Approved 4-27-89
Date

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY.

The meeting was called to order by Senator Wint Winter, Jr. at
Chairperson

10:00 a.m./~~p.m.~~ on March 20, 1989 in room 514-S of the Capitol.

All members were present ~~except~~: Senators Winter, Yost, Moran, Bond, Feleciano, Gaines, D. Kerr, Martin, Morris, Oleen, Parrish, Petty and Rock.

Committee staff present:

Mike Heim, Legislative Research Department
Jerry Donaldson, Legislative Research Department
Gordon Self, Revisor of Statutes
Jane Tharp, Committee Secretary

Conferees appearing before the committee:

Jerry Slaughter, Kansas Medical Society
Tom Bell, Kansas Hospital Association
William Rein, Kansas Department of Health and Environment
Ron Smith, Kansas Bar Association
Anne P. Garlinghouse, Kansas Trial Lawyers

Senate Bill 174 - Health Care Stabilization Fund; liability.
Senate Bill 223 - Medical Malpractice Liability Act; Health Care Stabilization Fund.
Senate Bill 225 - Civil procedures; limitations of actions.
Senate Bill 285 - Medical malpractice screening panels.
Senate Bill 364 - Medical malpractice liability actions; pretrial screening panels.
House Bill 2113 - Discovery of risk management records.
House Bill 2181 - Eliminating sunset for joint underwriting for medical malpractice insurance.
House Bill 2501 - Medical malpractice claims; phase out of health care stabilization fund.

The chairman stated it is our job as the committee to consider all testimony on the fact and not on the emotional issue. The testimony we hear this morning will be proponents of the bills.

Jerry Slaughter, Kansas Medical Soceity, testified the medical society appreciates this opportunity to offer comments on a number of questions and issues pertaining to medical malpractice liability. Most important perhaps, is the question of how to continue operating the Health Care Stabilization Fund during a very important phase-out period. It is essential to members of the medical profession that the phase-out of the Health care Stabilization Fund be accomplished in an orderly and responsible manner. A copy of his testimony is attached (See Attachment I). During discussion, a committee member commented "tail" coverage is insurance coverage that arises after retirement or move to another state. Mr. Slaughter replied it creates an inequitable situation. We feel it is unfair to physicians who have to pay "tail" coverage all the time. Another committee member inquired we are the only state that has this type of situation of "tail" coverage, where in any other state is it different? Mr. Slaughter replied Kansas is the only state that requires they have insurance. "Tail" coverage has been funded by the physicians. We have told them there is a cost in getting out of the fund.

Mr. Slaughter stated they do support Senate Bill 225 which establishes a uniform statute of limitations for all actions. He stated we also wish to express our support of the provisions of House Bill 2181 which extends the operation of the Health Care Providers Insurance Availability Plan. The Kansas Medical Society also wishes to express its support of the provisions of House Bill 2113 as amended by House Committee. A copy of his testimony is attached (See Attachment I).

Tom Bell, Kansas Hospital Association, testified the confidentiality provisions of House Bill 2113 are consistent with previous legislative enactments and represent a continuation of established legislative policy. A copy of his testimony is attached (See Attachment II).

William Rein, Kansas Department of Health and Environment, testified KDHE strongly supports passage of House Bill 2113. This legislation is important in further protecting the confidentiality of records obtained by state licensing agencies responsible for overseeing implementation of risk management programs in licensed medical care facilities and private psychiatric hospitals. Unless confidentiality is protected to the greatest possible extent, participation of individual health care providers and medical care facility employees cannot be fully attained. He pointed out a technical problem on page 2 in line 46 of the bill and explained the proposed amendment concerning clarifying KDHE's authority to review hospital records. A copy of his testimony is attached (See Attachment III).

Anne P. Garlinghouse, Kansas Trial Lawyers, appeared in support of Senate Bill 285. She testified the necessity for including the deposition is to provide the panel with the maximum amount of information available to enable them to make an intelligent decision about what occurred in the care and treatment of a patient. In response to a question, Ms. Garlinghouse replied I have never heard of screening panel going less than a year and some go as long as three years. She has served on one. She said there is a massive amount of records that doctors have to prepare. It takes a lot of time. The screening panel sticks to what the statute says on the information they need to consider. A copy of her testimony is attached (See Attachment IV).

Ron Smith, Kansas Bar Association, testified this legislation is a result of the KBA's Kansas Plan announced earlier this session. It attempts to find logical statutory solutions to the problems physicians face regarding high premiums, especially in rural Kansas. A copy of his testimony is attached (See Attachment V).

The meeting adjourned.

A copy of testimony from the Kansas Association of Osteopathic Medicine is attached (See Attachment VI).

A copy of testimony on Senate Bill 174 from Senator Parrish is attached (See Attachment VII).

