Approved 1/30/90
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by SENATOR RICHARD L. BOND at
Chairperson

9:00 a.m./~~p.m.~~ on TUESDAY, JANUARY 23, 1990 in room 529-S of the Capitol.

All members were present ~~except~~:

Committee staff present:
Bill Edds, Revisors Office
Bill Wolff, Research Department
Louise Bobo, Committee Secretary

Conferees appearing before the committee:
Bill Curtis, Kansas Association of School Boards
Jeff Ellis, HMO
Keith Hawkins, Pyramid Life Insurance Company
Bill Pitsenberger, Blue Cross Blue Shield
Terry Leatherman, Kansas Chamber of Commerce & Industry
Robert Frey, Kansas Trial Lawyers
Jerry Slaughter, Kansas Medical Society
Lori Callahan, Kansas Medical Mutual Insurance Company
Ron Smith, Kansas Bar Association

Chairman Bond called the meeting to order at 9:12 a.m.

Bill Curtis, Kansas Association of School Boards, was recognized by Chairman Bond for the purpose of requesting that a bill be introduced by the committee amending Kansas Statute 12-2617 and 12-2618. (Attachment 1) Senator Salisbury made a motion to allow introduction of this proposal. Senator Karr seconded the motion. The motion passed.

SB 396 - Subrogation rights under accident, health or sickness insurance policies.

Chairman Bond explained to the committee members changes in this bill were adopted by the Interim Judiciary Committee but no action was taken on this bill and it comes before the committee with no recommendations.

Jeff Ellis, HMO, appeared before the committee in support of SB 396. He stated that because subrogation is designed to assure that the loss is ultimately paid by the party legally responsible for the loss, premium increases would be kept down. (Attachment 2)

Mr. Ellis stated that he knew the Kansas Medical Society had a concern about the bill and his organization would support the amendment the Medical Society proposes.

Keith Hawkins, Pyramid Life Insurance Company, stated that his company firmly believes that subrogation can effectively reduce overall claim costs. (Attachment 3)

Bill Pitsenberger, Blue Cross Blue Shield, appeared in support of SB 396. He stressed that allowing for subrogation in health insurance has absolutely nothing to do with medical malpractice insurance reform. Mr. Pitsenberger further stated that the main concern of his company was to allow equitable treatment of small employers. (Attachment 4)

Terry Leatherman, Kansas Chamber of Commerce and Industry, testified before the committee in support of SB 396. Mr. Leatherman informed the committee that leading supporters of this bill agree that pursuing non-insured third parties is not the intent of subrogation and would not oppose an amendment to prohibit it. (Attachment 5)

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

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE,

room 529-S, Statehouse, at 9:00 a.m./p.m. on TUESDAY, JANUARY 23, 1990.

Robert Frey, Kansas Trial Lawyers, appeared before the committee in opposition to this proposal. Mr. Frey stated that the Kansas consumer should be free to collect for coverage and benefits they have bought and paid for and should be free to collect from someone who has injured them. (Attachment 6)

Jerry Slaughter, Kansas Medical Society, informed the committee that his organization was interested in this proposal primarily because of its implications in the area of medical malpractice litigation. He stated that he would not oppose subrogation legislation which would allow the exemption of medical malpractice actions. (Attachment 7)

Lori Callahan, Kansas Medical Mutual Insurance Company, appeared before the committee in support of SB 396. She stated that her organization believed that subrogation would have a real premium impact for liability insureds as well as the Health Care Stabilization Fund. She further stated that KaMMCO supported the Kansas Medical Society amendment. (Attachment 8)

Ron Smith, Kansas Bar Association, spoke before the committee in opposition to SB 396. Mr. Smith proceeded to explain that his organization had reviewed the work on this bill done by the Interim Judiciary Committee and had concluded that the ultimate result of such a law would be an increase in the number of lawsuits filed. (Attachment 9)

There being no further conferees, Chairman Bond pronounced the hearings on SB 396 closed.

Minutes of Wednesday, January 17, 1990, were approved as written on a motion by Senator Moran with Senator Reilly seconding the motion. The motion passed.

Chairman Bond adjourned the meeting at 10:02 a.m.

GUEST LIST

COMMITTEE: FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE DATE: Tues Jan 23, 1990

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
M. Keith Hawkins	6201 Johnson Drive Mission, KS	Pyramid Life Insurance Co
Bill Curtis	Topeka	Ks. Assoc. of School Bds.
Bill Sneed	Topeka	State Farm
Terry Slaughter	Topeka	KAUS
Chip Wheelen	Topeka	KMS
Ron Smith	"	Ks Bar Assoc
Lori Callahan	Topeka	KaMMCO
Bill Pitsenberger	Topeka	BCBSK / HMO Kansas
M. Hauver	"	Capital Journal
Terry Leatherman	Topeka	KCCI
L M Cornish	"	Ks Life & P/C Assns
Jack Roberts	"	Blue Cross Blue Shield
Jay Ellis	KC	KsHmo Assn
Cheryl Dillard	KC	Kaiser Permanente

Bill Curtis

12-2617. Authorization of municipalities to pool liabilities; certain insurance excluded from pools; pools not deemed insurance and not subject to regulation except as enumerated. Five or more municipalities as defined in K.S.A. 75-6102, and amendments thereto, may enter into agreements to pool their liabilities for Kansas fire, marine, inland marine and allied lines, as defined in K.S.A. 40-901, and amendments thereto, ~~and~~ casualty, surety and fidelity lines as defined in K.S.A. 40-1102, and amendments thereto, including workers' compensation and employers' liability~~.~~ ~~Such pools shall not include accident, health or life insurance.~~ Such arrangements shall be known as group-funded pools, which shall not be deemed to be insurance or insurance companies and shall not be subject to the provisions of chapter 40 of the Kansas Statutes Annotated, except as otherwise provided herein.

History: L. 1987, ch. 74, § 2; May 28.

Group sickness and accidents, as defined in K.S.A. 40-2209 and amendments thereto, and life insurance, as defined in K.S.A. 40-433, and amendments thereto.

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12-2618. Certificate of authority to operate pool; application; hearing upon denial of application. Application for a certificate of authority to operate a pool shall be made to the commissioner of insurance not less than 30 days prior to the proposed inception date of the pool. The application shall include the following:

(a) A copy of the bylaws of the proposed pool, a copy of the articles of incorporation, if any, and a copy of all agreements and rules of the proposed pool. If any of the bylaws, articles of incorporation, agreements or rules are changed, the pool shall notify the commissioner within 30 days after such change.

(b) Designation of the initial board of trustees and administrator. When there is a change in the membership of the board of trustees or change of administrator, the pool shall notify the commissioner within 30 days after such change.

(c) The address where the books and records of the pool will be maintained at all times. If this address is changed, the pool shall notify the commissioner within 30 days after such change.

(d) Evidence that the annual Kansas gross premium of the pool will be not less than $250,000 for each of the following categories: (1) All property insurance under article 9 of chapter 40 of the Kansas Statutes Annotated except motor vehicle physical damage; (2) motor vehicle liability and physical damage insurance; (3) workers' compensation and employers' liability insurance; ~~and~~ (4) all casualty insurance under article 11 of chapter 40 of the Kansas Statutes Annotated except insurance under categories (2) and (3) above [; (5) Group sickness and accident insurance; and (6) Group Life Insurance]. The pool shall notify the commissioner within 30 days if the Kansas gross premium is less than $250,000 for any of the above categories of insurance.

(e) An agreement binding the group and each member thereof to comply with the provisions of the workmen's compensation act. For all lines of coverage, all members of the pool shall be jointly liable for the payment of claims to the extent of the assets of the pool.

(f) A copy of the procedures adopted by the pool to provide services with respect to underwriting matters and safety engineering.

(g) A copy of the procedures adopted by the pool to provide claims adjusting and accumulation of income and expense and loss data.

(h) A confirmation of specific and aggregate excess insurance, as selected by the board of trustees of the pool, or adequate surplus funds as approved by the commissioner, in the pool. The pool shall notify the commissioner within 30 days of any change in the specific or aggregate excess insurance carried by the pool.

(i) After evaluating the application the commissioner shall notify the applicant if the plan submitted is inadequate, fully explaining to the applicant what additional requirements must be met. If the application is denied, the applicant shall have 10 days to make an application for hearing by the commissioner after the denial notice is received. A record shall be made of such hearing, and the cost thereof shall be assessed against the applicant requesting the hearing.

(j) Any other relevant factors the commissioner may deem necessary.

History: L. 1987, ch. 74, § 3; May 28.

TESTIMONY BEFORE

THE SENATE COMMITTEE ON FINANCIAL

SENATE BILL NO. 396 - SUBROGATION

By: Jeffrey O. Ellis

Kansas HMO Association

January 23, 1990

My name is Jeffrey O. Ellis, and I am from Johnson County. I am attorney and registered lobbyist for the Kansas HMO Association. I appreciate the opportunity to appear before you today to discuss legislation which would permit subrogation by health insurers.

The Kansas HMO Association in an affiliation of the fourteen health maintenance organizations serving more than 200,000 Kansans. Health maintenance organizations have been operating in Kansas since 1976 and were formed as an alternative to the traditional indemnity health insurance plans.

The HMO concept is to organize health care delivery into a local, efficient system that emphasizes the prevention and early treatment of disease and delivery of the full spectrum of health care services for a predetermined monthly charge rather than the more traditional reimbursement for expenditures used by indemnity carriers. There are no deductibles, although there are sometimes modest co-payments for individual services. As such, HMO's are not technically insurance companies, but since they provide health care services for a predetermined monthly charge, HMO's are similar to health insurance companies in their concern for control of rising health care costs, and they are, it fact, regulated by the Kansas Insurance Department. Those which are federally qualified or have Medicare contracts are monitored by the federal government as well.

Health insurers and HMO's are keenly aware that rising health care costs have become a major concern in this country and this state. Studies by the Group Health Association of America, Inc. (GHAA) released in April 1989 indicate HMO premiums nationwide will rise 16.9% this year while indemnity health insurance premiums will increase 20%-30%.

As health insurers and HMO's provide and pay for health care for their insured necessitated by the negligence of another, the wrongdoer escapes responsibility if he is lucky enough to have injured an insured person. Moreover, if the injured person recovers health care benefits which were previously paid by his insurance company, the injured insured gets a windfall of double recovery. In either event, the insurance company suffers increased expenditures which are truly the responsibility of the

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wrongdoer and which should not be extended to doubly enrich the insured. Subrogation provides a method of preventing this inequity. As the public's demand for reasonable insurance rates increases in intensity, the Legislature will be called upon time and again to provide a source of relief.

Subrogation is one of the tools available through the legal process to aid health care cost containment. Senate Bill No. 396 before you would allow health insurers and HMO's to subrogate against a wrongdoer to recover health care costs expended as a result of that person's negligence thereby enabling the health insurer or HMO to apply the recovery to contain rapidly rising insurance premiums.

Currently, subrogation is prohibited in health insurance contracts in Kansas by administrative regulation promulgated by the Kansas Insurance Department. K.A.R. 40-1-20 states:

> An insurance company shall not issue contracts of insurance in Kansas containing a "subrogation" clause applicable to coverages providing for reimbursement of medical, surgical, hospital or funeral expenses.

HMO's join health insurers in seeking legislation which would abrogate that administrative regulation. Senate Bill 396 which was first introduced in the 1989 session of the Kansas Legislature serves as a model for legislation accomplishing that purpose.

As background, I would like to review some of the legislative and legal history of subrogation and the ramifications of this legal theory as it applies to health insurance contracts.

As you know, in a general sense "subrogation" means substitution. Subrogation is the right of an insurer who has paid an obligation which a third party should have paid to be reimbursed by that third party. In other words, by "substituting" the insurer for the insured, the insurer is able to collect from the one responsible for the loss. Because the insurer recovers the amount paid out, subrogation allows insurers to contain costs, benefitting consumers who understandably object to rising premium rates. Along with the cost containment benefit, subrogation also prevents the insured from reaping a windfall by collecting from both the insurer and the party at fault.

There are two types of subrogation, "conventional" and "legal". "Conventional subrogation" is the result of an agreement between two parties; i.e., a contract which stipulates the subrogation rights of one of the parties. "Legal subrogation" arises out of the concept of fairness. Where there is no explicit subrogation agreement, or conventional subrogation, between parties, courts may nonetheless find legal subrogation. When subrogation is allowed, it is because the courts or legislature find it unfair for a wrongdoer to escape

financial liability for his actions or for the insured to collect twice for one incident. Here, we seek the right of conventional subrogation.

Although subrogation is prohibited by Kansas Administrative Regulation, it is regarded as a favorite of the law in other contexts; that is, legal subrogation has found favor as a concept of fairness with the Kansas courts. Definitions and purposes of the doctrine of subrogation can be found in early Kansas case law. In Tillotson vs. Goodman, 154 Kan. 31, 37, 114 P.2d 845 (1941) the Kansas Supreme Court described subrogation as:

> . . . founded on the principle that one cannot enrich himself at the expense of another by getting free of a debt by permitting the other, not so fundamentally or primarily bound, to pay the debt, but the matter is one of comparative equities, the root of the doctrine being in justice and equity and not in contract.

