Approved 6-27-90
Date

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY.

The meeting was called to order by Senator Eric Yost at
Vice-Chairperson

10:00 a.m./~~p.m.~~ on March 14, 1990 in room 514-S of the Capitol.

All members were present~~except~~:

Committee staff present:
Mike Heim, Legislative Research Department
Jerry Donaldson, Legislative Research Department
Gordon Self, Office of Revisor of Statutes
Judy Crapser, Secretary to the Committee

Conferees appearing before the committee:
Ron Smith, Kansas Bar Association
Chip Wheelen, Kansas Medical Society
Lisa Getz, St. Francis Regional Medical Center, Wichita
Bob Frey, Kansas Trial Lawyers Association
Jerry Slaughter, Kansas Medical Society
Dr. Charles Konigsberg, Kansas Department of Health and Environment, Division of Health
Richard Mason, Kansas Trial Lawyers Association

Vice Chairman Yost called the meeting to order by recognizing Ron Smith, Kansas Bar Association. Mr. Smith presented the committee with information in opposition to SB 686 and SB 708. (ATTACHMENTs I and II)

SB 686 - concerning criminal prosecution; relating to the statute of limitations.

SB 708 - concerning criminal procedure; relating to preliminary examinations.

Chairman Winter opened the hearing for SB 613.

SB 613 - limiting liability of health care providers rendering treatment during or immediately following a disaster.

Chip Wheelen, Kansas Medical Society, testified in support of SB 613. (ATTACHMENT III)

The Chairman shared with the committee a letter received from Senator Roy Ehrlich in support of SB 613. (ATTACHMENT IV)

Lisa Getz, St. Francis Regional Medical Center, Wichita, testified in support of SB 613. (ATTACHMENT V)

Written testimony was submitted by Donald Wilson, Kansas Hospital Association, in support of SB 613. (ATTACHMENT VI)

Written testimony was submitted by Stephen Spence, Outreach Program of Central Kansas Medical Center, Great Bend, in support of SB 613. (ATTACHMENT VII)

Bob Frey, Kansas Trial Lawyers Association, testified in opposition to SB 613. (ATTACHMENT VIII)

This concluded the hearing for SB 613.

The Chairman opened the hearing for SB 736.

SB 736 - amending and supplementing the Kansas tort claims act; providing that charitable health care providers are employees of the state for the purposes of such act.

Jerry Slaughter, Kansas Medical Society, testified in support of SB 736. (ATTACHMENT IX)

Dr. Charles Konigsberg, Division of Health Director, Kansas Department of Health and Environment, testified in support of SB 736. (ATTACHMENT X)

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY,

room 514-S, Statehouse, at 10:00 a.m./~~p~~m on March 14, 1990.

The committee was presented with copies of a letter from Senator Roy Ehrlich in support of SB 736. (ATTACHMENT XI)

Written testimony was received from John Campbell, Deputy Attorney General, in support of SB 736. (ATTACHMENT XII)

Written testimony was recieved from the Kansas Department of Social and Rehabilitation Services expressing concerns about SB 736. (ATTACHMENT XIII)

Written testimony was recieved from Donald Wilson, Kansas Hospital Association, expressing concerns regarding SB 736. (ATTACHMENT XIV)

The Chairman appointed a subcommittee to further study the concepts and procedures of SB 736. Senator Richard Bond was appointed Chairperson of the Subcommittee with Senators Kerr, Moran, Winter, Parrish, Gaines, Petty and Rock to serve as members. It was further announced that the subcommittee would meet on adjournment of this day's session of the Senate.

When asked by the Chairman, Richard Mason, Kansas Trial Lawyers Association, stated that he had not intended to testify on SB 736. However, he stated KTLA generally supports the concepts of SB 736. They have concerns with the riskier procedures, such as surgery, but not to the point that they would oppose the bill.

The meeting was adjourned.