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

GUEST LIST

COMMITTEE: SENATE JUDICIARY COMMITTEE DATE: 3-20-89

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Bill Rein	Topeka	KDHE
Virginia Hutson	"	"
~~Robert Mead~~ Robert Mealy	" "	Spkr Pro Tem Ofc.
Pam Scott	Topeka	Ks Ins Dept
Matt Truell	Topeka	AP
L M Cornish	"	Ks Assn P/C
Deborah [illegible]	"	KDA
[illegible]	"	"
Harold Andersen	Lindsborg	
Chester Peterson	Lindsborg	visitor
Nancy [illegible]	Salina	visitor
[illegible]	Topeka	[illegible]
Mr & Mrs D E Valentine	Wellington	
Lorene Valentine	Wichita	St. Frances
Chip Wheelen	Topeka	Ks Medical Soc.
R G Frey	"	KTLA
Tom Bell	"	KHA
Roland Smith	Wichita	WIBA
[illegible]	Topeka	WIBA
[illegible]	"	KS Ins Assoc
[illegible]	Topeka	Court Reporter
Paula [illegible]	Lawrence	Antoin
Kathleen Vonachen	Topeka	D. of Budget
Harold E. Riehm	Topeka	KAOM
Whitney Damron	Topeka	Mill. Assoc

Attachment VIII
Senate Judiciary Comm
3-20-89

GUEST LIST

COMMITTEE: SENATE JUDICIARY COMMITTEE DATE: _____

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
C. + McConnell	Topeka	UPI
J. S. Chaney MD	Wichita	Self
Paul Shelby	Topeka	DOA

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612 • (913) 235-2383
Kansas WATS 800-332-0156 FAX 913-235-5114

March 20, 1989

TO: Senate Judiciary Committee

FROM: Kansas Medical Society

SUBJECT: Medical Liability Issues

The Kansas Medical Society appreciates this opportunity to offer comments on a number of questions and issues pertaining to medical malpractice liability. Most important perhaps, is the question of how to continue operating the Health Care Stabilization Fund during a very important phase-out period. It is essential to members of the medical profession that the phase-out of the Health Care Stabilization Fund be accomplished in an orderly and responsible manner.

Background

As long ago as 1975, an interim committee of the Kansas Legislature recommended creation of the Health Care Stabilization Fund in order to address problems of availability and affordability. One of the many recommendations made by that committee was to limit the liability of the Health Care Stabilization Fund to $1 million per occurrence and $3 million annual aggregate for each health care provider required to purchase the excess insurance provided by way of the Health Care Stabilization Fund. For whatever reason, the 1976 Legislature did not adopt the interim committee's recommendation to enact coverage limits when they created the Health Care Stabilization Fund. During that same period of time, the Legislature chose to limit the amount of revenue that could be collected by the Insurance Commissioner for purposes of financing the Fund's liabilities. Apparently, the 1976 Legislature believed that because medical malpractice claims never amounted to a great deal of money at that time, that it would not be necessary to impose limits on the Fund's exposure to liability. Eight years later, in 1984, the Legislature realized that it was necessary to operate the Health Care Stabilization Fund on an accrual basis, rather than a purely cash flow operation. It was only then that the Legislature began to impose limits on the Fund's exposure to liability. The limits established at that time were $3 million per occurrence and $6 million annual aggregate.

In 1986 the Kansas Legislature, in addition to enacting a series of very important medical malpractice tort reform measures, imposed as well a $1 million limitation on the per occurrence liability of the Health Care Stabilization Fund. Two years later, during the 1988 Legislative Session, a bill was passed by both the House and the Senate which would have allowed health care providers to exercise the ability to make choices of excess coverage limits under the Health Care Stabilization Fund. This was entirely separate from any consideration to reduce the Fund's exposure to liability. The purpose, of course, was to grant health care providers more management

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decisionmaking prerogative than they otherwise had. As so often happens during the legislative process, that particular bill was not, in the final analysis, enacted because of differences that could not be resolved in conference committee.

On June 3, 1988, the Kansas Supreme Court reverted the Health Care Stabilization Fund's liability from $1 million per occurrence to $3 million per occurrence based on the idea that the Legislature would not have reduced the Fund's exposure to liability had it not been for the tort reform legislation that was passed during the same session of the Legislature. This resulted in a major increase in the Health Care Stabilization Fund surcharge, because it had a two year retroactive effect, as well as tripling the Fund's liability. A short while later, the Legislative Coordinating Council assigned an interim study of the Health Care Stabilization Fund phase-out concept to the special interim Committee on Commercial and Financial Institutions. Attached to this statement is a more detailed explanation pertaining to the background of the Health Care Stabilization Fund.

Optional Coverage Limits

As was mentioned before, the question of whether health care providers should be able to purchase optional levels of excess insurance coverage is really separate from the question of whether the Health Care Stabilization Fund should be terminated or phased-out. Many physicians believe that they truly need the $3 million of excess insurance coverage provided by the Health Care Stabilization Fund. By contrast, the majority of our members believe that $1 million per occurrence or less medical malpractice insurance coverage is adequate for their purposes. In fact, our surveys indicate that there are significant numbers of physicians who would purchase as little as $500,000 worth or $300,000 of insurance coverage. It is a very small minority of physicians who indicate that they would actually go bare, that is, without insurance coverage whatsoever.

We must point out, however, that in those states where there is no legal requirement that health care providers carry a minimum amount of medical malpractice insurance coverage, for practical purposes there is an informal system that accomplishes the same purpose. Most insurers of hospitals tend to insist that the hospital medical staff bylaws require that each physician practicing at that institution carry a minimum amount of liability coverage. This is something that we believe is a very important consideration. In many other states, physicians must carry at least $500,000 coverage and oftentimes as much as $1 million coverage in order to practice at a hospital and, of course, you know that hospitals and physicians are quite interdependent.