The idea that subrogation is based on justice and fairness is paramount throughout Kansas case law. In the more recent case of Western Surety Co. vs. Loy, 3 Kan. App. 2d 310,312, 594 P.2d 257 (1979), the court said:

> Subrogation is a creature of equity invented to prevent a failure of justice and is broad enough to include every instance in which one party is required to pay a debt for which another is primarily answerable. . . . Subrogation is termed a 'favorite of the law,' and the mere fact that it has not been invoked in a similar situation is no bar to its applicability.

The Legislature has followed the Court's lead and Kansas statutes permit subrogation in several specific situations in order to allow insurers to recover medical payments from the person responsible for the loss. The Kansas Automobile Injury Reparations Act (No-fault), K.S.A. 40-3113(a), allows an insurer to be subrogated when the injured party has recovered money from the tortfeasor. Subrogation is allowed in these cases in order to "prevent a double recovery by the claimant." Russell vs. Mackey, 225 Kan. 588, 592 P.2d 902 (1979).

In 1986, the Kansas Legislature amended the Uninsured Motorist Coverage Act, K.S.A. 40-284, by adding a provision allowing subrogation for insurers in cases involving an underinsured motorist. The Special Committee on Financial Institutions and Insurance determined that this amendment was necessary in order to remove the existing "impediment to claim settlement and encourage prompt claims adjustments". Interim Committee Reports, Proposal #13, October 7, 1985, p. 134. The minutes of the Senate Committee on Financial Institutions and Insurance meeting on March 8, 1986, indicate that subrogation was deemed necessary to remove the possibility of an impasse resulting from the injured person's ability to collect damages from both insurance companies.

K.S.A. 44-504 allows both an employer and the Workers' Compensation Fund to be subrogated when a payment is made under the Workers' Compensation Act. In adopting subrogation in the Workers' Compensation Act, the Legislature acknowledged that the theory of allowing the employer to be subrogated is well established in Kansas case law. That theory was enunciated by the Kansas Supreme Court in Fenly vs. Revell, 170 Kan. 705, 707, 228 P.2d 905 (1951):

> . . . where an employer or master, not at fault, has become obligated to respond in and does pay damages to a third person for the negligence of his employee or servant, he will be subrogated to the rights of the injured party and may maintain an action to recover from the employee or servant, the one primarily liable, the amount so paid.

This basic theory was expanded by the Legislature in 1988 to also allow subrogation by the Workers' Compensation Fund. The rationale behind expanding the statute as reflected in the minutes of the House Committee on Labor and Industry meeting on March 2, 1988 was that "In many cases, judges [were] reading subrogation rights of the Workers' Compensation Fund into the statute . . . this 'cleans up' the statute."

The rather incongruous result, despite this clear preference for subrogation by both the courts and the Legislature in other arenas, is that Kasnsas law presently denies the extension of the doctrine of subrogation to health and accident insurers through Kansas Administrative Regulation. The common law doctrine behind this administrative restriction of subrogation from the health insurance environment was based on the common law principle that, in personal injury contracts, the exact loss could not be precisely determined. Subrogation under property and casualty principles was historically allowed because a fixed financial loss was identifiable, and through subrogation, the responsibility of the loss was put on the wrongdoer.

Distilled to its essence, this common law prohibition of subrogation in health insurance has been perpetuated through administrative fiat even though subrogation has been extended to personal injury contracts by the Legislature in the No Fault Act, the Uninsured Motorist Act, and the Workers' Compensation Act. Furthermore, federal and state government financed health insurance, such as Medicare and Medicaid, permit subrogation. Even self-insurers in Kansas and large employer's health plans, such as Boeing's, written by out-of-state companies are free to include subrogation provisions in their health insurance contracts since self-insurers and foreign health insurance companies avoid Kansas Insurance Department regulation.

The clear trend, not only in Kansas, but also throughout the United States is to allow subrogation. As best we have been able to determine, thirty-eight states permit subrogation in health insurance. Exact numbers are difficult to determine because the right of subrogation is sometimes determined through case law

-inions rather than by clear legislative or regulatory pronouncements. It appears, however, Kansas is among twelve states which does not allow subrogation and one of only five states which specifically prohibits subrogation as a matter of law. We are certain Kansas is clearly in the minority position.

The Kansas HMO Association has long been an advocate of allowing subrogation as a health care cost containment measure. Health insurance costs rise as the costs of medical care increase, and, as we have been noting in the newspapers, and as we cited earlier, health insurance premiums have risen dramatically over the last several years and continue to rise. We hasten to caution that subrogation is not the panacea; it is only one of many tools which might be implemented by the Legislature to start coralling those rising costs. Our investigation reflects that revenue resulting from subrgation actions, and therefore costs saved, by health insurers and HMO's varies from insurer to insurer, often as a function of the vigor with which recovery is pursued. Our informal survey revealed national averages of additional revenue gained from subrogation ranged from one to five percent of total revenues with two percent being the most commonly reported figure.

Even though the Kansas HMO Association has long advocated subrogation, the issue unfortunately was raised initially during a time when the Legislature was faced with a crisis in rising medical malpractice insurance premiums. As the Legislature grappled with the difficult problems of tort reform, the idea of subrogation was bantered about as one of the methods through which the medical malpractice crisis could be solved.

Quite frankly, the HMO Association did not then and does not now feel that subrogation is appropriately a part of the tort reform debate. Rather, it is simply and straight forwardly a method of health insurance cost containment and a matter of putting all health insurers in Kansas on a level playing field whether they are regulated by the Kansas Insurance Department or are a function of the federal government.

Senate Bill No. 396 as it appears before you has been modified as a result of extensive discussions held this summer and fall before the Interim Committee on the Judiciary. The rationale for the changes is contained in the Committee's report. With those suggested modifications, we urge this Committee's favorable recommendation of legislation allowing subrogation clauses in any policy or contract of accident, health or sickness insurance issued in this state providing for reimbursement of medical, surgical, hospital or funeral expenses. The language of Senate Bill No. 396, as modified, allows subrogation to the insurer for the insured's rights of recovery when the circumstances of the insured's injuries create a legal liability against the third party for not more than the amount of the benefits that the insurer might have previously paid or provided in relation to the insured's injury by that third party. The bill also stipulates that subrogation should be available only to

the extent that the insured is not left with any uncovered, out-of-pocket expenses for medical and related health care services. The insurer would be allowed to enforce subrogation rights in its own name or the name of its insured, and any attorneys fees or costs would have to be paid by the insurer from any recovery it obtained.

In summary, let me state that the objectives of subrogation are to prevent the insured from recovering twice for one harm and to prevent the wrongdoer from being relieved of liability because the insured had the foresight to obtain insurance and had paid for it. Reimbursement to the insurer for payment it already made would enable the insurer to reduce costs and control premium rates. Extending subrogation to health and accident insurers would, therefore, benefit both the insurers and the insured through reduced health care insurance premium costs.

Other conferees today will tell you of the severe impact health care costs are having on small employers throughout this state and will describe for you the unfairness they confront in providing their employees with health insurance as compared with self-insurers and large employers providing out-of-state insurance, both of whom are allowed to subrogate in the current environment of the unlevel playing field.

I can also tell you as a current member of this Legislature's Commission on Access to Services to the Medically Indigent that the numbers of working citizens of this state who have no health insurance is rising dramatically because small employers are increasingly unable to provide health insurance as a benefit of employment because of rising health care costs.

We urge you to grant health insurers and HMO's the right of subrogation to be used as they deem appropriate, but under the supervision of the Kansas Insurance Department, as a health insurance cost containment tool. Bring Kansas into the camp of the majority of states allowing subrogation as a means of equity which has found overwhelming favor in the law.

Reply to:

KANSAS HMO ASSOCIATION
SUBROGATION
FACT SHEET

- Definition: Subrogation is the right of an insurer or HMO to be put in the position of its insured in order to pursue recovery from a third party responsible to the insured for a loss or benefit which the insurer or HMO has paid or provided. Example: A person with a health insurance policy is injured at a neighborhood party where the property owner was totally at fault. Such person sustains $20,000 in medical expenses, which are paid by his health insurer. He also recovers from the property owner at fault (or such owner's liability insurer) $40,000, including $20,000 for medical expense. With a right of subrogation, the health insurer would be permitted to recover the $20,000 it paid for the injuries caused by the negligence of the property owner.

- Subrogation is designed to assure that the injured party is made whole and that the loss is ultimately paid by the party legally responsible for the loss.

- Current Kansas Insurance Department regulations prohibit subrogation for reimbursement of medical, surgical, hospital or funeral benefits paid for by insurers to insured injured by a third party. K.A.R. 40-1-20 states: "All insurance companies are prohibited from issuing contracts of insurance in Kansas containing a subrogation clause applicable to coverages providing for reimbursement of medical, surgical, hospital or funeral expenses". This prohibition on subrogation has also been applied to HMOs which provide health care services to enrollees injured by a third party.

- The regulatory prohibition is based on the Kansas Insurance Department position that because no right of subrogation on contracts of personal insurance exists under common law, the right of subrogation must be statutorily created.

- Subrogation for insurers and HMOs would eliminate a costly duplicative recovery by the policyholder. Windfalls and excessive recoveries increase the cost of health insurance without a useful purpose.

- Kansas Legislature has allowed subrogation in certain instances:
  - Uninsured Motorist Coverage, K.S.A. 40-284.
  - Workers' Compensation, K.S.A. 44-504 and K.S.A. 44-532.
  - Kansas No-fault Law, K.S.A. 40-3113a.
  - Governmentally financed health insurance, such as Medicare and Medicaid, have a right of subrogation.
  - Employers who self-insure their health benefit program are free to include subrogation provisions in such programs.

MEMBER ORGANIZATIONS
CIGNA Health Plan of Kansas City, Inc. • EQUICOR Health Plan, Inc. • Family Health Plan Corporation • Health Plan of Mid-America
HMO Kansas, Inc. • Kaiser Permanente • Kansas City Advance Health Maintenance Organization, Inc. • Medplan, Inc.
Metlife Healthcare Network of Kansas City, Inc. • Prime Health • Principal Health Care, Inc. • Total Health Care

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- Objectives of Subrogation
  - Prevent insured from recovering twice for one harm.
  - Wrongdoer should not be relieved of liability because insured had the foresight to obtain insurance and had paid for it.
  - Reimburse insurer for the payment it has made thereby reducing costs and enabling the insurer to control premium rates.

- 38 states allow some form of health insurance subrogation. Of the 12 states which do not permit subrogation in health insurance contracts, Kansas is 1 of only 5 states prohibiting subrogation as a matter of law.

- Revenue income resulting from the use of subrogation varies from insurer to insurer, often as a function of the vigor with which recovery is pursued. National averages of additional revenue gained from subrogation ranges from one to five percent of total revenues, with two percent being the most commonly reported figure.

- Usually the employer has paid all or part of the insured's health coverage premium. If the insurer receives that money and uses it to keep premium increases down, employers and employees benefit from moderated insurance premium increases.

Hawkins

PYRAMID LIFE

SINCE 1913

THE PYRAMID LIFE INSURANCE COMPANY, 6201 JOHNSON DRIVE, SHAWNEE MISSION, KANSAS 66202 (913) 722-1110

M. KEITH HAWKINS
Vice President
Secretary and Counsel

RE: SENATE BILL NO. 396

Mr. Chairman and Committee Members:

My name is Keith Hawkins and I am Vice President, Secretary and Counsel of The Pyramid Life Insurance Company, a Kansas' domestic insurance company which specializes in the sale of individual health insurance to families and small businesses. I appreciate the opportunity to testify in favor of Senate Bill 396.

Like other health insurance companies, we are extremely concerned with affordibility of health insurance coverage. If premiums become too high, policyholders are forced to give up their coverage and self insure. As you well know, health care costs have skyrocketed and as a direct result, health insurance premiums have increased substantially. We, like others, have tried various cost containment measures including higher deductibles, increased coinsurance, second opinions and pre-certification for non-emergency surgeries. These have helped, but we must continually look for other alternatives.

We have just begun marketing a new individual major medical policy in states other than Kansas that contains a subrogation provision. Twenty-three of the states Pyramid Life is licensed in permit subrogation. Although we have no Company experience, we firmly believe based on industry experience that subrogation can effectively reduce overall claim costs. If such is the case, any savings can be used to offset medical care inflation and hopefully ebb the tide of increasing premiums.

licensed in 40 states

Availability means affordibility. The insuring public are our customers and we cannot price ourselves out of the market. On the other hand, we cannot ignore the financial impact of medical inflation and remain solvent. Our only course is cost containment, so we ask that you vote in favor of Senate Bill 396 for the benefit of all Kansans' concerned with affordibility of health insurance.

Thank you for your attention.

Sincerely,

M. Keith Hawkins
Vice President

Attachment 3
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Pitsenberger

TESTIMONY OF BLUE CROSS AND BLUE SHIELD OF KANSAS
ON LEGISLATIVE INTERIM STUDY PROPOSAL NO. 36
Bill Pitsenberger, General Counsel

Proposal No. 36 asks for a study on whether subrogation should be permitted in health insurance contracts in Kansas as a cost containment mechanism. The answer of Blue Cross is, "probably, if only as a matter of equitable treatment of small employers."

Before explaining that position in detail, there are a few brief items that we think we should touch on.

