kansas law, the system is adaptable to other jurisdictions by appropriate changes."

The model is better than what exists, the authors say, because it is consumer-oriented, emphasizes reduction of health-care injuries through effective methods of quality assurance and provides predictable, prompt and reasonable compensation for injury. It will stabilize insurance premiums through more predictable settlements and awards.

The editor-authors say their model is actuarially sound. Two Washburn finance professors — W. Gary Baker, Ph.D., and James R. Eck, Ph.D. — contributed a chapter to the book on the model's cost picture.

"Tort law approaches to the medical malpractice problem have not resulted in a permanent solution due to the inherent disadvantages of the fault approach," the authors write.

"Legislation of tort reforms to date has provided only short-term relief, has been accompanied by increasing disciplinary and regulatory measures for providers which have no direct impact upon the core of this problem, and has principally resulted in the availability of insurance to pay the constantly increasing awards and settlements in an expensive system.

"Moreover, tort reforms are generally consumer-hostile, since they make recovery for injury more difficult in addition to restricting the amount of compensation finally obtained."

Part of the reason that so few injured people file medical malpractice claims today is that malpractice lawyers carefully screen potential clients for only those with potentially winable cases, the authors said.

A major study in this field showed that about 5 percent of hospital admissions result in injury to patients, Halley said. One-fifth of that 5 percent is due to substandard care; the rest is due to circumstances not involving potential liability.

It's those patients injured due to bad care who would benefit in the authors' system without having to plead their case first to lawyers, then, if accepted, to a jury. A pure no-fault system, where all 5 percent would be compensated, couldn't be financed, the authors said.

Most lawyers — not just the few dozen in Kansas today who are regarded as malpractice specialists by their peers — would be able to handle claims under the proposed system, just as most lawyers can handle workers' compensation cases, the authors said. Lawyers would get 25 percent contingency fees, as opposed to 50 percent for malpractice cases.

Malpractice victims who win big awards in today's system sometimes continue to be victims, said law professor Fowks. If the victim needs ongoing, expensive care after using up his or her share of the award, the victim may end up on welfare. The proposed system would care for an injured patient as long as necessary.

"We're excited about this model," Halley said. "It has taken us years to get it into print. We think it's a good product. We think this is the solution for the future."

Groups skeptical about plan

By VICKIE GRIFFITH HAWVER
Capital-Journal health writer

Lobbyists for doctors and lawyers don't often agree when it comes to medical malpractice issues. But the two factions share reservations about the medical accident compensation model created by four Kansans.

The president of the Kansas Trial Lawyers Association finds many faults with the proposed system. And the director of public affairs for the Kansas Medical Society is skeptical about some aspects of the plan. Both men have doubts about the constitutionality of the plan.

The medical society considers tort reform a better route than the proposed new system, said Chip Wheelen, KMS director of public affairs.

"This is an unknown system, that has never been genuinely tried," he said. "It's advertised as being like a workers' compensation system, but it's not really.

"The fundamental difference between an administrative malpractice system versus workers' comp is that (in workers' compensation) you don't have to prove anybody was negligent.

"I don't think Kansas physicians nor physicians anywhere in the United States would cave in to be responsible where they are not negligent. In the majority of (malpractice) cases in Kansas, the physicians are not found negligent" but in those cases where they are found at fault, awards to victims often are high.

"Workers' compensation is constitutionally acceptable primarily because the injured workers do not have to prove negligence — that's the so-called quid pro quo. In a model where you require negligence to be proven, where is quid pro quo? We have to raise the question of is this constitutional?

"I admire the work of Dr. Halley and the others.

"If the Kansas Legislature is not willing to give voters the chance to amend the constitution for (certain) tort reforms, then we'll probably ask for it to be amended like Dr. Halley's model. It's probably the best alternative to tort reform available."

Wheelen said that about a year ago, the American Medical Association concluded a similar model using workers' compensation principles. He attended an AMA meeting where that proposal was discussed.

"One comment heard most often was that this particular type of a model, an alternative compensation system, is for those states where they have not been able to effectively implement any kind of tort reform," he said.

The medical society recently published the proposed plan in its journal, Kansas Medicine, so that doctors could read the Kansans' proposal.

Topekan Gary D. McCallister, the trial lawyers' president, found three major problems with the model, plus he has other questions about details contained within the act's 38 sections.

The most serious problem, McCallister believes, is that the system sounds unconstitutional.

"My initial reaction is that it has some constitutional problems," McCallister said. "There primarily doesn't seem to be a bargain for exchange, the quid pro quo (equal exchange of rights for benefits) that the workers' compensation laws have.

"It only says there will be an increase in the number of compensable events, totally in exchange for their (the victims') rights."