Both SB 223 and HB 2501 provide for optional limits of coverage under the Health Care Stabilization Fund. There are, however, a couple of important differences between the two bills. Senate Bill 223 would allow for a fourth option in addition to the three levels contained in HB 2501. Furthermore, SB 223 allows the health care provider to annually elect the option of his or her

choice for purposes of excess insurance coverage. By contrast, HB 2501 would require an irrevocable selection of coverage option for the period beginning July 1, 1989 and for the duration through June 30, 1994. We believe that it is important to allow health care providers to make annual elections in order to fully exercise the freedom of choice that is the basis for this concept in the first place. The decision as to how much insurance coverage is adequate should be based not only upon the nature of the medical practice but also cost considerations and the need to budget accordingly. Therefore, we would respectfully request that you amend HB 2501 to allow for the annual election of excess coverage (amendment enclosed).

Phase-out of the Fund

We wish to reiterate that the question of whether the Health Care Stabilization Fund should be terminated at some point in time is not necessarily related to whether health care providers should be able to select optional levels of coverage. The concept of a phase-out is based upon the theory that it is not proper for a governmental entity to administer an insurance program that should be a function of the private sector. But it is very important that we remember the reason that the Health Care Stabilization Fund was created in the first place. During the early 70s, not only was medical malpractice insurance expensive, but for some medical specialties, it was literally unavailable. The Health Care Stabilization Fund was created to address the availability problem. Obviously, we do not want to recreate the situation that made it so difficult for Kansas physicians to obtain adequate coverage. We are, however, optimistic that medical malpractice insurance coverage will be available in the future and want to express our gratitude to the Kansas Legislature for passing a law that allows associations of health care providers to form mutual insurance companies for the purposes of assuring availability of coverage.

There is one consideration pertaining to the phase-out process that is extremely important and that is, that we do so in the most efficient possible manner. There is a distinction between SB 223 and HB 2501 that would assist in accommodating an efficient phase-out of the Fund. This, of course, is the graduated scale of contingency fees that may be collected by plaintiff's counsel upon being awarded a payment from the Health Care Stabilization Fund. We believe that during the short period of time that the Fund would be phased-out, that these limitations on contingency fees could add an important ingredient for efficiency. For this reason, we recommend that you amend HB 2501 by inserting the contingency fee limits provision found in SB 223.

"Tail" Coverage

As you are probably aware, issues relating to tail coverage were the most controversial during the House committee and floor debates. There were numerous comments to the effect that health care providers are given "free" tail coverage by the state of Kansas. The important point to be made is that every year the percentage surcharge which is multiplied times the basic

premium for purposes of financing the cost of Fund coverage, includes a significant number of percentage points that are incorporated in the surcharge for purposes of financing tail coverage. Furthermore, the tail coverage provided by way of the Health Care Stabilization Fund applies only for the period of time during which the health care provider practiced in the State of Kansas. Therefore, the tail coverage is indeed paid for. It is important to note that the actuary has assumed that only six or perhaps seven percent of Kansas health care providers would become inactive in any one year. When you terminate the Health Care Stabilization Fund on one given day, then obviously 100% of all health care providers become inactive on that same day. This means that currently the Health Care Stabilization Fund is not adequately financed to afford the cost of providing tail coverage to all health care providers all at once.

We appreciate the sincerity of the House committee members as well as those who amended the bill (at p. 13, line 68-83) on the floor of the House to restrict the tail coverage provisions under the Fund. Obviously, their intent was to reduce the cost of providing tail coverage and thereby, suppress surcharges during the five year phase-out period. We certainly acknowledge the good intentions of these individuals but respectfully submit that for the reasons stated above, this would be totally unfair to those health care providers who have "paid their dues" all these years. If the Legislature is intent upon imposing limitations on the provision of tail coverage under the Fund, then we would respectfully request that you consider provisions similar to those contained in SB 174. While we would prefer not to change the tail coverage provisions at all, we would suggest that if the Legislature insists upon doing so, that the new rules of the game be applicable only for those health care providers who first become active in Kansas on or after July 1, 1989 (see enclosed amendment). At least this would be fair to those who have participated in the Fund for so long.

One other consideration that has not been referred to this Committee as yet is the question of tail coverage provided through the Health Care Stabilization Fund to residents who complete their training at Kansas institutions. As you may recall, a few years ago the University of Kansas Medical Center requested and obtained permission to use the Health Care Stabilization Fund for purposes of self insuring the residents in training at the University hospital. This has two benefits at KUMC, one of which is that when the resident completes his/her training, the tail coverage provided allows them to purchase their first claims made policy at the less expensive first year rate. By contrast, a resident who has three or four years of tail exposure would have to buy a claims made policy at the third or fourth year rate. Application of the KUMC model to all residents could assist the state of Kansas in terms of retaining those young physicians who complete their training here and hopefully, would establish their first practice in our state. The way the insurance mechanism would work is that if a claim should arise because of an incident that occurred during the residency training period, the Health Care Stabilization Fund would pay the claim but would be subsequently reimbursed from an appropriate source of revenue. One source of revenue could of course be the

State General Fund, but another source that has been suggested is the Medical Scholarship Repayment Fund. This general concept appears in HB 2304, which we support and commend to your consideration.