First, the 1988 Legislature considered allowing subrogation in health insurance in Senate Bill 630. That bill unfortunately appeared to be a part of the medical malpractice insurance reform package, which complicated consideration of the concept needlessly. Among other elements, some persons have felt that the medical malpractice insurance reform package's partial abrogation of the collateral source rule was threatened by, or somehow related to, allowing for subrogation in health insurance. Allowing for subrogation in health insurance has absolutely nothing to do with medical malpractice insurance reform. This simple, factual statement can be made in light of the fact that most of the forms of health care financing which exist in Kansas permit subrogation already. Medicare, which covers about 10% of the Kansas population, has a right of subrogation. Medicaid has

Attachment # II + I
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a right of subrogation. Workers Compensation coverage has a right of subrogation. Uninsured motorists coverage has a right of subrogation. No-fault insurance coverage has a right of subrogation. Employers who self-insure have a right of subrogation, and the number of employers who self-insure is both very large and increasing in numbers; most of the top ten employers in Topeka, for example, excluding the State, self-insure. Kansas residents who are employed by companies headquartered outside of Kansas, in a state where subrogation is permitted, have health care programs which include a right of subrogation.

In short, subrogation rights in health care financing programs are widespread in Kansas; whether another form of health care financing -- health insurance -- should be added to that listing needs to be considered as a policy matter wholly unrelated to any medical malpractice insurance reform issues.

Second, there are decent and compelling arguments both for and against permitting duplicate recovery of medical expense, and current state policy both denies it in some circumstances and permits it in others.

In the field of health insurance alone, we permit avoidance of duplicate benefits where a person is covered by two group health policies through a device called "Coordination of Benefits". That device, required of group health insurers, specifies what insurer is primary -- who pays first -- and what insurer is secondary -- who pays balances -- and specifically provides that the combination of policies will not pay more than the loss. Health insurance policies are allowed to exclude benefits to the extent covered by no-fault, Medicare, Medicaid, and workers compensation insurance, too. Where one has more than one individual or non-group health insurance policy, those policies may contain a clause entitled "Insurance in Other Insurers" which permits the insurers to prorate the loss in order to avoid duplication of benefits.

On the other hand, if one is covered by both a group health policy and a non-group health policy, there are no statutorily permitted devices to avoid duplication of benefits, and double recovery of a loss is common in such situations.

One theory for permitting double recovery -- for not allowing subrogation -- seems to be that if one pays a health insurance premium, one should enjoy the benefits of it without reduction because of other recoveries. Obviously, we have strayed far from that, given the duplication avoidance devices allowed in other circumstances of health coverage.

In addition to the contradiction that duplicate recovery is not permittted in many health insurance situations, there are also practical problems with this theory: most persons have health insurance through employment, and most employers pay at least a part of the bill for that. At least one policy question, then, is whether employers should be permitted to include devices such as subrogation in policies they acquire for their employees which help reduce the employer's cost.

Another argument sometimes made for not allowing subrogation is that it complicates settlements. I don't think that can be questioned. The health insurer wants to be certain the tort-feasor bears a proper share of the medical expense which he or she caused. On the other hand, is it better to have a policy which essentially frees the injured party and the tort-feasor from having to consider medical expense in settlement negotiations?

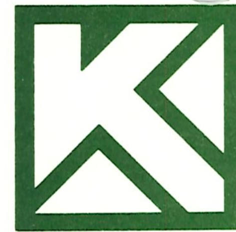
Subrogation is not a panacea for the problems of increasing costs of health care financing. Blue Cross and Blue Shield of Kansas has only limited data on recoveries through subrogation itself. Other Blue Cross and Blue Shield plans which subrogate -- and they are allowed to do so in 38 states -- averaged net recoveries after administration expense of one half of one percent of total claims in 1988. A number of factors work to make virtually certain that insurers will not recover all of the medical payments they make, particularly the comparative fault doctrine.

Other persons appearing here may have other figures, based on more direct experience with subrogation. The Blue Corss averages need to be understood in context. While they may be low on average, if a group is rated based on its own claims experience -- and all of our groups are, to a greater or lesser extent -- avoidance of a single large claim can dramatically affect the rate for that group.

I said at the beginning that Blue Cross felt that subrogation probably should be permitted as a matter of equitable treatment of small employers. As the corporate attorney, I am personally not enthusiastic about subrogation, because it requires a lot of administration, a lot of attorney contact, and attention to a lot of complicated facts. Blue Cross and Blue Shield of Kansas doesn't do subrogation much, and national insurance companies with whom we compete are probably more efficient at it than we will be for some time. Nevertheless, when state policies impact predominantly small employers adversely, while large employers who self-insure or who are a part of a national chain are free from such restrictions, the fairness of those policies needs close examination.

Leatherman

LEGISLATIVE TESTIMONY



Kansas Chamber of Commerce and Industry

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

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

SB 396 January 23, 1990

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

Senate Committee on Financial Institutions and Insurance

by

Terry Leatherman
Executive Director
Kansas Industrial Council

Mr. Chairman and members of the Committee:

My name is Terry Leatherman, with the Kansas Chamber of Commerce and Industry. Thank you for the opportunity to appear before you today in support of SB 396.

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

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

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

Every year, it becomes more costly to run a business in Kansas. While the expense of paying employee salaries, government taxes, and business equipment and materials grow

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each year, the fastest growing item on the expense side of the ledger is the cost of health care insurance programs. Annual double-digit hikes in insurance premiums leave Kansas employers with difficult choices of letting increases continue to eat away at the company's bottom line, requesting their employees shoulder more of the insurance premium burden, shopping for less comprehensive medical care programs, or to stop offering health care insurance to workers.

KCCI supports granting health care insurors subrogation rights because it is one step in slowing down the runaway costs of health care insurance. According to the Kansas H.M.O. Association, vigorous use of subrogation rights can retrieve between one to five percent of total insurance revenues. If applied to insurance premiums, those revenues can help make health care insurance more affordable.

While granting subrogation rights will help curb costs of health insurance, it will also bring fairness to the system. Subrogation would further limit legal double-dipping, where the injured person collects from an insuror to pay for medical expenses, and then collects again by filing a lawsuit against a responsible third party.

While KCCI supports this legislation, we do so with one reservation. Subrogation rights should not be extended to insurance companies and Health Maintenance Organizations to initiate lawsuits against uninsured third parties. The main purpose of this legislation is to allow the insurors to join existing lawsuits filed by their injured insureds. In some cases, when the responsible third party has liability insurance coverage, the health care insuror will need the right to initiate subrogation lawsuits. However, the purpose of this bill was not to have insurance companies and Health Maintenance Organizations initiate lawsuits against individuals and businesses. Without this exception, insurors would have the authority to sue an injured person's best friend or boss to recover medical expenses caused by an accident. Leading supporters of this bill agree that pursuing non-insured third parties is not the intent of subrogation, and would not oppose an amendment to prohibit it.

Once again, thank you for the opportunity to express KCCI's support for SB 396.

KANSAS TRIAL LAWYERS ASSOCIATION

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RICHARD H. MASON
EXECUTIVE DIRECTOR

TESTIMONY
of
KANSAS TRIAL LAWYERS ASSOCIATION
before
SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE

January 22, 1990

The Kansas Trial Lawyers Association wishes to go on record in opposition to SB 396 regarding subrogation rights in health insurance contracts. We concur with the existing Department of Insurance Administrative regulation holding that Kansas law prohibits subrogation clauses in health insurance.

Proponents of subrogation speak of the need to eliminate what they term "double recovery." Our experience in representing victims of negligence indicates there rarely are cases of overcompensation. Just the opposite, in fact, is true. This is especially evident when we consider the cost plaintiffs bear during the course of litigation for which they are not compensated, including legal expenses.

Subrogation generally will have a neutral effect on our members in their profession. Our testimony to you, then, is from the point of view of personal injury victims, who clearly stand to lose if subrogation is implemented.

Health insurance policyholders pay premiums to cover costs when injured, including injuries caused by someone else. They pay for those benefits, and they should receive them.

You have been told subrogation will reduce loss ratios for health insurors and thus lower the cost of health insurance itself. But how would SB 396 actually be reflected in the insurance bill of a typical policyholder? A savings of $50 per month? $25? $10? No one seems to know.

The effect of granting the right of subrogation to a medical insurance provider is to place a substantial penalty upon the injured victim by assuring that the proceeds from his or her insurance policy will be appropriated if he or she recovers any damages from a negligent third party.

In return, the insurance company avoids exposure to any risk and is under no obligation to reduce premiums to its insureds or to account for their windfall in any manner.

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What possible good can be seen in a public policy that takes from the injured the very thing that the injured party had purchased for protection and then gives it to the insurance company which has not suffered an injury and which has been compensated in advance for the risk that it was insuring?

We know subrogation will take compensation away from victims, but it is unlikely Kansans will get anything in return. Subrogation is a one sided proposition and should once again by rejected by the Kansas legislature.

Slaughter

KANSAS MEDICAL SOCIETY

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

January 23, 1990

TO: Senate Financial Institutions and Insurance

FROM: Jerry Slaughter
Executive Director

SUBJECT: Senate Bill 396 - Subrogation

The Kansas Medical Society appreciates the opportunity to provide some comments on the subject of mandated subrogation clauses in accident and health insurance policies. We are concerned about this issue because of its implications in the area of medical malpractice litigation. We will not go into any background about the subrogation issue, since other conferees have covered that already.

Simply put, mandating subrogation clauses in all accident and health insurance policies will negate the beneficial effect of the abolition of the common law collateral source rule in medical malpractice litigation. On three previous occasions, the Kansas Legislature has enacted collateral source rule legislation designed to eliminate duplicate recoveries in medical malpractice actions, thereby reducing claim costs paid by the Health Care Stabilization Fund and other professional liability insurers. As recently as 1988, this Legislature enacted collateral source rule legislation specifically for that purpose.

This is the manner in which the issue of subrogation becomes intertwined with the issue of medical malpractice litigation. While mandating subrogation clauses will benefit health insurers only marginally (expected recoveries from subrogation actions are estimated to be about 2% of total income), it has a significant impact on the Health Care Stabilization Fund and the few professional liability insurers in our state. Legal arguments aside, the issue for your consideration is which insurer should benefit from legislation designed to eliminate duplicate payments in personal injury litigation?

In our view, because of the enormous cost of medical malpractice insurance, and its effect on the health care system in general, any benefit which arises from avoiding duplicate payments in medical malpractice actions should go to the Health Care Stabilization Fund or the few insurers who provide professional liability insurance in this state. This can be accomplished by exempting medi-

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cal malpractice actions from legislation which mandates subrogation in accident and health insurance contracts. In 1988 when this issue first arose, we suggested such an amendment, and that has been our consistent position throughout consideration of this issue. As you can see from the attached draft, our amendment would merely exempt medical malpractice liability actions from the application of the mandated subrogation provision.

Additionally, if this Committee recommends to the 1990 Legislature similar legislation, we would ask that a statement of intent be placed in the Committee minutes which expresses the rationale to be that of reducing medical malpractice claim and premium costs, consistent with the collateral source rule legislation previously enacted by the Legislature.

Another issue this Committee may want to consider is whether subrogation should be mandated or merely made permissive.

We would not oppose subrogation legislation which included an exemption such as that we have outlined. We appreciate the opportunity to provide these comments, and we would be happy to respond to any questions. Thank you.

JS:nb

Attachment

SENATE BILL No. 396

By Committee on Ways and Means

4-6

AN ACT concerning insurance; providing for subrogation rights under accident, health or sickness insurance policies.

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

Section 1. (a) As used in this act:

(1) "Insurer" means and includes all corporations, companies, associations, societies, fraternal benefit societies, mutual nonprofit hospital service and nonprofit medical service companies, partnerships and persons engaged as principals in the business of insurance of the kinds enumerated in articles 4, 5, 6, 7, 11, 13, 18, 19, 19a, 19b, 19c, 22, 32 and 38 of chapter 40 of the Kansas Statutes Annotated and any amendments thereto, insofar as the business of insurance of the kinds enumerated in such articles relate to accident, health or sickness; and

(2) "insured" means and includes persons who are the beneficiaries, assignees, payees of, owners of or certificate holders under such policies or contracts of insurance as described in subsection (1) including enrollees of a health maintenance organization as defined in K.S.A. 40-3202 and amendments thereto.

(3) "medical malpractice liability action" means any action for damages for personal injury or death arising out of the rendering of or a failure to render professional services by a health care provider as defined by K.S.A. 40-3401 and amendments thereto.

(b) Any policy or contract of accident, health or sickness insurance, and any health maintenance organization subscriber contract, issued in this state shall include a subrogation clause providing for reimbursement of medical, surgical, hospital or funeral expenses.

Except for a medical malpractice liability action,

Such clause shall subrogate the insurer to the insured's rights of recovery when the circumstances of the insured's injury create a legal liability against a third party for not more than the amount of benefits that the insurer shall have previously paid or provided in relation to the insured's injury by such third party. Subrogation shall be available only to the extent that the insured is not left with any uncovered, out-of-pocket expenses for medical and related health care services necessitated by the injury in question. The insurer may enforce such rights of subrogation in its own name or in the name of the person to or for whom payment has been made, as their

KaMMCO
KANSAS MEDICAL MUTUAL INSURANCE COMPANY

January 23, 1990

TO: Senate Financial Institution and Insurance Committee

FROM: Lori M. Callahan
Legislative Counsel

SUBJECT: Senate Bill 396 - Subrogation

The Kansas Medical Mutual Insurance Company, KaMMCO, is a Kansas, physician-owned, non-profit professional liability insurance company formed by the Kansas Medical Society. KaMMCO currently insures 400 Kansas doctors and has capitalized and anticipates insuring in the next few months 400 more. KaMMCO feels it is in a unique position to provide insight to the Kansas legislature with regard to professional liability insurance for doctors and, therefore, appreciates the opportunity to testify today.