GUEST LIST

COMMITTEE: SENATE JUDICIARY COMMITTEE DATE: March 14, 1990

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
James A Zell	Wichita	RSVA
Dennis D Tietze	Topeka	KAFP Dir of Gov
Steve McDowell	KDHE Topeka	
Bill Dean	O.P.	
Joyce Whitehead	Prairie Village	guests of Sen Langworthy
Jean Gilham Spreen	Fairway	" of Sen Langworthy
Mary Ellen Conlee	Wichita	St Francis Reg. Med Center
Martha Gabehart	Topeka	Commission on Disability Concerns
Michael Lechner	"	"
Tom Bell	"	KS Hosp. Assn
Jim Clark	Topeka	KCDAA
Paul Shelby	Topeka	OJA
Ron Smith		
[redacted]		
Kim Perkins	Spring Hill	Page
Matt Meek	Bucyrus	Page
Jay Belcher	Olathe	Page
Cal Schwerdtfeger	Topeka	KOA

March 14, 1990

A SECOND CENTURY OF SERVICE
1882
KANSAS BAR ASSOCIATION

SB 686
March 12, 1990

Five Year Statute of Limitation

Mr. Chairman, members of the House Judiciary committee. I am Ron Smith. I represent the Kansas Bar Association.

KBA opposes SB 686 for the following reasons.

Federal law generally has five year statutes of limitation while most state crimes have a two year statute. Certain sex crimes, however, have a longer 5-year statute of limitation. KBA supports this status quo. There were special policy considerations in each reason for the extention of state statutes of limitations. In the case of children victimized by sex crimes, there was a recognized need for children to be a little older for them to be brave enough to come forward and testify.

This bill broadly increases statutes of limitation without regard to the type and nature of the crimes involved. While statutes of limitation in criminal actions clearly are functions for legislators, we believe broadly increasing the current two year statutes generally to five years raises procedural problems for prosecutors, defense counsel and judges that, taken as a whole, do not enhance our criminal justice system.1/ In fact, we're concerned it may affect other court operations to some degree,2/ perhaps adversely.

In most instances where a crime is cleared with an arrest by law enforcement officers, the two year statute of limitation is adequate for prosecutors.3/ Further, as this bill shows there are

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[1]For example, in a run of the mill burglary if police can't solve the burglary within two years extending the time to five years does not greatly enhance chances of solving it.

[2]Older crimes present difficulties of prosecution not present in other crimes, where evidence is fresh. Thus, these prosecutions will take longer, which affect other court operations, such as scheduling civil trials.

[3]Federal attorneys have longer statutes of limitation, but they
(Footnote Continued)

1200 Harrison • P.O. Box 1037 • Topeka, Kansas 66601-1037 • FAX (913) 234-3813 • Telephone (913) 234-5696

House Judiciary Committee
3-14-90
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statutory exceptions to the running of the statute of limitations if the crime is concealed or the defendant is absent from the state.4/

Whatever might be gained in the efficiency of prosecutions is more than offset by further delays in court proceedings and the difficulty of keeping witnesses available for protracted criminal prosecutions occurring long after the crime was committed. There would be a slight impact on the Aid to Indigent Defense Fund, too. We oppose the bill for these reasons. Thank you.

(Footnote Continued)
have greater staff and investigatory resources than most Kansas county attorneys. Given these practical limitations, lengthening the statute of limitation for state prosecutors solely because it is similar to periods allowed federal prosecutors does not necessarily equate with better prosecutions or investigatory abilities. The "federal similarity" argument, we believe, is apples and oranges.

[4]Lines 35-43 of page 1, and line 1, page 2, SB 686.

(3-14-90)
I 2/2

KANSAS BAR ASSOCIATION

SB 708
March 12, 1990

Hearsay Evidence at Preliminary Hearings

Mr. Chairman, members of the Senate Judiciary committee. I am Ron Smith. I represent the Kansas Bar Association.

KBA opposes SB 708 for the following reasons.

1. We acknowledge that there is no constitutional problem with doing what SB 708 does. Our reasons for opposition are economic and procedural.

2. You will save some time at preliminary hearings by allowing hearsay evidence. However, the basis of the hearsay must be reliable. If the basis for the credibility is not established, the witness can be compelled by subpoena to attend and testify. State v. Sherry, 233 Kan. 920 (1983)

3. We've suggested this legislation would be more appropriate if there were rights to criminal discovery depositions. That was studied last summer, with no recommendation made on that legislation, HB 2420.

4. Trials may increase, and be longer, with this bill. If that happens, you'll spend more, not less, aiding indigent defendants. Statistics in other states and the federal system itself seem to indicate -- and the Kansas Judicial Council Criminal Law advisory committee agrees -- that if you rely solely on hearsay evidence in preliminary hearings, both the prosecutor and the defense will misjudge the strengths and weaknesses of their case and the credibility of witnesses. The result would be an inability to agree on appropriate plea bargains.