Special Assessment

We would like to point out that one of the provisions amended into HB 2501 during Committee of the Whole debate, was the special assessment (at p. 15, lines 142-152) in the event that at some point in the future, it might be determined that the Health Care Stabilization Fund balance was inadequate for purposes of financing its liabilities. While we can accept the concept of a special assessment, we must point out that the opposite situation could arise. What if, at some distant time in the future, the Health Care Stabilization Fund balance is obviously excessive by comparison to the liabilities that eventually run out. In this event, we would respectfully request that a special provision be incorporated in the bill for that eventuality, such that any balance remaining in the Health Care Stabilization Fund would be apportioned equitably among all health care providers in Kansas who were active during the phase-out period.

Conclusion

We want to express our sincere appreciation to the Legislature for the many hours of study and deliberation devoted to the question of medical malpractice insurance coverage for Kansas health care providers. We know that this has been an arduous task for everyone involved. At the same time, we wish to emphasize that this legislation should not be perceived as a panacea. Because of the very expensive cost of accruing adequate revenue to afford tail coverage for all health care providers, we cannot expect a sizable reduction in the Health Care Stabilization Fund surcharge. We do, however, expect some stabilization for a short period of time during which we must continue to pursue the long term stability that will be provided by way of effective tort reform measures. We are referring of course to the subject of the hearing which you will commence this afternoon. In this same regard, we must emphasize that many high risk physicians who, because of their specialty, desire to purchase higher coverage limits, will still be spending outrageous sums in order to adequately indemnify their medical practice. The reduction in Health Care Stabilization Fund coverage will not necessarily result in any savings for those physicians who must purchase higher coverage limits in the commercial marketplace.

Joint Underwriting Authority

We also wish to express our support of the provisions of HB 2181 which extends the operation of the Health Care Providers Insurance Availability Plan. As you are probably aware, because of the limited availability of liability coverage in the marketplace, many health care providers have been forced to purchase their coverage from what is referred to as the JUA. We are hopeful that the development of our own medical mutual insurance company will take

care of the availability problems for physicians in the not too distant future. On the other hand, there may still be other categories of health care providers besides physicians who may need a JUA in order to obtain coverage at all. This is not because of the individual provider but because of the liability environment in Kansas. We are not certain why the House Committee chose not to include the provisions of HB 2181 in the same bill with HB 2501, but that certainly would be a consideration for this committee.

Risk Management Records

The Kansas Medical Society also wishes to express its support of the provisions of HB 2113 as amended by House Committee. This bill was the product of a meeting and negotiations among representatives of the Kansas Department of Health and Environment, the Kansas Hospital Association, one of its members and the Kansas Medical Society. The original bill draft, however, exceeded somewhat the discussions that took place during the negotiation meeting. The amendments adopted by the House Committee make the bill more closely reflect the agreements that were entered into on that day. The purpose of the bill is, of course, to grant access to certain records for the Department of Health and Environment employees who are given the responsibility of assuring risk management in hospital facilities. At the same time, we wish to make absolutely certain that confidential records do indeed remain confidential. This is what the bill would accomplish in its current form and for that reason, we respectfully request that you recommend it for passage.

Statute of Limitations

We also would like to express support for SB 225, which establishes a uniform statute of limitations for all actions. While we are pleased with the current statute regarding actions against health care providers, in light of the Farley decision, we think SB 225 would provide assurance that it would not be struck down. In Farley, the Kansas Supreme Court invalidated a bill which abolished the Collateral Source Rule in medical malpractice actions on the grounds that it violated the equal protection provision of our State Constitution. (While the Kansas court in 1981 upheld the reduced statute of limitations, K.S.A. 60-513 in Stephens V. Snyder Clinic, there is no assurance that the court will not reverse its opinion, given the Farley decision.) By establishing a uniform statute of limitations for all actions, we believe the Kansas Supreme Court would at least not be able to rely on the equal protection argument if it should be considering invalidating this law.

lg

Attachment

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

March 20, 1989

TO: Senate Judiciary Committee

FROM: Thomas L. Bell, Vice President

SUBJECT: H.B. 2113

The Kansas Hospital Association appreciates the opportunity to comment regarding H.B. 2113. This bill amends Kansas statutes dealing with mandatory hospital risk management to resolve a question related to confidentiality of certain records.

In 1986, the Kansas Legislature enacted a series of laws pertaining to medical malpractice lawsuits. These laws included limits on awards in such cases and requirements for paying certain damages in the form of an annuity. Because of a 1988 Kansas Supreme Court ruling, there is essentially only one portion of that package remaining today. This enactment directed all hospitals in the state to develop a "risk management program." Such programs were to be based on an elaborate reporting system requiring that all hospital employees directly involved in the delivery of health care services must report "reportable incidents" to certain hospital management. These incidents were then to be investigated by an internal hospital committee and reported to the state licensing agency if a variance from the standard of care was found.

Those persons required to participate in this reporting system include physicians, optometrists, podiatrists, pharmacists, registered nurse anesthetists, dentists, chiropractors, physical therapists, dental hygienists, registered nurses, licensed practical nurses, mental health technicians, occupational therapists, occupational therapy assistants, respiratory therapists, and any other hospital employee directly involved in the delivery of health care services. Each hospital must be prepared to make a report to each appropriate licensing agency. In addition, each hospital must report quarterly to the Kansas Department of Health and Environment the number of "reportable incidents" it has. Clearly, Kansas now has one of the most strict and detailed risk management laws in the country. Despite this,

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Kansas health care providers have worked hard to give effect to these laws. Much time, money and effort has been put into understanding this legislation and trying to make it work.