Throughout the discussion of legislation affecting professional liability insurance rates for doctors, consideration has been given to methods to prevent "double-dipping" by plaintiffs. As a result of those discussions, collateral source legislation was enacted. The purpose for enacting such collateral source legislation, as opposed to any other method to prevent double-dipping, was to insure physicians and others affected by high liability insurance premiums would realize the resulting savings.

By way of subrogation, health care insurers are now seeking relief for themselves, rather than physicians, from the double-dipping phenomena. Granting such subrogation rights to health insurers would abrogate the collateral source legislation, shifting the relief granted in 1988 away from Kansas physicians to health insurance companies.

KaMMCO believes such a shift should be considered in light of its financial and public policy implications. Health insurers can demonstrate little, if any, premium affect from subrogation. KaMMCO, however, believes, as demonstrated by the Rand study of collateral source, that collateral source has a very real premium impact for liability insureds as well as the Health Care Stabilization Fund.

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KaMMCO, therefore, supports the exemption from subrogation for medical malpractice actions as suggested by the Kansas Medical Society. We believe this exemption will allow health care providers and, therefore, the people of Kansas to obtain the most effective benefit from precluded double-dipping, which occurs from collateral source, as opposed to subrogation. With the inclusion of such an exemption as outlined by the Kansas Medical Society, KaMMCO would not oppose subrogation legislation. We appreciate the opportunity to testify and would be happy to answer any questions.

Ron Smith

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SB 396
January 23, 1990

Mr. Chairman, members of the Senate Financial Institutions and Insurance Committee. I am Ron Smith. I represent the Kansas Bar Association.

> *KBA opposes SB 396. While subrogation is allowed in other third party claims, we believe the ultimate result of such law is to increase likelihood that more lawsuits would be brought.*

KAR 40-1-20 prohibits subrogation clauses applicable to health insurance companies regulated by the Commissioner of Insurance. This is so even though thirty eight states now allow some form of subrogation of health insurance.

Nevertheless, our KBA legislative committee reviewed this issue based on the work by the 1989 Interim Judiciary Committee. Its recommendation to our Board of Governors, and subsequently adopted by our Board as Bar legislative policy, was that KBA oppose allowing health insurance to subrogate in Kansas.

While we acknowledge several statutes exist giving various insurance systems subrogation rights in third party tort claims, we believe subrogation clauses generally tend to create a more litigious environment. Further, even if health insurance were allowed subrogation rights, in order to be fair to all litigants, many amendments would be required to conform such laws with existing collateral source rules and our comparative negligence act. (See the attached article)

Thus, the minimal cost savings when compared with the potential rise in litigousness is unwarranted, in our view. Thank you.

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More Goo for Our Tort Stew:

Implementing the Kansas Collateral Source Rule

By James Concannon* and Ron Smith**

Trial lawyers and consumer groups believe "tort reform" is an overcorrection to a fickle insurance boom and bust cycle, and higher liability premiums are a self-inflicted wound brought on by an imprudent insurance investment policy called cash flow underwriting.[1] Business owners and professionals feel the legal system is not as sensitive as it should be to what high premiums do to the quality of medicine or the economic chill on Main Street.[2] Between these polar extremes important changes in the collateral source rule were made as tort reform. This article examines these changes and some of the legal and evidentiary questions raised by the new law.

The Kansas Coalition for Tort Reform set the climate of the legislative debate, arguing legislative regulation of the common law collateral source rule merely "allows juries to know the facts and do what is fair."[3] As this article demonstrates, the legislation does considerably more.

Purpose and History

The collateral source rule received little scholarly attention until the mid-20th century, when commentators began focusing on the rule's underlying theories.[4] Fanning the fire of change were numerous no-fault automobile insurance systems and the movement toward social safety nets like Medicare and various state-sponsored mandatory insurance mechanisms.[5] The 1970s brought the first medical malpractice "crisis." The 1980s saw both product liability and medical malpractice insurance emergencies. In each instance, changing the collateral source rule became a focus of reform.[6]

The battle over the collateral source rule raged for years in the courts with innovative arguments.[7] The struggle shifted in the mid-1970s to state legislatures. There is little uniformity in the types and breadth of statutory regulation of collateral source rules.[8] We say regulation because nowhere does a statute completely abolish a state's common law rule.

Kansas Legislative Responses

As a reaction to the first medical malpractice crisis in 1976, K.S.A. 60-471 was enacted. That statute allowed juries in actions against health care providers to hear evidence of reimbursements or indemnifications paid to injured plaintiffs, except for insurance payments and HMO benefits where the plaintiff or plaintiff's employer paid for the premiums, in whole or in part. It excluded evidence of collateral benefits where subrogation or lien rights existed. The resulting law was declared invalid by one federal district court[9] and in 1985 the Kansas Supreme Court held it violated equal protection provisions of the U.S. and Kansas Constitutions.[10]

In 1985, rapidly increasing premiums prompted health

FOOTNOTES

*Concannon is a graduate of the University of Kansas School of Law and is dean of the Washburn University Law School. **Smith is a 1977 graduate of Washburn Law School and is Legislative Counsel for the Kansas Bar Association. Both have made presentations to the Kansas Legislature on the collateral source rule. The views in this article are those of the authors and not of any organization.

1. **Report on Kansas Legislative Interim Studies to the 1987 Legislature**, Proposal #29, Tort Reform and Liability Insurance, by the Special Committee on Tort Reform and Liability Insurance, p. 584, and p. 589. Hereafter this report is referred to as "Interim Reports."
2. 1986 Interim reports, p. 583.
3. From a May 1987 mailing by the Kansas Coalition for Tort Reform, the Kansas arm of the American Tort Reform Association.
4. Bell, **Complete Elimination of the Collateral Source Rule — A Partial Answer to Criticism of the Present Injury Reparations System**, 14 N.H.B.J. 20 (1972); Fleming, **The Collateral Source Rule and Loss Allocation in Tort Law**, 54 Calif. L. Rev. 1478 (1966); Peckinpaugh, **An Analysis of the Collateral Source Rule**, 32 Ins. Counsel J. 32 (1965); Schwartz, **The Collateral Source Rule**, 77 Harv. L. Rev. 741 (1964).
5. **Prosser on Torts**, 4th Ed., pp. 559-570.
6. Richardson, "The Collateral Source Rule," 42 Missouri B.A. 373, 378 (1986).
7. Richardson, supra, reports a 1921 case where a Kansas City, Missouri newsboy hitched a ride on the outside of a trolley car. The conductor angrily knocked the boy under the trolley, which severed the boy's leg at mid-thigh. On appeal, defense counsel argued the $3,350 verdict was excessive because, "Everyone knows, and the writer believes the court will take judicial notice of the fact that a crippled boy does make more money selling newspapers than a boy who is not crippled." Citing **Samples v. Kansas City Railway Co.**, 232 S.W. 1049 (Mo. Ct. App. 1921).
8. See footnote 70, infra, listing various state collateral source rule statutes. See also **Alabama**, Code §6-5-523-525 effective 1987; **Arizona**, Rev. Stat. Ann. §12-565, Effective 1985; **California**, Civil Code §3333.1, effective 1975; **Nebraska, Rev. Stat.** §44-2819, effective 1976; **Utah**, Code **Ann.** §78-14-4.5, effective 1985; and **Washington**, Rev. Code, §7.70.080, effective 1975. In October 1987, the Ohio legislature enacted a comprehensive tort reform package that contained some collateral source changes.
9. **Doran v. Priddy**, 534 F. Supp. 30 (D. Kan. 1981). Judge Theis used a "heightened scrutiny" test.
10. **Wentling v. Medical Anesthesia Services**, 237 Kan. 503, 701 P.2d 939 (1985). A 5-2 majority agreed with Judge Theis' opinion in **Doran**, supra.

9-2

care providers to propose a broader statute. Contrary to the 1976 act, K.S.A. 1985 Supp. 60-3403 allowed submission to the jury of evidence of all defined collateral sources, regardless of whether subrogation interests existed. Evidence of subrogation interests was also allowed. During the 1987 session, other non-medical organizations introduced HB 2471, which attempted to broaden K.S.A. 1986 Supp. 60-3403 for use in all personal injury actions but the bill failed in the House of Representatives.[11]

K.S.A. 1987 Supp. 60-3403 was ruled unconstitutional in **Farley v. Engelken.**[12] Justice Lockett's concurring opinion in **Farley** suggested a statute might fare better constitutionally if it affected all litigants alike. The 1988 legislature accepted Justice Lockett's invitation for a broader approach to reform but learned construction of a statutory rule change was not a simple task.

Chapter 222 — An Overview

Chapter 222 of the 1988 Session Laws (K.S.A. 1988 Supp. 60-3801 *et seq.*) implemented the collateral source rule change. It is a unique piece of legislation. It not only changes the law of damages but also implements new economic and compensatory theory. Within its provisions are conflicts, the most obvious being that the legislature wants juries to hear evidence of present and future collateral source benefits but only when the entire claim exceeds $150,000.[13]

K.S.A. 1988 Supp. 60-3801(b) broadly defines collateral sources with three major exemptions: (1) life insurance, (2) disability insurance, and (3) any other service or insurance where subrogation or lien rights exist. The act itself does not create a lien or subrogation interest. Gratuitous services remain exempt, as at common law. Most important, **any** collateral source must be received "as the result of the occurrence upon which the personal injury action is based" or the statute is inapplicable.[14]

The statutory definition of collateral source is different from its common law root. The common law collateral source rule blocked admission only of evidence of payments made "independent of the tort-feasor."[15] If the tort-feasor paid part or all of the damages, for example a parent's hospitalization insurance for the child's injuries, such evidence was not shielded from the jury in states where children can sue parents for injuries in automobile accidents.[16]

"Collateral source benefits" is a term with a distinctive definition based only on the receipt of benefits by the plaintiff and the nature of those benefits, not the payor of the benefits. Parental benefits may be collateral sources because of the definition in K.S.A. 1988 Supp. 60-3801(b) even if the parent is a codefendant for comparative negligence purposes and even though at common law the collateral source rule would not apply to these benefits.

This "independent of the tort-feasor" point is important for two reasons. First, K.S.A. 1988 Supp. 60-3802 appears to prohibit any collateral source benefit as defined in the statute from being introduced unless the claim exceeds $150,000. Thus, in actions for less than $150,000, amounts which heretofore had not been collateral payments subject to the common law rule now may be excluded from evidence. The threshold and the definition may have changed the common law so that evidence the defendant previously could introduce is no longer admissible.

Second, even if evidence of payments by a tort-feasor is introduced, the K.S.A. 1988 Supp. 60-3805 credits and offsets temper much of the advantage of the tort-feasor.

K.S.A. 1988 Supp. 60-3802 limits presentation of collateral source evidence to a jury. Defendant appears to have the burden of proof to establish the extent to which collateral benefits have been or will be provided, and the plaintiff has the burden to establish the cost of the benefits.

The legislature included future collateral source benefits as admissible evidence.[17] The difficulties this will create at trial are discussed below.

The legislation is prospective in application and effective for claims "accruing" on or after July 1, 1988.[18]

11. HB 2471 was introduced as a committee bill, originally resembling K.S.A. 1987 Supp. 60-3403, except it applied in all personal injury cases. After floor amendments were added, the bill was killed on the House Floor, 50-72. (1987 House Journal, p. 421.)
12. 241 Kan. 663, 740 P.2d 1058 (1987).
13. K.S.A. 1988 Supp. 60-3802. There is no individual rationale for the $150,000 figure except that is the number to which four of the six conferees on the conference committee could agree.
14. K.S.A. 1988 Supp. 60-3801(b).
15. Restatement (Second) of Torts, §920A.
16. A parent may be a codefendant for comparative negligence purposes.
17. K.S.A. 1988 Supp. 60-3802.
18. K.S.A. 1988 Supp. 60-3807.

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Collateral Source Law as Economic Theory

Whatever problems the common law causes insurance companies or their insureds, the common law collateral source rule simplifies a trial. Whether a plaintiff is listed in the Fortune 1000, receives payments from insurance, gratuities from Mom, or exists on welfare is irrelevant to determining whether plaintiff was injured by defendant's negligence and the amount of damages sustained. The jury focuses on the culpability of the parties, not on the private resources of either party to pay damages. The legislation undoes this symmetry.

The legislature's new economic theory may be stated as follows. Each injury produces total damages, economic and noneconomic. If the injury is self-inflicted, first party insurance pays the damages up to limits in the policy. Where the injury is caused by another's negligence, the total cost is determined by a trier of fact. That determination is made without the jury knowing what ceilings state law imposes on awards or exactly what the court will do with the jury's comparative negligence determinations.

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The principle is that "net collateral source benefits" should be used to reduce the judgment against a defendant only when plaintiff would otherwise receive total compensation exceeding the total damages determined to be suffered by plaintiff. Before any reduction, plaintiff is entitled to apply collateral benefits first to any portion of total damages suffered which for one reason or another is self-insured or otherwise uncollectable.