5. In Florida federal court in 1988 where defendants are bound over on grand jury hearsay evidence exclusively, proportionately 400% more cases go to a full jury trial than in Florida state district courts. Florida's federal district courts tried over 20% of their felony indictments while the trial rate in Florida state courts was 5 percent. Florida officials credit that difference to the more open use of discovery depositions in state courts.

6. In Kansas, evidentiary preliminary hearings serve the same purpose of discovery depositions in Florida. Professor Michael Barbara states the following about the purpose of a Kansas preliminary hear-

Senate Judiciary Committee
3-14-90
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ing: "The preliminary examination also provides an opportunity for the defense for discovery of the state's case. The defendant has the right to subpoena witnesses and to cross-examine witnesses as well as the right to introduce evidence in his own behalf. The hearing also serves to perpetuate evidence and for developing impeachment testimony against the state's witnesses. In addition to these advantages for the defendant, the proceeding serves as a screening device." Barbara, Kansas Criminal Law Handbook, Second Ed., (1987), p. 7-3 (emphasis added)

7. In Kansas, federal district courts handled 101 felony indictments last year and 8 went to a jury trial: about 8%. The Board of Indigent Defense Services indicates that of 3,951 felonies handled by their public defenders, 116 went to a trial either to the judge or jury. That is 2.9%. The discovery process through preliminary hearing transcripts appears to make a difference in the number of cases that go to a time-consuming trial. Limiting that use would logically lead to a greater number of trials.

8. While streamlining our criminal justice system is noble, the judicial council's 1985 report on this issue doesn't think that will happen by allowing hearsay evidence at preliminary hearings. Their report states:

> "It would seem likely that any person whose hearsay testimony was introduced at the preliminary examination to establish probable cause would be subject to subpoena by the defendant. This would seem to mitigate any savings or avoidance of inconvenience and harassment promoted by [hearsay rule legislation]. . . . Committee members were concerned that establishing the requisite basis for crediting the hearsay evidence may be as time consuming as calling the actual witness.
>
> " . . . Prosecutions are often filed based on investigators' reports containing witness interviews which do not accurately reflect the strength of the witnesses' eventual testimony. The use of otherwise inadmissible and potentially unreliable hearsay would appear to detract from the likelihood of informed resolution of such cases."

For these reasons we oppose the bill. Thank you.

(3-14-90)
II 2/2

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

March 14, 1990

TO: Senate Judiciary Committee

FROM: Kansas Medical Society Chip McClean

SUBJECT: Senate Bill 613; Liability of Health Care Providers During or Immediately Following a Disaster

The Kansas Medical Society appreciates this opportunity to express our support of SB 613. We believe that this measure recognizes the very important difference between health care rendered under normal circumstances and the situation which occurs during or immediately following a disaster, such as a tornado.

It is only reasonable to assume that during a time when many persons have been injured, that health care providers cannot provide the same standard of care that they would under other circumstances. The pressures and haste to save as many lives as possible necessitate extremely difficult decisionmaking and judgement exercised by health care providers that resemble a combat situation (triage). Furthermore, SB 613 does nothing more than extend to health care providers the same privilege of immunity as extended to a governmental employee involved in emergency activities.

Thank you for considering our comments. We respectfully request that you recommend SB 613 favorable for passage.

CW:lg

Senate Judiciary Committee
3-14-90
Attachment III page 1 of 1

STATE OF KANSAS

ROY M. EHRLICH
SENATOR, THIRTY-FIFTH DISTRICT
RICE, BARTON, RUSSELL COUNTIES
ROUTE 1, BOX 92
HOISINGTON, KANSAS 67544-0092

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS

CHAIRMAN: COMMISSION ON ACCESS SERVICES FOR THE MEDICALLY INDIGENT AND HOMELESS
CHAIRMAN: PUBLIC HEALTH AND WELFARE
MEMBER: FEDERAL AND STATE AFFAIRS
LABOR, INDUSTRY, AND SMALL BUSINESS
LOCAL GOVERNMENT
ADMINISTRATIVE RULES AND REGULATIONS
ADVISORY COMMITTEE OF STATE DEPARTMENT OF AGING
NATIONAL CONFERENCE OF STATE LEGISLATURES SPECIAL SELECTED COMMITTEE—HEALTH CARE
NATIONAL SPECIAL SELECT STANDING COMMITTEE OF THE MENTAL HEALTH ASSOCIATION

Senator Wint Winters
Chairman, Senate Judiciary Committee
Room 120S, Statehouse
Topeka, KS 66612

Dear Senator Winters:

In reference to Senate Bill No. 613, I want to point out the diaster which the city of Hesston experienced yesterday and the persons which helped to pull victims from the ruins.