The Department of Health and Environment is the agency charged with overseeing the implementation of hospital risk management programs. In performing this duty, the Department first reviewed all risk management plans. The Department then began a series of "site visits" to monitor hospital plans.

During those site visits, a question arose regarding the confidentiality of risk management records once they have been reviewed by the Department. The Department filed a lawsuit against Wesley Medical Center, claiming it was being denied access to hospital records. The lawsuit was later dismissed. H.B. 2113 is an attempt to resolve those confidentiality issues.

One of the most integral parts of the entire risk management scheme adopted by the Kansas Legislature is the idea that records pertaining to this process are to be confidential and privileged. The Legislature recognized the necessity for this from the very beginning. Indeed, lawmakers have codified this concept in both the risk management and peer review statutes. Most other states and the federal government have also adopted this method of encouraging peer review and risk management activities. The confidentiality provisions of H.B. 2113, therefore, are consistent with previous legislative enactments and represent a continuation of established legislative policy.

TLB:mkc

STATE OF KANSAS

DEPARTMENT OF HEALTH AND ENVIRONMENT
Forbes Field
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Mike Hayden, *Governor*

Stanley C. Grant, Ph.D., *Secretary*
Gary K. Hulett, Ph.D., *Under Secretary*

TESTIMONY PRESENTED TO

SENATE JUDICIARY COMMITTEE

by

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

House Bill 2113

I. Background

A. Passage of House Bill 2661 in 1986 and House Bill 2643 in 1988

With the passage of House Bill 2661 in 1986 (now KSA 65-4921, et seq), every medical care facility in Kansas was required to establish an internal risk management program. The Kansas program is based upon mandatory reporting, investigation, and analysis of what the law defines as "reportable incidents" or those acts of health care providers which either were or might have been below applicable standards of care and had a reasonable probability of causing injury to a patient.

All health care providers and employees of medical care facilities must report any "reportable incident" of which they have knowledge to the risk manager, chief of the medical staff, or hospital administrator. Once reported, these incidents must be investigated by designated executive committees to determine whether or not services provided by a health care provider were below the applicable standards of care. Moreover, if the investigating committee determines that care did not meet applicable standards expected in the facility, a report specific to individual health care providers must be filed with the licensing agency responsible for licensing, registering, or certifying the involved providers.

On October 1, 1987, the Bureau of Adult and Child Care, Kansas Department of Health and Environment (KDHE), began reviewing written risk management plans which had been submitted by approximately 160 medical care facilities affected by risk management laws. Prior to receiving a renewal of its license in 1988, every medical care facility had to receive approval of its risk management plan from KDHE. Licensed medical care facilities affected by original House Bill 2661 in 1986 were: hospitals, ambulatory surgical centers, and recuperation centers.

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With passage of House Bill 2643 in 1988, both private psychiatric hospitals and state institutions were included in those facilities required to meet the provisions of state risk management laws and regulations.

B. Initiation of KDHE Onsite Reviews

On January 18, 1988, two master's level nurses were employed by KDHE as risk management specialists. These nurses were employed following passage of legislation in 1987 (1987 Session Laws, Chapter 22) for the specific purpose of reviewing records:

> . . . of licensed medical care facilities [and analyzing the] quality of health care services provided to assist in correcting substandard services and to reduce the incidents of liability resulting from the rendering of health care services.

In May of 1988, KDHE began scheduling risk management site reviews of all licensed medical care facilities whose plans had already been approved. The site review process was necessary in order to better assure that the requirements of risk management laws and regulations were actually being implemented and also in specific response to the 1987 legislation mentioned earlier. The difference between simply reviewing a written plan and walking through the process of implementation with individual staff at each facility is significant.

All licensed medical care facilities have had their written risk management plans approved by KDHE. Of the facilities made subject to state risk management laws in 1988, only two private psychiatric hospitals are still working on their plans.

There are now 167 medical care facilities subject to state risk management laws. As of February 1, 1989, 133 onsite surveys of risk management programs had been conducted.

C. Need for Current Legislation

As stated earlier, the purpose of conducting onsite reviews was to reasonably assure that medical care facilities were complying with state risk management laws and regulations. In conducting site reviews, the two registered nurse risk management specialists interviewed appropriate facility staff and reviewed risk management systems created under KSA 65-4921. Specifically, agency specialists reviewed employee incident reports, the minutes of each facility's risk management committee, medical staff executive committee minutes, and the minutes and records of any other executive committee responsible for determining whether or not the facility or individual health care providers acted below acceptable standards of care as set forth in KSA 65-4923.

During the early stages of the site review process, four hospitals refused agency access to original minutes of risk management committees.

Moreover, one of those hospitals refusing original access also indicated, in writing, that the agency lacked statutory authority to review records of such committees. A written response indicating the agency's statutory authority to review such records was made to each of the four hospitals refusing that access. Only one hospital refused agency access when the names of individual health care providers and/or patients were deleted from the records.

As an overview, it was pointed out to facilities that KDHE is vested with broad responsibility and authority for assuring that licensed medical care facilities maintain compliance with licensure laws and regulations. KSA 65-4925 authorizes the agency to make such inspections and investigations as it deems necessary to prove compliance with such laws and regulations. In addition to general licensing authority, it was noted that KSA 65-4922 requires the Secretary of Health and Environment to approve all risk management plans. Subsection (b) of that same statute requires the hospital not only to write a plan but to implement a program. Moreover, Subsection (e) of KSA 65-4923 states that if the licensing agency determines that an executive committee is not fulfilling its duties with respect to the investigation of "reportable incidents," the agency, after notice and hearing, may require all reports to be filed directly with it.