When plaintiff has collateral sources, the legislation provides a rational way of allocating such collateral sources to account for the holes or the uncollectible damages now imposed by other Kansas law.[19] Connecticut has a similar allocation law,[20] and Montana allows a post-judgment reduction of an award only after the plaintiff is fully compensated.[21]

Procedural Due Process

When criticizing the rational basis of K.S.A. 1987 Supp. 60-3403, Justice Lockett in **Farley** worried about "inherent ambiguities" of collateral source statutes.[22] One of the difficulties was permitting judicial discretion whether to admit evidence of payments by the claimant to purchase the benefits while removing judicial discretion whether to admit evidence of payments to the claimant.[23] Similar ambiguities have caused remedial tort reform such as K.S.A. 60-471 to be declared unconstitutional.[24] The Kansas Supreme Court has a lengthy history of constitutional concerns about legislation which alters or limits remedies.[25]

Practical Problems with the Statute

I. Property Collateral Sources

No legislation is gap-free. The collateral source law is no exception. For example, K.S.A. 1988 Supp. 60-3801(a) purports to limit the act to personal injury and death claims. In the real world personal injury claims often are mixed with property damage actions. The common law collateral source rule apparently still applies to the property damage claim brought within a personal injury or death action.

An illustration makes the point. Assume because of negligent maintenance of a railroad right of way a train derails, destroying a multimillion dollar bridge over a downtown traffic-way as well as injuring motorists driving underneath. Depending on the facts, the municipality might be a codefendant in a suit by the motorists but may also file a cross-claim against the railroad for property damage. The municipality may receive a federal grant to repair the damaged bridge or may have purchased property insurance for such calamities.[26]

Individuals with personal injuries suffered in the derailment may have their collateral sources of indemnification deducted from their awards yet the city's receipt of property collateral source payments is not used to reduce its award. The railroad is the common defendant in both claims and the root negligence is the same. The only difference is that one claimant's collateral source is health insurance and the other claimant's benefits come from a governmental grant or property insurance. The first mixed insurance case involving personal injury and property collateral sources will raise an interesting equal protection argument for the plaintiff.

II. Comparative Negligence

Kansas plaintiffs injured by defendants' negligence can be partially responsible for their own injuries. The absence of joint and several liability reduces the incidence of double payments under the common law collateral source rule.[27]

19. K.S.A. 60-258a, K.S.A. 1987 Supp. 60-19a01, Chapter 216 of the 1988 session laws of Kansas, and K.S.A. 60-1903. There is also a $500,000 overall limit on awards under the Kansas Tort Claims Act, K.S.A. 1987 Supp. 75-6105.
20. §52-225a-225d.
21. §27-1-307 and §27-1-308.
22. 241 Kan. at 681.
23. "As written, the statute could be interpreted to give a judge in a particular case the discretion to admit or exclude evidence of a plaintiff's payments. **It is unlikely that the intent of the legislature in enacting this statute was to confer greater rights upon defendants than upon plaintiffs.**" 241 Kan. at 681; emphasis added.
24. **Wentling v. Medical Anesthesia Services**, supra, at 517, where a divided court outlines "inequitable treatment of two patients suffering similar injuries at the hands of the same health care provider" and other "invidious hypothetical" examples.
25. See **Hanson v. Krehbiel**, 68 Kan. 670, 75 P. 1041 (1904), and its offspring.
26. See **Town of East Troy v. Soo Line R.R. Co.**, 476 F. Supp. 252 (E.D. Wis. 1979), aff'd 653 F. 2d 1123 (7th Cir. 1980), cert. denied 450 U.S. 922 (1981). There is, of course, an exception to the common law rule on government payments where the government is the defendant. A payment by one agency of the government to a plaintiff for medical expenses would not be excluded by the common law collateral source rule merely because another agency was the defendant. The common fund is the state general fund. In some jurisdictions, jurors are entitled to know that a fund common to the collateral source agency and the defendant has already paid part of the damages. **Green v. U.S.**, 530 F. Supp. 633 (E.D. Wis. 1982) aff'd 709 F.2d 1158 (7th Cir. 1983). Further, the common law collateral source rule impermissibly allows a form of punitive damages against a municipality where punitive damages are not otherwise allowed by statutes. **City of Salinas v. Souza and McCue Const. Co.**, 66 Cal. 2d 217, 57 Cal. Rptr. 337, 424 P.2d 921 (1967). In **City**, the court rejected use of the collateral source rule against a public entity since it would impose an unjust burden on the taxpayer while having no deterrent effect on a government since "government" is an abstract entity and government's employees were the true culprits.
27. Until the mid-1980s, when the latest wave of "tort reforms" began in state legislatures, Kansas was one of only four states which by statute had totally abolished joint and several liability for unintentional acts or omissions.
28. K.S.A. 60-258a. A claimant declared to be 25% negligent in his own injury sees the codefendants pay only 75% of all damages, including those for which the plaintiff has already been compensated, such as medical expenses paid by health insurance.
29. Because all such uses of the statute were appealed and **Farley, supra**, struck down the statute, the court was not called upon to solve this procedural conundrum.
30. K.S.A. 1988 Supp. 60-3802, 60-3803 and 60-3804.
31. K.S.A. 1988 Supp. 60-3805.

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By definition there is no double recovery for the proportionate damages a plaintiff pays or absorbs from plaintiff's own resources.[28]

In K.S.A. 1987 Supp. 60-3403 the legislature did not indicate how judges were to mesh the change in the rule with the judicial duty to reduce the jury's gross verdict because of comparative negligence.[29] K.S.A. 1988 Supp. 60-3805 recognizes that problem. An elaborate system is created whereby the jury determines total damages, percentages of negligence attributed to the parties and collateral source benefits and costs,[30] but the judge apportions payment of the whole loss between plaintiff and defense resources.[31] This procedure is no more than a logical addition to post-trial judicial duties imposed by the comparative negligence act.[32]

By definition there is no double recovery for the proportionate damages a plaintiff pays or absorbs from plaintiff's own resources.

To avoid possible unfairness meshing comparative negligence with the collateral source statute, K.S.A. 1988 Supp. 60-3805 gives plaintiff credit for that portion of collateral source benefits which pay plaintiff's proportionate share of liability.[33]

Assume plaintiff has $200,000 in damages, and $50,000 in BC/BS payments already received, plaintiff was 20 percent negligent, and two codefendants D(1) and D(2) were equally at fault for the remaining negligence (40 percent each). If the common law collateral source rule remains in place, plaintiff recovers only $160,000 from defendants and keeps $50,000 paid by BC/BS.

Under the new law, $40,000, representing the plaintiff's proportionate negligence, is first credited against the $50,000 of the medical expenses already paid by plaintiff's health insurance resources. The remainder, $10,000, is reduced from the total remaining defense liability, and the $160,000 judgment becomes a $150,000 judgment split equally if both codefendants are solvent.

A. Limits on Recovery: Immune and Insolvent Codefendants

If a codefendant is either insolvent or immune or is a phantom or not otherwise subject to personal jurisdiction, another consideration applies.[34] If D(1) is immune, D(2) as the sole remaining solvent defendant does not get to claim the remaining $10,000 collateral source reduction because by law plaintiff must absorb D(1)'s share of liability.

Because of the self-insurance/economic theory behind the bill, plaintiff's collateral sources must also back fill for defendants who are insolvent, immune or uninsured.[35] In these circumstances, D(2) receives no deduction for plaintiff's collateral sources and owes his proportionate $80,000 in full, which is no more than the comparative negligence statute otherwise imposes.[36]

Plaintiff cannot receive collateral source credits under K.S.A. 1988 Supp. 60-3805 for the negligence of any party with whom plaintiff previously has settled or agreed not to assert a claim. Plaintiffs either make good or bad settlements and it was not felt appropriate to allow poor settlement negotiations to produce a credit. Presumably the reverse also is true. If plaintiff settled for an amount more than the jury awards against the settling defendant, the excess is not considered a collateral source. The law generally favors settlements and it seems inconsistent to penalize litigants who do so.

To trigger the exception, the plaintiff must make a "decision not to assert a legally enforceable claim against a named or unnamed party."[37] It is an open question what happens when plaintiff does not learn of the possible liability of a person until after a statute of limitations has expired, perhaps because of a defendant's refusal to supply pertinent information.

Can plaintiff argue there was no decision not to assert a claim against that person thus allowing any collateral source benefits to be offset under K.S.A. 1988 Supp. 60-3805? The word "decision" implies a conscious choice. Defendant may argue there is a "decision" when reasonable diligence would have uncovered the party. Plaintiff will counter that without a Rule 11 (K.S.A. 60-211) basis upon which to file the claim, there is no decision not to assert it.[38]

To trigger the exception, the plaintiff must make a "decision not to assert a legally enforceable claim against a named or unnamed party."

While bankruptcy seems cut and dried, insolvency may present factual issues. Does a defendant who seeks to have the judgment reduced have the burden of persuasion that plaintiff will be able to collect the judgment, or does the plaintiff who opposes reduction in the judgment have the burden to prove the plaintiff is unable to collect the judgment? Post-verdict discovery may be necessary in either event, probably in connection with a motion pursuant to K.S.A. 60-260(b)(1) or (2) when an insolvency becomes apparent after a K.S.A. 1988 Supp. 60-3805 reduction has been made. The reference to insolvency or bankruptcy of a "person" in this statute parallels the generic reference to "person" in the comparative negligence statute and thus should include corporate insolvencies and bankruptcies.[39]

32. Courts may need to instruct juries their only role is to determine disputed collateral source benefits received and costs thereof. They are not to reduce the gross verdict; such power is reserved to the court under K.S.A. 1988 supp. 60-3805.

33. Dean Concannon suggested this change to the 1987 House Judiciary Committee considering HB 2471. With a year to ponder, the 1988 legislature adopted the Concannon theory as the crux of K.S.A. 1988 Supp. 60-3805 post-trial adjustments.

34. K.S.A. 1988 Supp. 60-3805(a) (3) and (a) (4).

35. How K.S.A. 1988 Supp. 60-3805 affects proportionate judgments of underinsured codefendants is not specified in the act. The co-defendant may be partially insolvent under K.S.A. 1988 Supp. 60-3805, giving plaintiff partial credit for collateral source payments. Reductions in the judgment should be apportioned according to amounts actually paid by each defendant.

36. Plaintiff recovers $50,000 from his own resources and $80,000 from D(2), $130,000 total on a $200,000 injury. There is no double recovery in the classic sense.

37. K.S.A. 1988 Supp. 60-3805(a) (2).

38. Obviously, plaintiff's counsel should make sure the decision not to file a timely claim is the client's in order to avoid a later malpractice claim.

39. See a previous discussion of this question in Palmer and Snyder, **"A Practitioner's Guide to Tort Refort of the 80's: What Happened and What's Left After Judicial Scrutiny?"**, 57 J.K.B.A. 25-26, November/December 1988 pp. 25-26.

40. K.S.A. 1988 Supp. 60-3805(a) (4).

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B. Limits on Awards:

Statutory Caps

The act recognizes statutory barriers may prevent a full recovery. Plaintiff's collateral sources are not to be deducted when plaintiff does not receive full recovery. Any difference between limits imposed by law and the jury's itemized verdict becomes a K.S.A. 1988 Supp. 60-3805 credit for the plaintiff against net collateral source benefits.[40]

III. Subrogation Interests

A. Generally

The legislature's treatment of subrogation interests is a key element in use of the new law. At common law the existence of subrogation interests is kept from the jury unless the subrogee is a real party in interest and made a party to the litigation.[41] Under the collateral source statute, if the plaintiff already has been paid by insurance for part of or all the medical expenses but the insurer has a subrogation or lien interest, the evidence is inadmissible.[42]

The legislature faced a public policy dilemma. It has created statutory subrogation interests in third party negligence claims by a variety of interests, especially in mandatory no-fault insurance compensation systems.[43] Subrogation forces the liabilty insurance or private resources of the defendant to bear the risk of loss, not the claimant's first-party insurance.[44] K.S.A. 1988 Supp. 60-3801 *et seq.* leaves collateral source benefits with statutory and contractual subrogation rights unaffected. The theory behind this *status quo* arrangement is that no double recovery occurs.

Current Kansas regulations prohibit **domestic** health insurance companies from subrogating third party litigation claims.[45] Kansas hospitals are allowed statutory $5,000 liens against third-party recoveries by accident victims not covered by workers' compensation.[46] Consideration of subrogation interests — by alerting the jury to their presence — has been deemed inappropriate in a previous law journal article discussing Kansas legislative changes to the common law rule.[47] In any event, the 1988 legislature chose to abandon its 1985 theory and not put subrogation evidence in front of the jury, for some very practical reasons.[48]

B. Workplace negligence

Workers' compensation laws were not intended to eliminate or curtail all of the employee's common law rights to sue for negligence and resulting damages. Workers' compensation only prohibits tort actions against the employer. Actions against third party tort-feasors who cause workplace injuries are common.[49]

An injured Kansas employee must bring a third-party action within one year (the limit is 18 months if the injury causes death) or an automatic assignment of rights operates to preserve the *employer's* right of subrogation against the tort-feasor.[50] Public policy allows the employer to recover from the tort-feasor not on a strict subrogation basis, but on the theory the *employer* was harmed by the tort-feasor's negligence.[51]

Sometimes an employer is made a party to the lawsuit for comparative negligence purposes. Although the employer is immune from paying damages, workers' compensation law limits the employer's subrogation rights to a reciprocal of the percentage to which an employer is negligent. If the employer is found 25 percent negligent, the employer collects only 75 percent of its subrogation interest.[52] The employee keeps the other portion of his economic loss which he otherwise would owe through subrogation. This 1984 workers' compensation amendment intended (1) to penalize the employer who is partially negligent in the employee's injury and (2) benefit the employee.