McCallister thinks the model incorporates many tort reform measures that haven't been passed by state legislatures, "not the least of which is the elimination of the right to jury trial."

He thinks the plan places harsh limitations on such awards as compensation to dependents in wrongful death caused by malpractice and compensation for disability. He also finds unfair the plan's rule that compensation to the dependents of dead malpractice victims would take into consideration the victims' own life insurance coverage.

McCallister also thinks the plan unfairly restricts expert testimony, and that it limits the evidence available to review panels.

"This is not an alternative that provides a fair trade, an equal trade," McCallister said. "It's asking victims to give up many things. It's very one-sided.

"This is unconstitutional, in my view, because you still have to prove fault. You have to prove a standard of care, a departure from it, causation and the nature and extent of injury. That is precisely what we have to prove today (in the current system), only this would be to doctors (on the expert review panel), not to a jury of your peers.

"They're trying to create a hybrid workers' compensation system, but they've missed the mark in my view, because of the requirement of proof. This is a fault-based system."

The other two major problems with the plan, McCallister thinks, is that it doesn't help lessen the incidence of actual negligent care (malpractice) and it won't create more affordable and available malpractice insurance for health-care providers.

"This is not an alternative that provides a fair trade, an equal trade. It's asking victims to give up many things. It's very one-sided."

—Gary D. McCallister

TESTIMONY BY

DICK BROCK
ADMINISTRATIVE ASSISTANT
KANSAS INSURANCE DEPARTMENT

BEFORE THE

HOUSE INSURANCE COMMITTEE

HOUSE BILL NO. 2181

FEBRUARY 15, 1989

House Bill No. 2181 recommends that the statutory "sunset" provisions relating to the Health Care Provider Insurance Availability Plan (HCPIAP) be deleted. The law now in effect would result in the termination of the HCPIAP, the plan that makes medical malpractice insurance available, as of July 1, this year (1989). As a result, many health care providers will be unable to procure necessary professional liability protection unless the authority underlying the HCPIAP is continued.

As an alternative, the legislature may, of course, simply extend the date of termination to some future year. This is the procedure that has been followed in the past but, as the report of the 1988 Special Committee on Commercial and Financial Institutions suggests, the medical malpractice situation is not one that will be ignored if some statutory reminder is not present. In addition, the legislature established the authority for the HCPIAP in the first place and the legislature can remove such authority at any time. Thus, a statutory date certain does not appear to be necessary.

I, of course, realize there are a number of legislative decisions yet to be made regarding the medical malpractice situation and the disposition of this bill may depend on the action taken on other proposals. This bill should, however, be a part of that agenda as the availability plan does play a prominent role.

TESTIMONY BY

DICK BROCK
ADMINISTRATIVE ASSISTANT
KANSAS INSURANCE DEPARTMENT

BEFORE THE

HOUSE INSURANCE COMMITTEE

HOUSE BILL NO. 2381

FEBRUARY 15, 1989

House Bill No. 2381 is a proposal that was developed through a cooperative effort of the Kansas Department on Aging, the Department of Social and Rehabilitation Services, the Department of Health and Environment, the Kansas Association of Homes for the Aging, the American Association of Retired Persons, a representative of a private continuing care facility and the Insurance Department. While the bill does not involve insurance, the legislation enacted in 1986 made the Insurance Department the repository of the disclosure statements and annual audits required of providers of continuing care as defined in that legislation. As a result of some problems revealed by a change of ownership of a facility providing continuing care, the increase in the number of continuing care facilities and general concerns of organizations such as the AARP, the Insurance Department served as the facilitator of the meetings that resulted in the bill now before you.

As a result, I don't pretend to be knowledgeable about continuing care agreements or facilities. I can, however, explain the changes and/or the basic reason for the changes provided by House Bill No. 2381 and the 1986 legislation.

First, the definition of continuing-care contract has been expanded to include different forms of payment that are utilized by some of the homes the legislation is intended to reach as well as to recognize that some continuing care agreements are on a month-to-month or some other base of time of less than the one year minimum period defined by current law. In addition, the revised definition establishes a basis for voluntary adherence to the requirements of the law by homes that would otherwise not be subject to its provisions.

The change in the definition of the entrance fee is necessary to be compatible with the expanded payment arrangements that are now recognized in the definition of continuing-care contract.

The definition of "home", "provider" and "resident" are unchanged from existing law.

The definition of "commissioner" has been added because the term appears more frequently in House Bill No. 2381 and, as will become evident, the Commissioner is delegated more responsibilities and authority under the proposed legislation. In this regard, we want to emphasize that the Commissioner is not seeking additional responsibilities or authority and we did not seek to become the repository of the information now required to be filed with the Department. Thus, if there is a more appropriate agency to perform the duties required, the Department will certainly not oppose an amendment.