Although KDHE believed that it had statutory authority to review the risk management records of licensed medical care facilities, one hospital refused to acknowledge that authority. As a result, a lawsuit was filed in the Shawnee County District Court on July 12, 1988, seeking declaratory relief on the issue of whether KDHE had authority to access original records under risk management laws. This lawsuit was subsequently dismissed when the parties and various health care organizations, such as the Kansas Hospital Association and the Kansas Medical Society, agreed to seek joint legislation which would clearly authorize agency access to original risk management records. None of the parties had objections to agency inspection of records but were concerned with the possibility of the discovery of those records in a lawsuit filed against the facility or individual health care providers whose actions had been subject to review by executive committees operating pursuant to state risk management laws. Passage of this legislation will implement the agreement of interested parties to seek additional statutory safeguards against legal discovery of records obtained by state licensing agencies in response to their risk management oversight responsibilities.

Specifically, House Bill 2113 would clarify KDHE's authority to review hospital records in assuring that medical care facilities are implementing the risk management program required by KSA 65-4921, et seq. Clarifying language to this effect appears in new Subsection (c) of KSA 65-4922, or page one, line 40, of House Bill 2113 as it is currently worded. Subsection (g) of the same statute, appearing on page two at line 65, grants specific statutory protection from legal discovery of records reviewed by the department during onsite inspections.

The House Judiciary Committee struck Section 2 of the original bill as a means of simplification, preferring to incorporate the more detailed language of KSA 65-4925 by reference in Subsection (g) of Section 1. However, in doing so, the reference to a stricken subsection was not deleted on page two at line 48. That reference to "subsection (e) of KSA 1988 Supp. 65-4925, and amendments thereto," should also be stricken. A period after the word "act" in line 47 might accomplish this needed goal or the following language might be used beginning on page two at line 46:

> the reports and records of ~~all executive committees designated to investigate reportable incidents under this act as well as all other records specified in subsection (e) of K.S.A. 1988 Supp. 65-4925, and amendments there to~~ each medical care facility subject to the provisions of this act.

Recommendations

KDHE strongly supports passage of House Bill 2113. This legislation is important in further protecting the confidentiality of records obtained by state licensing agencies responsible for overseeing implementation of risk management programs in licensed medical care facilities and private psychiatric hospitals. Unless confidentiality is protected to the greatest possible extent, participation of individual health care providers and medical care facility employees cannot be fully attained.

Presented by: William C. Rein, Director of Hospital
and Medical Programs
Bureau of Adult and Child Care
Kansas Department of Health and Environment
March 20, 1989

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Anne P. Garlinghouse
Camille A. Nohe

Testimony on
Senate Bill No.: 285
(Medical Malpractice Screening Panels)

On behalf of the Kansas Trial Lawyers Association, I am here this morning to testify in support of SB 285.

The proposed amendment to K.S.A. 65-4903 would allow medical malpractice screening panels to see and consider the depositions of the health care provider involved. The necessity for including the deposition is to provide the panel with the maximum amount of information available to enable them to make an intelligent decision about what occurred in the care and treatment of a patient.

It is unrealistic to expect health care providers to record and document all their thoughts, opinions, and reasons for their actions during the course of treatment of a patient. It is equally unrealistic to expect the screening panel to read between the lines of the medical records. The availability of the deposition will provide the panel with much more complete and accurate information upon which to base their opinions of the adequacy of the care and treatment. In many cases the deposition will promote a quicker resolution to the questions involved. I therefore urge that this amendment be passed.

Respectfully submitted,

Anne P. Garlinghouse

Anne P. Garlinghouse

Attachment IV
JC
3-20-89

SB 364
Senate Judiciary Committee
March 20, 1989

Mr. Chairman, members of the Judiciary committee. I am Ron Smith, appearing on behalf of the Kansas Bar Association.

KBA is the Bar's legislation. Kansas already has a very conservative screening panel law. It is modeled after the Indiana screening panel law, and has been in effect since July 1, 1986. The results are admissible at trial. Further, in 1987, Kansas went further by allowing all professional malpractice cases to be screened. That goes further than any other state. I would point out, however, since 1987, I'm aware of no request in any court to screen other professional malpractice actions. That is why SB 364 applies only to medical malpractice.

This legislation is a result of the KBA's Kansas Plan announced earlier this session. It attempts to find logical statutory solutions to the problems physicians face regarding high premiums, especially in rural Kansas. As far as I can tell no other state which allows medical malpractice screening panels has a fee shifting law where if you have a unanimous screening panel finding and proceed to trial and lose, that attorney fees and costs can be imposed.

Judicial Discretion. Discretion as to amounts of such costs and fees to impose is left to the judge based on several factors and after hearing evidence and arguments at a post-trial evidentiary hearing. KBA believes in judicial discretion, because we believe in the judicial system. We also recognize that while screening panels are important, they are not perfect devices. Not all cases are screened now, even though defendants have the authority. Accordingly, KBA would consider an amendment removing judicial discretion on these fees to be an unfriendly amendment.