Although the employer is immune from paying damages, workers' compensation law limits the employer's subrogation right to a reciprocal of the percentage to which an employer is negligent.

Yet the new statutes create a Hobson's Choice for the employee and procedural problems for the Court. The exclusion of collateral source ". . . services or benefits for which a valid lien or subrogation interest exists . . ." might be construed to preclude evidence of the employer's payment in all such cases. Potentially at least, all benefits paid are subrogated. However, the amount of the reduction of the employer's lien also might be held to be a collateral source under K.S.A. 1988 Supp. 60-3801(b). The benefits were paid as compensation for injury due to the accident.

How do the court and counsel present evidence to the jury when K.S.A. 1988 Supp. 60-3801(b) says if the benefits are subrogated such benefits are not collateral sources? Sometimes benefits are subrogated, sometimes not, depending on the jury's assignment of percentages of negligence. Further, if the reduction in the amount subject to subrogation becomes the employee's collateral source, the full amount of damages attributed to the employer's fault then must be considered uncollectible damages from an immune codefendant for purposes of K.S.A. 1988 Supp.

41. **Klinzmann v. Beale**, 9 Kan. App. 2d 20, 28-29, 670 P.2d 67 (1983).

42. K.S.A. 1988 Supp. 60-3801(b). An exception might be a case of malingering, where the defense wants to show the medical damages are high because of the direct action of the plaintiff. Such inquiry is complicated and requires that counsel lay a strong foundation. **Acosta v. Southern California Rapid Transit Dist.**, 2 Cal.3d 19, 84 Cal. Rptr. 184, 465 P.2d 72 (1970).

43. K.S.A. 40-3113a and K.S.A. 44-504.

44. The theory is the subrogee is damaged by the actions of the third party causing injury to the insured and has a separate cause of action.

45. K.A.R. 40-1-20. Self-insured health insurance by employers or companies in other states doing business in Kansas is not regulated by the Kansas rule. A major sideshow in the 1988 session occurred over subrogation rights of health insurance. SB 630 allowed full health insurance subrogation. It passed the Senate, but stalled in the House without becoming law. Current Kansas law is in the minority, however; 38 other states allow subrogation of health insurance to third party claims.

46. K.S.A. 1987 Supp. 65-406. Even Veterans' Administration hospitals invoke this lien. An attempt in 1987 to increase the amount of the statutory lien to $50,000 did not pass.

47. "The state cannot effect the reforms called for by abolishing the collateral source rule if it leaves the right of subrogation in place." McDowell, "The Collateral Source Rule — The American Medical Association and Tort Reform." 24 Washburn L. J. 205, at 225 (1985).

48. See the interesting result that happens when state tort reforms do not take into account the supremacy of federal law and subrogation of federal workers' compensation statutes in **U.S. v. Lorenzetti**, 467 U.S. 167, 81 L.Ed.2d 134, 104 S.Ct. 2284 (1984). "More important, **the fact that changing state tort laws may have led to unforeseen consequences** does not mean that the federal statutory scheme may be judicially expanded to take those changes into account." (467 U.S. 169, emphasis added).

49. A 1980 book documents the growth of cases where employees injured in workplace accidents by defective manufacturing, products sue the manufacturer, but the author concludes this may be due in part to state workers' compensation benefits being "inadequate." Lieberman, **The Litigious Society**. In 1980, 4,239 of 13,554 product liability cases filed in federal district courts nationally (31% of all federal civil filings) were asbestosis cases, a form of third-party personal injury arising primarily in the workplace environment.

50. K.S.A. 44-504(b).

51. Keeton, **Insurance Law — Basic Text**, p. 151 (West 1971).

52. See **Wilson v. Probst**, 224 Kan. 459, 581 P.2d 380 (1971), and statutory changes that resulted in K.S.A. 44-504(b) and (d).

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60-3805(a)(2) credits.[53] The solution may be to have the jury determine the amount of workers' compensation payments as part of the verdict, then let the judge determine whether any amount is a collateral source. However, this solution is not currently allowed by the statute and further legislative amendment may be needed to clarify it.

The effect of the new law on third party negligence cases is an interesting, and perhaps unavoidable, paradox in public policy. K.S.A. 44-504(b)'s reduction in subrogation rights for employer negligence is clearly intended to reward the plaintiff employee, but the new law may transfer the intended benefit to the other negligent tort-feasor whose actions at least partly contribute to the employer having to expend workers' compensation benefits in the first place.

C. PIP Subrogation in Automobile Negligence Cases

Subrogation rights in Personal Injury Protection benefits (PIP) are controlled by K.S.A. 40-3113a.[54] Subsection (b) of that statute limits subrogation rights ". . . to the extent of **duplicative** personal injury protection benefits provided to date of such recovery . . . ." The Kansas Supreme Court has defined "duplicative" to mean those damages recovered by an injured insured which, if subrogation is thwarted, constitutes a double recovery.[55]

Once subrogated, the collateral source law does not apply. If the amounts paid are not duplicative, then they are collateral sources under the act, which defendant can seek to use post-trial to reduce the verdict.

Under present case law where defendant tenders policy limits and the claimant accepts the limits in settlement of the total claim, the PIP carrier is subrogated as a matter of law because the settlement duplicates the benefits provided.[56] Once subrogated, the collateral source law does not apply. If the amounts paid are not duplicative, then they are collateral sources under the act, which defendant can seek to use post-trial to reduce the verdict.

Our no-fault law raises other considerations.

PIP subrogation interests are handled differently than other automobile subrogation statutes such as K.S.A. 40-287 which governs subrogation of uninsured and underinsured motorist coverage. Where both ordinary PIP subrogation and uninsured motorist subrogation are part of the trial, the judge will have a complex determination whether the extent of the subrogation interest precludes double recovery.

Whether a K.S.A. 40-3113a subrogation right can be exercised often cannot be determined until a trier of fact decides total actual damages.[57] This might mean that a claimant who seeks a judgment in excess of policy limits has preserved maximum subrogation and thus avoided application of the collateral source statutes. More likely, this situation sets up the need for a post-trial evidentiary hearing on the nature and existence of "duplicative" PIP coverage.

What are the rights, duties and responsibilities of an automobile insurance company that insures both the plaintiff and defendant? Can a company write in its contract that if two of its insureds collide and one sues the other, no subrogation right exists? While certainly this is a voluntary waiver under previous law, such a decision under K.S.A. 1988 Supp. 60-3801 *et seq.* means the company's insured defendant can introduce medical and other PIP payments to influence the jury's consideration of the overall award. The claims must exceed the dollar threshold for this possibility to occur.

D. Subrogation of Federal Entitlement Programs

About 10 percent of all Kansans are eligible for Medicare benefits, for which federal law allows subrogation.[58] The Veterans' Administration has subrogation interests for certain services it provides veterans.[59] Federal employees in Kansas are subject to FECA subrogation if injured on the job.[60] Even the Kansas Department of Social and Rehabilitation Services has a program subrogating third party claims where medical expenses were first paid by Medicaid.[61]

The type and extent of subrogation is important. If the benefit is not fully repaid under the subrogation clause, it is a double recovery and might be a collateral source subject to K.S.A. 1988 Supp. 60-3801 *et seq.*

IV. Future Collateral Source Benefits

K.S.A. 1988 Supp. 60-3802 states "evidence of . . . collateral source benefits which are reasonably expected to be received in the future shall be admissible." Several interesting problems are created by this clause. If damages to a child are severe and defendant's experts testify the child will not live very long, on equity grounds will defendant be precluded from introducing evidence of future medical benefits to be received for a period longer than life expectancy? Defendant may argue that evidence of benefits to be received for the life expectancy determined by plaintiff's experts is admissible, leaving it to the jury to determine the amount of future benefits based upon its resolution of the dispute over life expectancy.

K.S.A. 1988 Supp. 60-3802, the threshold and "when applicable" section, plainly states evidence of future collateral sources is admissible only when such evidence is "reasonably expected" to be received in the future. This implies a judicial determination whether to allow evidence of future collateral source benefits.

An earlier version of the act would have imposed a "reasonably certain" test before such evidence would be

53. Is this both a collateral source benefit **and** an amount of an award constituting a "payment" by an "immune" codefendant?

54. **Easom v. Farmers Insurance Co.**, 221 Kan. 415, syl. 4, 560 P.2d 177 (1977). Easom established a three part test: (1) The PIP subrogation right is limited to those damages recovered by the injured insured which are duplicative of PIP benefits; (2) damages are duplicative when the failure to reimburse the PIP carrier results in a double recovery by the insured; and (3) PIP benefits are presumed to be included in any recovery effected by an injured insured, either by way of settlement or judgment **in the absence of proof to the contrary**, and the burden of supplying such proof is on the insured.

55. Interestingly, this statute allows health insurance benefits paid by a casualty insurance company to be subrogated, while K.A.R. 40-1-20 prohibits domestic health insurance companies — which may have made payments in the same automobile accident — from subrogating.

56. **Russell v. Mackey**, 225 Kan. 588, 592 P.2d 902 (1979).

57. **Kansas Farm Bur. Ins. Co. v. Miller**, 236 Kan. 811, 696 P.2d 961 (1985).

58. 42 U.S.C. §1395y(b); 42 CFR §405.322 *et seq.* For an excellent treatment of Medicare's subrogation interests in tort litigation, see Williams, "Medicare as Secondary Payor," 31 Res Gestae 188 (Indiana Bar Assn. Oct. 87).

59. 38 U.S.C. §629 *et seq.*

60. 5 U.S.C. §§8101 *et seq.*

61. K.S.A. 39-719a.

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admissible. New York has such a test.[62] The standard in most states is that such benefits "will be payable." None has the relatively unstructured "reasonably expected" test like Kansas.[63]

The legislature did not define what standard of proof is necessary for defendants to show that benefits are "reasonably expected" to be received in the future. That means initially the judiciary will legislate this standard. The

The legislature did not define what standard of proof is necessary for defendants to show that benefits are "reasonably expected" to be received in the future.

phrase "reasonably expected" is used in P.I.K. Civil 9.01, Elements of Personal Injury Damage instructions. Since P.I.K. 9.01 is part of the standard instructions given to personal injury juries, this indicates the "more probably true than not true" standard of proof would be appropriate.[64] Until judicial standards of what constitutes "reasonably expected" benefits are formed, counsel will cross swords often.

V. Future Eligibility for Private Health Insurance

While evidence of health insurance covering future medical care can be introduced, the new statutes do not specifically allow claimants to show any difficulty they may have in maintaining eligibility for future health insurance. However, the definition of the cost of the collateral source benefits appears to allow such leeway. The operative words are "amounts paid . . . to secure" a collateral source benefit.[65] To read the new law as precluding evidence other than premiums would not make sense. Had the legislature meant to admit only premiums paid, it could have so stated. Further, if the jury is to determine accurately if future benefits are "reasonably expected" to be received, it must be made aware of the ease with which health insurance benefits are subject to cancellation or loss based on job choices.

The right to future private or public health insurance benefits is not guaranteed. Such benefits must be purchased. Health insurance for a catastrophically injured child's future medical care depends on the parents' maintaining continuous medical insurance coverage.[66]

Proving the cost of covered future medical care or the cost of remaining eligible for such care requires additional discovery as well as testimony. Clearly, if the statute allows introduction of future collateral source benefits, it must also allow evidence of how inflation may affect future costs of securing such benefits.

Rapidly rising health insurance costs may make current employer-paid health insurance unaffordable in the future.[67] Claimants who receive health insurance as part of their employment benefits may be disadvantaged if their union elects to change health insurance plans as part of its collective bargaining strategy. If such a change occurs after the jury assumed these benefits would be paid in the future, the claimant not only loses the health insurance but also has no way to reopen the verdict to have the negligent tortfeasor pay the future medical care resulting from his actions. A change of employers by a child's parents (or a change in private health insurance carriers for whatever reason) invokes new "waiting periods" and exclusions of known diseases or preexisting injuries. Once the jury's decision is made and post-trial motions are completed, claimants have limited remedies since **res judicata** applies.[68]

VI. State Medical Services or Institutional Care

In cases where the $150,000 threshold is not exceeded, the existence and availability of tax-funded institutional care for injured citizens is inadmissible. However, such benefits are an admissible collateral source under the new law if the threshold is exceeded and there is no government subrogation or lien interest in the benefits provided. Some states have seen new types of "experts" testify to the "availability" of state or federal programs to assist the injured person or the family.

The new statutes are silent as to whether defendant can argue the existence of future government benefits if the plaintiff fails to seek benefits from government programs to which plaintiff is entitled. Plaintiff may not need public assistance, but may have to admit the reason is private

62. Civil Practice L & R. §4545.

63. A key amendment to understanding legislative intent came during Senate floor debate. The Senate Judiciary Committee had taken the House version, which allowed the jury to consider future collateral source benefits, and modified the bill so that only **present** damages could be considered for reduction from the verdict and only by the trial judge in a post-verdict hearing. Senator Gaines amended the bill on the floor so that the judge could consider evidence of future collateral source benefits. He explained his reasoning by reading a portion of a letter from the primary proponents of the legislation, the Kansas Medical Society: "I've asked the Kansas Medical Society to tell us what are those outside sources we are going to consider. In their writing they said,

> '. . . the rationale for allowing the judge to consider benefits to be received in the future is that, especially in medical malpractice cases involving minors, there are frequently collateral source benefits paid which can have a substantial impact on award costs. For example, in addition to the traditional benefits of health insurance etc., there are many publicly funded programs for children such as rehabilitation and counseling services and the providing of equipment in services for special needs educational pruposes in physical or occupational therapy services programs."