Section 2 of the proposed bill is a key ingredient in House Bill No. 2381 in that it addresses some deficiencies in the disclosure requirements of the current law. First, rather than permit each home to devise its own disclosure statement, House Bill No. 2381 requires providers to use a disclosure statement prescribed by the Commissioner. Second, the proposed law makes it clear that current residents are entitled to a copy of the annual disclosure statement upon request. Third, the information required to be disclosed is expanded to include certain estimates and information that must be provided if the home has not commenced operations; a statement as to whether the manager or any director or official of the home has been convicted of certain crimes or had any licenses or permits revoked; a statement as to operational experience; and, a specification of the provider's fiscal year to avoid evasion of the annual filing and audit requirements by changes in the fiscal year.

Section 3 requires a filing of the annual disclosure statement and continuing care agreement by December 31 of each year. Under the existing law, there is no specified time for the filing of the disclosure statement so it is not known for twelve months whether the provider is due to file or not.

Section 4 is a significant new provision which requires continuing care agreements to be filed with the Commissioner and prescribes certain items the agreements must contain or have attached.

Section 5 is also new in that it requires providers covered by the law to register with the Commissioner. Under the current law there is no way to determine who is supposed to comply with the disclosure and audit requirements and nothing that can be done if a particular provider is supposed to but doesn't. The registration mechanism combined with the penalties authorized under section 6 should correct this deficiency. Also, as mentioned earlier, providers not required to comply with the law may do so voluntarily by applying for a certificate of registration and complying with the requirements.

Section 7 is, I believe, self-explanatory but I do want to note that a specific statutory provision specifying the obligation of new owners of a home covered by the law will correct a practical problem actually encountered under the current statute.

Section 8 is also new but is necessary in view of the enlarged responsibilities of the Commissioner that are required by the proposed bill.

Finally, Section 9 repeals the current law rather than amend and repeal it only because of convenience in drafting the legislative proposal. If this is inappropriate or presents some kind of problem for the revisor, the results anticipated by enactment of the bill will not be affected if the format of its presentation is changed.

I will be happy to respond to questions but there are other conferees that are better versed in the technicalities of continuing-care agreements and facilities than I. Thus, on technical questions I will defer to their knowledge and expertise.

AARP

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T E S T I M O N Y

SUPPORTING CONTINUING CARE PROVIDER REGISTRATION & DISCLOSURE

February 14, 1989

Chairman Sprague and Committee Members:

The State Legislative Committee (SLC) appreciates the opportunity to support the need for legislation to replace K.S.A. 16-1101 to 1105 inclusive; this was HB No. 2251 adopted in 1986.

The originally proposed bill was comprehensive and representative of a model act. The legislation that was adopted however was just a fraction of the proposed bill and has provided practically no protection or benefits for current or prospective occupants of such facilities.

Unfortunately, residents of Clearview City (the old Sunflower Ordinance quarters near Desota) became the pawns last summer of a Texas development group that has since gone bankrupt, but not before creating a traumatic situation for some 240 resident.

The proposed legislation was recommended by an ad hoc committee appointed by Commissioner Fletcher Bell in an effort to find answers to the inadequacies of the existing statute. The ad hoc committee was represented by AARP's SLC, the Kansas Association of Homes for the Aging, the Kansas Departments on Aging, the Department of Health and Environment, the Kansas Department of Social and Rehabilitation Services and Branden-Woods retirement community in Lawrence, Kansas.

As with most such matters the recommendations proposed to Commissioner Bell are a compromise but one which it is felt will be a big improvement and one deserving of a favorable recommendation by your committee.

It should be pointed out that continuing care type operations constitute one of Americas fast growing industries. Numerous new facilities are being constructed in Kansas. By first hand knowledge, for example, in the Johnson County area one such facility is a $25 million operation for 135 residential units featuring a 40-bed health care center where residents will pay a reported entrance fee with a range from $100,000 to $275,000 plus a monthly service fee from $800 to $2,200. Such investments are deserving of protection as are those involving much lesser sums.

Persons who are or plan retiring and entering into contracts or agreements for continuing care residency are members of the faster growing segments of our population. Many are availing themselves to home-equity arrangements and/or are using lifetime savings to provide for their later years. These are people who are least able to undergo traumatic situations such as those that were forced upon the residents of Clearview City last year. The proposed legislation will fill the following voids in the current statute:

If the operation of the facility has not yet commended, there will be a statement of the anticipated source and application of the funds used or to be used in the purchase or construction of the facility, including:

1. an estimate of costs of financing, legal, land, marketing and similar costs a provider expects or becomes obligated for prior to commencement of operations;

2. a description of any mortgage loan or other financing and anticipated terms and costs thereof;

3. an estimate of the total entrance fee;