Senate Bill 613 is needed to protect these good Samaritans from being sued by individuals who receive help during emergencies. There are many people who respond to others in an emergency situation, giving their time and even offering possibly their own lives to help those that need help when needed. It is only fair that these people be protected.

I am attaching also a letter from Mr. Stephen Spence, of the St. Joseph Memorial Hospital, in support of Senate Bill 613.

Thank you for your consideration of this most important bill in aiding the citizens of Kansas and allowing them to freely be true Good Samaritans when needed without the threat of a lawsuit hanging over their heads.

Sincerely,

Roy M. Ehrlich

Roy M. Ehrlich
State Senator
Thirty-Fifth District

RME:sn
Attachment

Senate Judiciary Committee
3-14-96
Attachment IV page 1 of 3

ST. JOSEPH MEMORIAL HOSPITAL
DIVISION OF
CENTRAL KANSAS MEDICAL CENTER
923 CARROLL • LARNED, KANSAS 67550 • 316-285-3161

April 4, 1989

Senator Roy Ehrlich
Kansas Senate
State Capitol Building
Topeka, Kansas 66600

Dear Senator Ehrlich:

In an effort to meet the needs of our area residents during a health care disaster, St. Joseph Memorial Hospital maintains a disaster preparedness plan designed to maximize the efficient use of health care personnel, facilities, and other resources. To meet J.C.A.H. standards, hospitals are required to hold disaster drills at least twice a year to determine our level of preparedness in meeting health care needs during a disaster. During our last disaster drill we found that the number of health care professionals who responded was insufficient to meet our needs, and that if a real disaster had occurred, some of our patients would not have received adequate care.

In an attempt to increase the number of health care professionals available during a disaster, we recently contacted physicians, nurses, dentists, and other health care professionals in the Larned area who do not customarily work in a hospital environment, but who have skills that would be useful during a disaster. A number of the health care professionals we contacted asked if the Good Samaritan Laws which protect health care providers from liability in emergency situations would apply during a health care disaster. Our legal counsel has advised us that KSA 65-2891, which is the applicable law, in fact does not protect voluntary health care providers in a disaster situation when their services are rendered in a hospital.

The purpose of this letter is to ask that you assist us in getting a paragraph added to KSA 65-2891 to protect these individuals under the Good Samaritan Laws.

(3-14-90)
IV 2/3

This paragraph might read: (e) Any health care provider may in good faith render treatment to the injured during a health care disaster in which there is a significant number of injured due to tornado, fire, or other catastrophies or acts of God, in a hospital or elsewhere. The health care provider rendering such care shall not be held liable for any civil damages other than damages occasioned by gross negligence or by willful or wanton acts or omissions.

I will contact your office in the next few weeks to discuss the possiblity of getting this law changed.

Thank you in advance for your assistance.

Sincerely,

Stephen L. Spence
Chief Operating Officer

(3-14-90)
IV 3/3

ST. FRANCIS REGIONAL MEDICAL CENTER

March 14, 1990

Chairman Winter, members of the committee, I am Lisa Getz, here representing St. Francis Regional Medical Center, Wichita, in support of SB 613.

In a disaster, hospitals operate under standards of care that dictate which patients will be cared for first and how that care will be administered. Triage is the method of evaluation which categorizes a patient's condition. In triage, physicians and nurses determine which patients need urgent care, which appear to require minimal care, which should be stable if care is delayed and in some instances, which may require transfer to another facility. The first care provided is to:

1. prevent deaths from shock
2. prevent deaths from loss of body fluids
3. stabilize as many patients as possible

Doctors and nurses providing care in an emergency are forced to make some educated guesses in evaluating patients' stability. Patients on hold are rechecked and conditions are upgraded as needed.