Under questioning as to what programs he intended be included by the amendment, Gaines stated, "I tried to answer as best I could about what those would be. I envision those as applied by the trial judge to be things that are **vested**. Let me read again, for example, 'in addition to the traditional benefits of health insurance etc., there are many publicly funded programs for children such as rehabilitation and counseling services, the providing of equipment and services for special needs educational purposes in physical or occupational therapy services programs.' That's not difficult for a judge to determine. If those things are available, why do we want the HCSF to pay for that a second time? The logic to that is understandable. *** When they approached me and said, 'we want the judge to be able to consider the fact that there are many federal programs out there that substantially would result in a double payment. The government is going to provide those [benefits] **despite any type of a judgment or award** and we want credit to that extent.' Those are **vested types of benefits** that aren't going to run away from anyone; **they aren't conjectural**. It applies particularly to a brain injured child. ***" (Emphasis added)

The Conference Committee later changed the Senate version of the bill so that the jury instead of the judge decided the amount of future collateral source benefits. But it appears Senator Gaines intended that his amendment apply to future collateral source benefits which vest, presumably by time of trial. A complete transcript of the House and Senate floor debates on this legislation is available from the Kansas Bar Association. The minutes of judiciary committees are available from the Legislative Services Department in the Statehouse.

64. See P.I.K. Civil 2d 2.10. This definitional hiatus by the legislature raises the age old question of how much speculation and conjecture courts should tolerate concerning the future availability of collateral source benefits. Review the Kansas rule in **Ratterree v. Bartlett**, 238 Kan. 11, 707 P.2d 1063 (1985) where the Kansas Supreme Court restated its general rule that opinions by expert witnesses should not concern matters which are mere speculation or conjecture. Also see **Admissibility of Expert Medical Testimony as to Future Consequences of Injury as Affected by Expression In Terms of Probability or Possibility**, 75 A.L.R.3d 11 (1977). The lead case in this annotation is **Nunez v. Wilson**, 211 Kan. 443, 507 P.2d 329 (1973), later modified in **Ratterree**, supra.

65. K.S.A. 1988 Supp. 60-3801(c).

66. Blue Cross and Blue Shield typically covers medical care for a dependent child only until age 21 and only up to stated policy limits ($1 million for major medical). At age 21, with existing medical problems requiring long-term care, a disabled child probably will not qualify for his or her own Blue Cross plan for the preexisting injury. Even if a policy is available, the covered procedures within each policy vary from year to year.

67. The June 22, 1987 **Washington Post** reports health care expenditures account for nearly 11% of the current U.S. GNP, but are headed towards capturing 15% of GNP by the year 2000. Total U.S. Health costs will triple by 2000, from $458 billion to $1.5 trillion. Per capita costs will grow from $1,837 in 1986 to $5,551 in 2000. Price inflation rather than increased use, says columnist Michael Specter, accounted for 54% of the 1986 increase.

68. Try to argue that K.S.A. 60-260(b) (5) or (b) (6) allows reopening the judgment if the problem occurs. A simpler approach (substantively, not necessarily procedurally) to proving future collateral source benefits is a periodic payment of judgments statute, which was considered in 1987 SB 258. It did not pass.

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resources or wealth. This presents a clash between the admissibility of "reasonably expected to be received" public resources and the "gratuitous services" exception.

To the extent evidence of publicly-funded benefits is presented to the jury, rebuttal should try to show (1) such programs are subject to future funding by the legislature or Congress, funding over which the claimant has no control, and (2) the benefits provided in such programs change frequently. However, the speculative nature of future welfare program funding goes only to the weight, not the admissibility, of the evidence, if the court otherwise rules the benefits are reasonably expected to be received. The new statutes allow evidence of non-subrogated public assistance even when it will benefit foreign individuals, corporations or insurers whose Kansas tax burden to help pay for this tax-funded alternative is slight or nonexistent.

VII. Life and Disability Insurance

All collateral sources are subject to the act except those expressly excluded, such as life and disability insurance. Life insurance is excepted because it often is purchased for investment motives in addition to its traditional purpose.[69] Life insurance often is exempted in other states' collateral source legislation.[70]

The portion contributed by the employee plus investment earnings should not be deemed a *:ollateral source.*

However, discrimination between similar types of col- ateral sources has been held unconstitutional by one Kansas ourt.[71] A wage continuation plan is an understanding with n employer that salary will be paid to an employee or xecutive of a company during any period of time that such erson is disabled or injured. Such plans are collateral ›urces under K.S.A. 1988 Supp. 60-3801(b) unless there a subrogation interest.[72] Yet another form of insurance, isability insurance, is an exempt collateral source even ıough its function is similar to a wage continuation plan. Some employers have ERISA pension plans which allow e accumulated retirement fund to be given to the nployee if the employee is disabled (or employee's estate the employee dies). While the portion of the fund con- buted by the employer certainly is a common law col- eral source, it is uncertain whether ERISA proceeds are considered a collateral source under the new definitions.[73] The portion contributed by the employee plus investment earnings should not be deemed a collateral source.

VIII. Trial Concerns

Obviously the biggest change in the law is the conduct of the trial. The following is not an exhaustive list of concerns for trial counsel but gives an idea of some issues counsel must address.

A. Discovery Issues and Costs

Since the common law rule did not allow evidence of collateral source benefits or costs "paid to secure" the benefits, litigants heretofore spent little time developing such evidence. K.S.A. 1988 Supp. 60-3801 *et seq.* may require presentation of such evidence at trial. This means new costs of litigation in developing and presenting this evidence.[74]

Showing amounts paid to secure the right to the collateral source benefit requires new and perhaps extensive discovery, depending on the interpretation of the phrase costs "paid to secure" the benefit.[75] Experts from health insurance companies and personnel planning administration fields may be needed to testify. Indeed, the legislature may have spawned a whole new class of witnesses: public benefits experts.

What relevant time period is to be used to determine amounts paid "to secure the benefits"? As a practical matter few consumers keep their cancelled insurance premium checks for twenty or thirty years. Reconstructing insurance coverage and premium payments over a long time period is a significant financial burden.

B. Additional Discovery Impact on Employers

Absent pretrial stipulation by the parties, where an employee's health or disability insurance is provided by an employer and the employee (or dependent) is injured by negligent third parties, the employer must be prepared to testify on the cost of the benefit in any personal injury action in which an employee or employee's dependent is the claimant.

The purpose of plaintiff's evidence will be to persuade the jury that future collateral source benefits are not "reasonably expected to be received." Defendant, of course, will want to show the benefits will be provided. If the availability of future medical care through plaintiff's own health insurance is an issue, the employer might testify to the claimant's long-term job prospects and the corporate philosophy on maintaining health benefits as a long-term

). See Dean Concannon's written testimony to the House Judiciary Committee, February 11, ∶.

). State statutes that limit the common law collateral source rule but which exempt life insur- proceeds from the definition of a collateral source include: **Alaska**, Stat. §09.55.548, medi- ıalpractice only, effective 1976, §09.17.070; **Colorado**, Rev. Stat. §13-21-111.6, excludes teral sources directly purchased by the injured party, effective 1986; **Connecticut**, Gen. Stat. 225a-225d, medical malpractice only effective 1985, applied to all tort actions by amend- 1987; **Delaware**, Code Ann. tit. 18, §6861-6862, medical malpractice only; **Florida**, Stat. 50, effective 1976, but see §768.76, allowing deductions for life insurance if there is no subro- n right, effective 1986; **Georgia**, Code §51-12-1 (105-2005), effective 1987; **Illinois**, Rev. ch. 110, §2-1205, excluded only if there is subrogation right, effective 1985, §2-1205.1, effec- 986; **Indiana**, Code §34-4-36-1-3, effective 1986; **Iowa**, Code §147.136, does not include of a claimant or claimant's immediate family, amendment effective 1987; **Michigan**, Stat. §27A.6303, 27A.6304, effective 1986; **Minnesota**, Stat. §548.36, effective 1986; **Montana**, Ann. §27-1-307, §27-1-308, effective 1987; **New Hampshire**, Rev. Stat. Ann. §507-C:7, al malpractice only, declared unconstitutional in **Carson v. Maurer**, 120 N.H. 925, 424 25 (1980); **New York**, Civ. Prac. Law and R. §4545, effective 1986; **North Dakota**, Cent. §26-40.1-08, effective 1977 but repealed 1983; **Ohio**, Rev. Code Ann. §2317.45, effective ee also §2305.27, effective 1976, held unconstitutional in **Simon v. St. Elizabeth Medical Center**, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (19760, and **Graley v. Satayatham**, 74 Ohio Op. 2d 316, 343 N.E.2d 832 (1975), but see **Holaday v. Bethezda Hosp.**, 29 Ohio App. 3d 347, 505 N.E.2d 1003 (1986); **Oregon**, 1987 Or. Laws ch. 774; **Pennsylvania**, Stat. Ann. tit.40, §1301.602, medical malpractice only, public collateral sources only, effective 1975; **Rhode Island**, Gen. Laws §9-19-34, medical malpractice only, effective 1976; **South Dakota**, Codified Laws Ann. §21-3-12, medical malpractice only, exempts privately purchased insurance, effective 1977; **Tennessee**, Code Ann. §29-26-119, medical malpractice, exempts privately purchased insurance, effective 1975.

71. Discriminatory treatment between victims of negligence whose "collateral sources" are different ". . . does not have a reasonable and substantial relation to the purpose of keeping down rates." **Doran v. Priddy**, 534 F. Supp. 30, at 38 (D. Kan., 1981), cited with approval in **Farley**, supra.

72. Or unless wage continuation plans are considered "gratuitous services" under K.S.A. 1988 Supp. 60-3801(b) and thereby exempt.

73. One might argue that to include ERISA funds diminishes the intended benefit conveyed thereunder, contrary to federal supremacy considerations. Further, Key Man insurance is another form of insurance that is neither fish nor fowl, neither disability insurance or life insurance. Is it a collateral source benefit under K.S.A. 1988 supp. 60-3801 *et seq.?*

74. K.S.A. 1988 Supp. 60-3801(b) and (c).

75. K.S.A. 1988 Supp. 60-3801(c) and 60-3803.

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benefit. If a corporation is considering scaling back the work force or reducing employee fringe benefits over the period a dependent child may need care, that is a material fact the jury must know before deciding which benefits are "reasonably expected" to be received in the future. Employer layoff histories necessarily will be explored.

Unfortunately if a child-claimant's parent is a discipline problem at work and may be fired in the future (thus impairing access to continuous employer-paid health insurance), this evidence may have to come out to dissuade a jury from including those amounts in the future benefits "reasonably expected" to be received. Yet such information may have other, unintended consequences.[76]

C. Thresholds

No reduction of a judgment occurs, nor should evidence be introduced, if the demand for judgment does not exceed $150,000. Defendants will need to invoke Supreme Court Rule 118 to obtain a statement of the amount of damages sought. The threshold is a "claim" threshold, not one based on the amount of duplicative damages contained in the pleadings.

No reduction of a judgment occurs, nor should evidence be introduced, if the demand for judgment does not exceed $150,000.

Presumably, damages that are sought other than "personal injury or death," such as property damages and consequential economic loss from damage to property, are disregarded in determining whether the threshold is met, but K.S.A. 1988 Supp. 60-3802 is unclear on this point. For tactical purposes, when collateral sources cover many of the damages, claims exceeding $150,000 might be scaled back to within the threshold limit to avoid this new burden.

An unanswered question is whether a claim by plaintiff exceeding the threshold means that collateral sources are admissible on a defense counterclaim for personal injury tried in the same lawsuit. Whether the defendant's collateral sources can be introduced then or whether a defendant must have a separate $150,000 counterclaim to trigger the statute remains to be addressed judicially or legislatively.

D. Relief from Judgment

An open question is whether relief from the judgment will be available pursuant to K.S.A. 60-260(b)(5) or (6) if a serious error is made. If a defendant thought to be solvent is shown — long after rendition of the judgment — to have been insolvent, or when a collateral source the jury assumed would be available in the future later proves not to be available, what can a court do? The current answer appears to be nothing.

E. Defense Strategy

The new law opens up additional defense strategies. If the evidence is admissible, defense counsel presumably may make references to the evidence beginning with **voir dire** examination to mitigate the nature and extent of the damages.

Because the object is to bring as many collateral sources into the equation as possible, defense counsel seeing the existence of a subrogation interest may consider a pretrial "buy out" of the subrogee's lien or subrogation interest. Plaintiff has no vested interest in a subrogee's contract rights regarding repayment of a subrogation or lien interest, and, subrogation interests usually being a creature of contract, assignment of such interests is common. The buy out becomes a form of financial "hedging" by defendants or, more probably, their insurers. Employers may jump at the chance to recoup a small percentage of every loss associated with third party negligence rather than wait for subrogation interests that might not materialize.