4. an estimate of funds that may be anticipated to be needed to fund start-up losses and provide reserves to assure full performance of the contract;

5. a statement relative to the manager, any official, director, corporation or entity having been convicted of a crime or been a party of any civil action claiming fraud, embezzelement or fraudulent conversion or misappropriation of property against such person and any judgment has resulted in any state or federal license or permit being revoked;

6. a statement of the years of experience of the provider and the manager in operating such facility;

7. a requirement for the provider to furnish the Commissioner of Insurance a copy of the current agreement form;

8. a description of all fees and or charges, all services to be provided or committed to as well as a description of any services requiring extra charges and any periodic charges;

9. the listing of terms under which the agreement may be canceled by either party and under which any or all of the entrance fee would be refunded, less value of services received;

10. a statement of health and financial conditions required for acceptance and any changes in these conditions of residents;

11. a statement as to whether a facility is a Medicare/Medicaid provider and

12. such provider shall hold a certificate of registration as a continuing care provider issued by the Commissioner, including required fees. This particular section of the proposed legislation fills a critical void in the current statute.

In addition the proposed bill provides for more meaningful penalty provisions, including provisions for revocation of the certificate and provisions covering changes in ownership and finally provisions for the Commissioner to promulgate rules and regulations necessary to carry out the provisions of the act.

As of the time of preparation of this testimony the only known estimate of cost to implement the act was one prepared for the originally proposed bill and dated March 12, 1985. The total estimated expense then was $88,584. Since the original bill was so comprehensive it would be my estimate that the proposed new act would require a considerably lower fiscal note.

KAHA

KANSAS ASSOCIATION OF HOMES FOR THE AGING

February 15, 1989

Representative Dale Sprague
Chairman House Insurance Committee
Room 330 North
Statehouse
Topeka, Kansas 66612

Re: House Bill No. 2381 - An act concerning continuing care contracts.

Dear Representative Sprague:

Our association represents 120 private not-for-profit retirement and adult care homes of Kansas. We have several members who utilize continuing care contracts.

We respectfully request the committee to amend the bill to read the following way:

line 111-line 115
A provider shall file with the insurance commissioner within four months of completion of the fiscal year of the corporation, an annual disclosure statement, the continuing care contract referred to in section 4 and an annual audit certified by a certified public accountant.

The purpose of this amendment is to combine the filing times of audit and disclosure statements and to extend the filing time for one month from three to four months. This will provide a little more time for the provider to have their audit completed and meet the deadline of the law.

Other than this item, we find no further objections to the bill.

Our members have a long tradition of quality care and operate in a fiscally responsible manner. Hopefully, the provisions of this bill will prevent unscrupulous operators from entering the market and provide consumers with more than adequate protection of their rights.

Thank you and I am available for questions.

Sincerely yours,

John R. Grace
President/CEO

cc House Insurance Committee

STATE OF KANSAS ATTACHMENT 8

DEPARTMENT ON AGING
Docking State Office Building, 122-S
915 S.W. Harrison
Topeka, Kansas 66612-1500
(913) 296-4986

Mike Hayden
Governor

Esther Valladolid Wolf
Secretary of Aging

TESTIMONY FOR THE HOUSE INSURANCE COMMITTEE ON HB 2381 FEBRUARY 16, 1989

The Kansas Department on Aging (KDOA) supports HB 2381 which strengthens current law by requiring certain providers of continuing care services to register with the Insurance Department and disclose additional financial and related information to current and prospective residents of continuing care facilities. This bill is the consensus product of a task force convened by the Insurance Department which included both public and private sector representatives.

While it falls short of some of the provisions contained in the American Association of Homes for the Aging model bill, HB 2381 does represent a significant improvement over current law. Currently 29 states have enacted legislation in this area. The need for strong legislation is readily apparent. Serious problems have occurred in Kansas with the Clearview City facility. John Knox Village in Kansas City has also had financial problems. A national study of 109 Continuing Care Retirement Communities in 1988 found that 44 (40%) had a negative net income or a negative net worth profile. An additional 20 had both net income and net worth deficits.

H.B. 2381 will enable consumers of continuing care services to make better quality decisions about investing what is often a significant portion of their life savings. It may also help deter financially vulnerable facilities from entering the Kansas market.

This bill does not impose onerous reporting requirements. Facilities that require a transfer of assets or an entrance fee that is less than $5,000 are exempt from the provisions of HB 2381. The information required to be provided by this bill should be readily accessible by providers. It is interesting to note that a task force member who represents a facility that would not fall under this bill has expressed an interest in voluntarily complying with the requirements of this bill; hence the provisions in lines 29-31 of this bill.

KDOA supports this bill as an improvement to our consumer protection laws and urges its favorable consideration by this committee.

GAD:mj
6.2119

Attachment 8