Treating patients in a disaster differs from the normal course of treatment. The attempt is to treat as many people as effectively as possible. Sometimes that means that doctors and nurses must delay care to those whose lives are seriously threatened if it would appear that medical personnel could be better utilized to care for greater numbers of people whose conditions could deteriorate without prompt treatment.

Doctors, nurses and other medical personnel are always held to a high standard of care. In a disaster, the medical staff must act without hesitation-- without concern for potential litigious fallout. We live in such a litigious society that often people are inclined to sue any time there are bad results. Medicine is not an exact science. If it were, every procedure and treatment would have known results. Due process of the law is served by SB 613, which allows redress if gross and wanton negligence can be proved.

In conclusion: St. Francis Regional Medical Center supports SB 613. We, as citizens, cannot afford to create hesitation on the part of medical personnel, at the very time when there is the greatest need for them to respond with all of their resourcefulness to save lives.

Senate Judiciary Committee
3-14-90
Attachment V page 1 of 1

929 North St. Francis / Wichita, KS 67214 / 316-268-5000
"Owned And Operated By The Sisters Of The Sorrowful Mother"

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

March 12, 1990

TO: Senate Judiciary Committee

FROM: Kansas Hospital Association

SUBJECT: SENATE BILL 613

The Kansas Hospital Association supports Senate Bill 613 as a logical extension of protection against liability for health care providers rendering care immediately after disasters.

The Legislature has previously extended such protection in other areas. K.S.A. 65-2891 provides for protection against liability for health care providers who in good faith give care at the scene of an emergency or accident or provide emergency care to minors injured during competitive sports.

K.S.A. 65-6124 providers that a physician or registered nurse should not be held liability for instructions given to emergency medical technicians during an emergency, unless the instructions were grossly negligent.

It should also be noted that liability under S.B. 613 may only be limited when there is a disaster involving a significant number of persons. This severely reduces the number of instances in which the bill would be applicable.

Thank you for your consideration of our comments.

TLB:mkc

Senate Judiciary Committee
3-14-90
Attachment VI page 1 of 1

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

ST. JOSEPH MEMORIAL HOSPITAL
DIVISION OF
CENTRAL KANSAS MEDICAL CENTER
923 CARROLL • LARNED, KANSAS 67550 • 316-285-3161

Date: March 5, 1990

To: The Kansas State Senate Judiciary Committee

From: Stephen L. Spence, Vice President - Outreach
Central Kansas Medical Center, Great Bend

Re: Changes to Senate Bill No. 613

Before I start, I would like to thank the Judiciary Committee for hearing my testimony. I would also like to thank Senator Ehrlich for introducing the changes to Bill No. 613.

You may be aware that all hospitals in Kansas and throughout the United States are required to maintain a disaster preparedness plan to deal with large numbers of individuals injured during natural or other types of disasters. This plan incorporates, 1) a system of triage, where patients are treated according to the severity of their injuries, 2) transfer and referral systems, integrating all available health care services, and 3) a systematic approach to identifying and contacting health care professionals to assist in the care of the injured.

In hospitals in smaller communities, the number of hospital-affiliated health care professionals may not be adequate to manage a large number of injured during a disaster. To compensate for this potential lack of trained personnel, we have contacted a number of health care professionals who have either

Senate Judiciary Committee
3-14-90
Attachment VII page 1 of 3

retired from practice or who have never been affiliated with our health care system. The health professionals contacted included dentists, veterinarians, and retired physicians and nurses.

The role of these health professionals would be to use their treatment skills under the direction of a hospital-affiliated health care professional. It might seem odd that we would consider using veterinarians or that they would consider working in this environment; however, in a disaster, a veterinarian has many useful skills (for example, reducing blood loss or stabilizing fractures) which apply in the treatment of animals and people alike. Dentists, who may have training in the treatment of facial injuries, also can assume an important role during a disaster.

When we contacted these health care professionals, we found that there was an overwhelming willingness to participate in the disaster plan. Since their participation would be completely voluntary, and there would be no fees for their services, the question arose as to their level of liability, and conversely, their level of protection under existing Good Samaritan laws in Kansas.

Our legal counsel's interpretation is that current Good Samaritan law in Kansas only protects health care providers outside of the health care environment. Our employees and physicians are protected by malpractice insurance during a disaster. It appears, however, that these non-hospital-affiliated health care professional, who are providing voluntary services in a hospital during a disaster, are not protected by either the hospital's malpractice insurance or the Good Samaritan laws. Since these

providers are working under the direct supervision of a trained, actively practicing health care professional, they should not be held liable for personal injury resulting from their efforts to save lives.