If defendant makes a pretrial purchase of the subrogee's interest and plaintiff prevails at trial, is defendant then able to subtract the subrogated interest from the award by treating it as a collateral source? Plaintiff might respond that defendant has no standing to introduce evidence of the subrogated amount unless the defendant formally waives enforcement of the subrogation lien. These waters are all uncharted, and the record is silent on legislative intent.

Some practical limitations on hedging exist. If the defense is lack of liability or causation, then hedging is a waste of defense resources. Hedging may be attractive only in medium size cases where damages are not limited by other statutes and the plaintiff is only slightly at fault. The $150,000 threshold precludes hedging smaller cases. The larger the subrogation interest purchased by defendant and the greater the possibility of a substantial pain and suffering verdict, the more plaintiff's K.S.A. 1988 Supp. 60-3805 protections come into play.

If the defense is lack of liability or causation, then hedging is a waste of defense resources.

Assuming statutory limits on recovery of noneconomic loss withstand analysis by the Kansas Supreme Court, where there are catastrophic injuries and the jury awards noneconomic damages in excess of statutory amounts, K.S.A. 1988 Supp. 60-3805(a) (4) would preclude larger hedged amounts from being offset. Hedging too big a piece of pie means the plaintiff may get to keep most of it anyway, yet with additional defense costs.[77]

76. Corporate counsel take heed! Employers swearing under oath as to the disciplinary status of an employee at the time of the deposition or trial may be impeached by such statements in later unrelated employment law proceedings.

77. The contrary is also true. If the Kansas Supreme Court extends the rationale of **Kansas Malpractice Victims Coalition (KMVC) v. Bell**, 243 Kan. 333, 757 P.2d 251, 257 (1988) to 1988 legislation limiting noneconomic losses in other lawsuits, it will **increase** the likelihood defense hedging could significantly reduce defendant's exposure. In medical malpractice actions where the plaintiff has little or no comparative negligence, buying out a $200,000 workers' compensation subrogation claim for ten cents on the dollar allows defendant to introduce $200,000 of collateral sources into evidence. If the jury returns a verdict for the defense, the defense costs are $20,000 higher. If it finds for the plaintiff but indicates $200,000 in collateral benefits were received, less costs, defendant's exposure is potentially reduced by $180,000 — the $200,000 in benefits not paid in the verdict minus the cost of hedging.

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F. Plaintiff's Strategies

A tactical reason behind allowing juries to learn of plaintiff's collateral source benefits is to reduce the sympathy factor.[78] That might facilitate a defense verdict, or perhaps affect noneconomic damages awarded. To the extent these are valid considerations, plaintiff's counsel wants to keep collateral source evidence away from the jury while maximizing recovery. Turning otherwise admissible benefits into benefits with a subrogation interest is one way to create inadmissible evidence.

One method is a voluntary bilateral subrogation contract between the claimant and the provider of the benefits.[79] All parties are represented by counsel, so overreaching or adhesion does not appear to be a problem. The contract might work better than a unilateral subrogation right, since counsel can negotiate contingencies that trigger subrogation reimbursement similar to those in K.S.A. 1988 Supp. 60-3805(a). Timing of the contract is important because pretrial discovery and negotiations with defendant may produce a settlement without need of the bilateral subrogation agreement.

Turning otherwise admissible benefits into benefits with a subrogation interest is one way to create inadmissible evidence.

There are pitfalls to these bilateral subrogation contracts. Such contracts are not advisable in cases where the jury may assess a significant portion of negligence to the plaintiff. It is not fiscally prudent to contract to give away additional portions of the damages if the plaintiff may have to absorb part of the liability because of comparative fault. Certainly in creating the bilateral subrogation contract, plaintiff can agree to make various levels of subrogation available to the subrogee depending on the jury's total award, the jury's assignment of negligence to the plaintiff, or a combination thereof.

If evidence of future collateral source benefits is allowed, defendant apparently has the burden of showing the present value of such benefits if the future economic loss is stated in terms of present value. This is an abnormal process especially when defendant has disclaimed liability and does not want to discuss damages except through cross examination of plaintiff's experts.

G. Request for Admission

Another way to avoid presenting collateral source evidence to the jury is to use a Request for Admission. If the claimant's benefits are fairly certain and claimant wants simply to offer five or ten years worth of paid premiums as the offsetting costs of the collateral source benefits, claimant can submit to defendant a Request for Admission.[80] If defendant agrees to the figures requested to be admitted, then claimant can argue that such evidence need not go to the jury because none of the facts are in dispute. To allow a jury to hear undisputed collateral source evidence makes no more sense than allowing juries to hear evidence of negligence when negligence is stipulated and the only trial issue is damages. If the request is denied without a good reason and the jury returns the same numbers plaintiff requested be admitted, plaintiff can seek additional attorney fees and costs for having to prove that which should have been stipulated.[81]

H. Instructions

The new law changes the law of damages in Kansas, even though the award itself is not directly affected by a jury decision. The parties may seek instructions on this new law.

Instructions should make clear that the jury must not reduce damages because of collateral source benefits and that the court will make any reduction that is appropriate. The instructions should also note the collateral benefits introduced as evidence are the only ones that may be used to reduce the judgment and the jury should not concern itself with other payments plaintiff might have received or may receive in the future.

In some cases, it might be appropriate to explain that other payments plaintiff received will not be used to reduce the judgment because plaintiff is legally obligated to repay the provider from the judgment. The substance of the instruction would be similar to the P.I.K. instruction allowing the jury to know the consequence of a 50 percent determination of comparative negligence.[82]

Conclusion

K.S.A. Supp. 60-3801 *et seq.* add a major new dimension to personal injury cases. It may prove to be highly litigious reform, requiring many supreme court decisions to define its parameters. While the legislation appears to meet constitutional concerns in **Farley** that the rule change apply to all tort cases,[83] other uncertainties as well as added litigation costs arise. In comparison to previous legislative enactments on the subject, the new law meshes the collateral source economic theory with existing statutory law in a better comprehensive scheme but, as this article shows, not without questions. The problems raised herein indicate why common law courts left collateral source evidence outside the province of the jury in the first place. ■

It may prove to be highly litigious reform, requiring many supreme court decisions to define its parameters.

78. Ten states limit evidence of collateral sources paid to post-verdict hearings to the trial judge. Juries do not consider the evidence. See the statutory citations in footnotes 8 and 70 above for the following state collateral source statutes: Alaska, Colorado, Connecticut, Illinois, Michigan, Minnesota, Montana, Nebraska, New York and Utah.

79. Presumably, insurance regulations do not prohibit domestic health insurers from entering into bilateral contracts with private persons represented by counsel on terms that may be just to all parties. See footnote 45.

80. K.S.A. 60-236, or Federal Rule 36.

81. K.S.A. 60-237(c) or Federal Rule 37(c).

82. See **Nail v. Doctor's Blg.**, 238 Kan. 65, 708 P.2d 186 (1985).

83. Curiously the statute is available for use to diminish damages by intentional, reckless or wanton tort-feasors when no other part of Kansas law benefits tort-feasors exhibiting more than ordinary negligence.

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Session of 1989

SENATE BILL No. 396

By Committee on Ways and Means

4-6

permitting

AN ACT concerning insurance; ~~providing for~~ subrogation rights under accident, health or sickness insurance policies.

13
14 *Be it enacted by the Legislature of the State of Kansas:*
15 Section 1. (a) As used in this act:
16 (1) "Insurer" means and includes all corporations, companies,
17 associations, societies, fraternal benefit societies, mutual nonprofit
18 hospital service and nonprofit medical service companies, partner-
19 ships and persons engaged as principals in the business of insurance
20 of the kinds enumerated in articles 4, 5, 6, 7, 11, 13, 18, 19, 19a,
21 19b, 19c, 22, 32 and 38 of chapter 40 of the Kansas Statutes An-
22 notated and any amendments thereto, insofar as the business of
23 insurance of the kinds enumerated in such articles relate to accident,
24 health or sickness; and
25 (2) "insured" means and includes persons who are the benefi-
26 ciaries, assignees, payees of, owners of or certificate holders under
27 such policies or contracts of insurance as described in subsection (1)
28 including enrollees of a health maintenance organization as defined
29 in K.S.A. 40-3202 and amendments thereto.
30 (b) Any policy or contract of accident, health or sickness insur-
31 ance, and any health maintenance organization subscriber contract,
32 issued in this state ~~shall~~ [may] include a subrogation clause providing for
33 reimbursement of medical, surgical, hospital or funeral expenses.
34 Such clause ~~shall~~ [may] subrogate the insurer to the insured's rights of
35 recovery when the circumstances of the insured's injury create a
36 legal liability against a third party for not more than the amount of
37 benefits that the insurer shall have previously paid or provided in
38 relation to the insured's injury by such third party [to the date of any judgment, settlement or recovery against or from such third party]. Subrogation shall
39 be available only to the extent that the insured is not left with any
40 uncovered, out-of-pocket expenses for medical and related health
41 care services necessitated by the injury in question. The insurer may
42 enforce such rights of subrogation in its own name or in the name
43 of the [injured] person ~~to or for whom payment has been made~~ [or the representative or dependents of the injured person], as their
44

(c) In the event an insured, such person's dependents or personal representative fails to commence an action against such third party within 18 months after the date of the act resulting in the injury, such failure shall operate as an assignment to the insurer of any cause of action in tort which the injured person, the dependents of such person or personal representatives of such person may have against such third party for the purpose and to the extent of recovery of damages which are duplicative of benefits paid or provided by the insurer.

Attachment 9-12
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1 interest may appear, by proper action in any court of competent
2 jurisdiction. Attorney fees and costs shall be paid by the insurer
3 from any recovery obtained by the insurer and the attorney shall
4 have a lien therefor against any such recovery and may intervene
5 in any action to protect and enforce such lien.
6 Sec. 2. This act shall take effect and be in force from and after
7 its publication in the statute book.

(d) In the event of a recovery pursuant to K.S.A. 60-258a, and amendments thereto, the insurer's right of subrogation shall be reduced by the percentage of negligence attributable to the injured person.

(e) Pursuant to this section, the court shall fix attorney fees which shall be paid proportionately by the insurer and the injured person, such person's dependents or personal representatives in the amounts determined by the court.

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malpractice actions, to make subrogation an optional feature of health and accident insurance policies and to limit subrogation recoveries to not more than the amount of duplicative benefits. He also agreed that a statutory time delay before subrogation rights could be exercised would not be a problem.

Representatives of the Kansas Medical Society, the Kansas Hospital Association, and the Kansas Insurance Department on behalf of the Health Care Stabilization Fund, urged an exemption from subrogation rights involving actions against health care providers. Concern was expressed that savings, which may be realized by the recent enactment of a collateral source law permitting a deduction from awards for these benefits, would be negated. The representative of the Insurance Department further stated the use of subrogation encouraged litigation, was less efficient in dealing with the problem of double recoveries, and may permit the full payment of attorneys' fees as if there were a double recovery.

The representative of the Kansas Trial Lawyers Association opposed allowing subrogation rights in health insurance contracts noting tort victims were rarely overcompensated. He argued subrogation would have the result of taking needed compensation from victims and giving it to health insurers.

The representative of the Kansas Bar Association (KBA) noted the KBA had no public position on the issue. He urged the Committee to consider the impact that proportionate recoveries under the Kansas Comparative Negligence Act would have on a health insurer's right to subrogation.

Committee Conclusions and Recommendations

The Committee spent a considerable amount of time discussing various issues involving subrogation and health insurance using S.B. 396 as its discussion vehicle. The Committee agreed that S.B. 396 should be amended to permit subrogation clauses in health insurance contracts rather than require these clauses. It also agreed that subrogation only be for expenses that actually have been incurred up to the time of settlement or judgement and not be permitted against payments made for future medical expenses. It was agreed that language in the bill should be deleted that provides attorneys' fees and costs shall be from any recovery obtained by the insurer and that the attorney would have a lien against the recovery and be able to intervene in any action to protect his lien. The Committee felt the latter provision was confusing and agreed in lieu of it to provide that attorneys' fees are to be paid proportionally from the injured plaintiff's and the insurer's recovery.

The Committee likewise agreed that an insurer's subrogation recovery should be reduced by the percentage of negligence attributable to the injured party and that the injured party be given the sole right to commence an action within 18 months after the date of the injury.

The majority of the Committee rejected a proposal to exempt medical malpractice liability actions from the insurer's subrogation rights.

After reaching the decisions noted above, there was considerable discussion about the possible impact, if any, this proposal would have on workers' compensation insurance. No consensus or agreement was arrived at on this issue.

The Committee then concluded that it would make no recommendation regarding Proposal No. 36 or regarding the passage of S.B. 396.

Respectfully submitted,

November 30, 1989

Rep. Mike O'Neal, Chairperson
Special Committee on Judiciary

Sen. Wint Winter, Jr., Vice-Chairperson	Rep. Denise Everhart
Sen. Dick Bond	Rep. Clyde Graeber
Sen. Paul Feleciano, Jr.*	Rep. Gilbert Gregory
Sen. Bill Morris	Rep. Robert Krehbiel
Sen. Lana Oleen	Rep. Barbara Lawrence
Sen. Nancy Parrish	Rep. J. C. Long
Sen. Jack Steineger	Rep. Alex Scott
	Rep. John Solbach
	Rep. Hank Turnbaugh

* Ranking minority member.