Our reason is simple. Most other statutes that allow fee shifting to the winning party are discretionary in whether to impose a fee. If you make SB 364 mandatory, that is contrary to the trend in our law.

Written Findings. SB 364 provides the judge will make written findings of fact and conclusions of law as to his reasoning whether to impose the costs and fees. Such orders can be collected as part of your data analysis via the Supreme Court.

Equal Protection. The bill provides equal protection because it creates the same fee-shift penalty against a defendant who stubbornly pro-

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Attachment I
SJC
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ceeds to trial in the face of a unanimous screening panel recommendation against the doctor if there is a subsequent plaintiff's verdict.

Effect on Settlements. There is no direct effect on settlements. This statute does not give judges authority to implement sanctions in the settlement process.

Effect on Federal Courts. Federal courts, under the Erie v. Tompkins doctrine, are not obliged to use state procedural law in federal court. The federal rules of civil procedure control. Federal rules do not require screening panels. They have not been used in federal court in Kansas, and neither will SB 364.

Elements Triggering Its Use. The following things must occur in order to have this bill be used in a malpractice action.

1. There must be a screening panel requested.

2. The panel must unanimously agree that there was, or was not, a departure from the standard of care, and such departure did or did not cause the damages. A 2-1 decision by the panel either way voids the penalty in SB 364. This is because obviously one panelist agrees with the claimant.

3. If the panel report is inconclusive on the issue of standard of care or causation, then in fairness, the penalty should not apply.

4. It is not mentioned specifically, but clearly the jury must hear or read the contents of the panel report. The report must be admitted into evidence.

5. There must be a jury trial and an adverse verdict against the person who received the adverse ruling of the screening panel.

6. There must be a post-trial evidentiary hearing and an opportunity for all parties to be heard. The parties may present any evidence and arguments.

7. There are other considerations. Subsection 1(e)(4) and (5) allows an exception if a good faith argument for the extension, modification or reversal of existing law is attempted.

> Example. Let's assume a physician does not disclose the true nature of medical injuries that has caused serious injury or death, and the malpractice is hidden for four years. The claimant is kept from filing the lawsuit solely by this fraud. Defendant denies the fraud, and relies on the falsified records. The statute of repose has run. (These were exactly the facts in Nebraska six months ago.) Further, defendant screens the claim and relying on the false records, a unanimous screening panel decision comes back for the defendant.
>
> Plaintiff's sole purpose is to test the law as to whether fraudulent concealment of the injury by one in a fiduciary capacity is

constitutional under our remedy section. Therefore, he files suit and files for an interlocutory appeal. The court rules the statute does not bar his case, and the patient proceeds to trial. That issue has not previously been tested in Kansas. At trial, the jury disagrees and the plaintiff loses. It is still not not intended that SB 364 sanctions apply in that type of case because important issues were advanced on appeal.

8. Subsection (e) gives some guidance to courts as to the issues to consider on a motion to grant fees and costs. They are not all inclusive. The written findings and any fees or costs imposed can be appealed by any party.

Retroactivity. The bill does not include a clause indicating that it is intended to apply prospectively only. It is our intent that it be inferred from the content of the bill that it apply prospectively. Conceivably there could be a case where the trial is set for July 1, 1989 and there has been a screening panel render an opinion two or three years ago when the results of the panel could not even be introduced into evidence. Yet all of a sudden, in the middle of trial, the stakes for an adverse jury verdict change dramatically. In such a case, the judge can take that into consideration and not award a reasonable fee -- part of the judicial discretion that I mention. The cleaner way is an amendment making prospective application clear by adding the following new subsection (g):

"(g) The new changes in this section that are effective July 1, 1989 shall apply only to cases filed on or after that date."

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

1260 S.W. Topeka
Topeka, Kansas 66612
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March 20, 1989

To: Chairman and Members, Senate Judiciary Committee

From: Harold E. Riehm, Executive Director, Kansas Association of Osteopathic Medicine

Subject: H.B. 2501, H.B. 2181 S.B. 174 S.B. 223 S.B. 225 S.B. 285

My name is Harold Riehm and I appear in support of all of the Bills you are hearing today, with minor reservations. Our interest, however, is most directed to H.B. 2501.

We think the provisions for terminating the Health Care Stabilization Fund in 1994, with optional levels of coverage permitted in the interim, are a positive step in helping to alleviate the serious provlem of rapidly rising medical professional liability insurance premiums. It is, we think, a reasonable approach that offers flexibility to covered health care providers.

We do, however, have some reservations about the provisions now in S.B. 2501 that would end tail coverage for most providers. While it may be true that those covered by the Fund have not paid for future tail coverage, there has been a clear "understanding" that tail coverage was a part of the total package. To suddenly deny that tail coverage to a physician who may have been planning to avail himself or herself of such coverage, is clearly breaking that "understanding".

Furthermore, the amendment on tail coverage appears to deny that coverage to providers who currently are enjoying tail coverage because they are no longer rendering professional services in the State, and who also were not covered by the Fund for 10 years. This, we think, comes even closer to backing off of a commitment that the provider clearly thought would be in place.

We can support termination of tail coverage for those commencing Fund participation after July 1, 1989, and, perhaps, for requiring a total of 10 years participation for those currently in practice and covered by the Fund, before tail coverage is available. We think the present provisions, however, are too restrictive on tail coverage.

On S. B. 223, we have long supported limits on attorney fees in medical malpractice cases. We think these are reasonable limitations and their enactment long overdue.

We also support S.B. 225 and S.B. 285.

Thank you for this opportunity to appear.

Attachment II
Senate Judiciary Committee
3-20-89

STATE OF KANSAS

NANCY PARRISH
SENATE DEMOCRATIC POLICY CHAIR
STATE SENATOR, NINETEENTH DISTRICT
SHAWNEE COUNTY
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SENATE CHAMBER

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RANKING MINORITY MEMBER: EDUCATION
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JUDICIARY
LEGISLATIVE AND CONGRESSIONAL APPORTIONMENT
LEGISLATIVE POST AUDIT
WAYS AND MEANS
CHAIRMAN: SHAWNEE COUNTY LEGISLATIVE DELEGATION

TESTIMONY ON S.B. 174

March 20, 1989

S.B. 174 modifies the current statutory policy of providing tail coverage for all health care providers through the Health Care Stabilization Fund. The purpose of S.B. 174 is to reduce the liability of the Fund which would subsequently reduce the surcharges assessed to health care providers.

A brief background is necessary to understand the concept of tail coverage. As I understand, in the mid 70's when the Health Care Stabilization Fund was established, the legislature changed medical malpractice insurance coverage from "Occurrence" policies to "Claims-made" policies. "Occurrence" policies are ones in which the insurance company that carries the insurance at the time a medical malpractice incident occurs is liable for the claim. A "Claims-made" policy is one in which the insurance company that carries the insurance at the time the claim for damages is made, is liable for the claim. There is not a problem with tail coverage if the insurance policy is an Occurrence policy because the insurance carrier who provides the insurance at the time of the incident is still responsible 2 or 3 years later when the claim is filed.

But in the case of a "Claims-made" policy, tail coverage is important. For example, in 1980, Dr. X performs an operation at which time malpractice occurs. Company A is the insurance company for Dr. X in 1980. In 1982 Dr. X leaves the state of Kansas to practice in Arizona at which time he purchases insurance with Company B. In 1983, victim files medical malpractice suit against Dr. X. Neither Company A nor Company B is liable to cover Dr. X's case. Company A isn't liable because Dr. X didn't have coverage with Company A during 1983. Company B isn't liable because Dr. X didn't purchase tail coverage from Company B. Instead, the Health Care Stabilization Fund is liable for the tail coverage from the first dollar of liability.

Attachment VII

SJC 3-20-89 AM

Kansas is the only state in the U.S. that provides tail coverage. Our total premiums appear high in comparison to some other states because included in the Kansas premium is tail coverage for the physician. The attached charts that were compiled by the Insurance Commissioner's office show Kansas rates in Comparison to several other states. (The charts were prepared in 1987).

There are several problems with providing tail coverage. First of all, by the Fund providing tail coverage, doctors inadvertently are encouraged to leave the state to avail themselves of lower premiums for at least the initial 2 to 3 years. Some of these doctors have lost their licenses in Kansas.

Out-of-state doctors tend to be unavailable to defend cases against themselves when it involves travel back to Kansas. This makes it difficult for the Fund to defend a case on behalf of an out-of-state doctor.

Providing tail coverage is not altogether an undesirable feature. It provides flexibility to doctors who want to change companies and provides tail coverage for retired doctors no longer in practice.

Realizing the benefits as well as the pitfalls of the tail coverage, S.B. 174 provides that tail coverage will continue if the health care provider has participated in the Fund for 10 or more years. Under S.B. 174, the Fund would no longer pick up the tail coverage for a young doctor practicing less than 10 years who decides the grass is greener and the medical malpractice premiums are less in the west. No longer would the Fund pay tail coverage for a doctor who leaves Kansas because he lost his license if that doctor had been practicing less than 10 years, but under S.B. 174 the Fund would pay tail coverage for retired doctors if they had practiced in Kansas 10 years or more.

The bill doesn't apply to doctors currently practicing in Kansas. It only applies to new doctors starting practice as of July 1, 1989. In addition, the bill provides an exemption for any doctor who becomes disabled through no fault of his or her own.

COST COMPARISON FOR A OB / GYN SPECIALIST INSURED BY ST. PAUL

State	Total Coverage Limits	Total Costs	Additional Cost For Tail Coverage
Oklahoma	$1,200,000 / $3,600,000	$32,232	$55,060
Nebraska	$1,200,000 / $3,600,000	$36,681	$65,483
Indiana	$500,000	$45,578	$37,515
Kansas	$1,200,000 / $3,600,000	$51,815	– 0 –
Colorado	$1,200,000 / $3,600,000	$66,818	$105,703
St. Louis, MO	$1,200,000 / $3,600,000	$143,092	$252,432
Los Angeles, CA	$1,200,000 / $3,600,000	$169,060	$267,719

COST COMPARISON FOR A FAMILY PRACTICE DOCTOR INSURED BY ST. PAUL

State	Total Coverage Limits	Total Cost	Additional Cost For Tail Coverage
Oklahoma	$1,200,000/$3,600,000	$10,310	$17,529
Nebraska	$1,200,000/$3,600,000	$11,760	$20,869
Indiana	$500,000	$16,578	$26,483
Kansas	$1,200,000/$3,600,000	$18,162	$0
St. Louis, MO	$1,200,000/$3,600,000	$46,267	$81,442
Los Angeles, CA	$1,200,000/$3,600,000	$51,740	$81,797