I will conclude by restating that by passing this amendment, you will be insuring the protection of many volunteer professionals and you will be providing many health care systems in Kansas with a mechanism for using all available human resources during a disaster.

(3-14-90)
VII 3/3

KANSAS TRIAL LAWYERS ASSOCIATION

Jayhawk Tower, 700 S.W. Jackson, Suite 706, Topeka, Kansas 66603
(913) 232-7756 FAX (913) 232-7730

TESTIMONY
of the
KANSAS TRIAL LAWYERS ASSOCIATION
before
SENATE JUDICIARY COMMITTEE

Regarding SB 613

The Kansas Trial Lawyers Association appears today for the purpose of expressing our concern regarding the proposed amendment to K.S.A. 48-915 which, if adopted, would grant total blanket immunity for ordinary negligence to all health care providers who provide medical services to persons under emergency conditions.

The terminology of the new language in subsection (b) of the bill raises many more questions than it solves. If the language is inspected closely, it can quickly be seen that several ambiguities exist which would predictably give rise to litigation. Some of those ambiguities are as follows:

1. "Good faith" - This phrase adds nothing to the bill other than to inject an element of uncertainty as to what the status of the liability of the provider to the patient will be. What real difference does it make to the injured person whether the person was acting in good faith or bad faith? The mental status of the provider is really irrelevant.

2. "in a hospital or elsewhere" - Does this mean anywhere and everywhere? If so, why not say so.

3. "during or immediately following a disaster" - This phrase simply does not define when the provider would be granted blanket immunity for negligent acts, nor for how long that special privileged status would be in effect. If subsection (c) of the statute is taken into consideration, it would lead one to believe that the only time a bona fide emergency disaster situation would exist is after a proclamation is issued pursuant to K.S.A. 48-924. Certainly is would be questionable policy of the state to allow immunity to be granted <u>after</u> a negligent injury occurs and subject to the possible political considerations of the authorities responsible for declaring disaster emergencies.

4. "a significant number of persons" - What is a significant number of persons? There is no possible way that people could know when this law would be in effect or when it would not. They would not know because they would never know for sure if there were a "significant number" of persons who were injured.

Senate Judiciary Committee
3-14-90
Attachment VIII page 1 of 2

K.S.A. 65-2891 is the current section of the law which deals with emergency treatment of persons by health care providers. That law has been carefully thought out and is generally regarded as a fair statement of public policy regarding the needs of persons to receive emergency care and the protection of the persons who provide that care. It seems questionable to us that blanket immunity from civil liability for negligence should be granted to health care providers under this section of the law when other law adequately addresses the issue. Passage of SB 613 would set up a certain conflict in the law between the immunity granted in Chapter 48 with the immunities which may exist in Chapter 65.

The Kansas Trial Lawyers Association urges this Committee to move cautiously in this area. We find no substantial reason for granting blanket immunity for negligence in providing emergency health care and we doubt, given close inspection by this Committee, that there is any reason to do anything with this bill other than to report it adversely.

(3-14-90)
VIII 2/2

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

March 14, 1990

TO: Senate Judiciary Committee

FROM: Kansas Medical Society

SUBJECT: Senate Bill 736; Charitable Health Care Providers

Thank you for this opportunity to express our support for the provisions of SB 736. This bill is a product of much deliberation and work by the Kansas Medical Society and others who are interested in the provision of health care to medically indigent Kansans.

In May, 1989, the KMS House of Delegates adopted a resolution calling for "alternative liability coverage to physicians who provide free health care services." This resolution was adopted primarily because there are a number of retired physicians throughout Kansas who maintain what is called an exempt license in order to provide medical care in a very limited manner. Exempt under the Healing Arts Act means that the physician is not required to purchase medical malpractice insurance nor pay a surcharge into the Health Care Stabilization Fund. This licensure is contingent upon the condition that the physician may not accept compensation for medical services rendered. Exempt certainly does not mean that the physician is in any way immune from liability.

Originally, the exempt license was created by the Legislature to enable retired physicians to perform and provide basic health care services that would not expose those physicians to significant liability. In the meantime, because of an increasing demand for charity care to indigent patients, we have discovered that there are a number of retired physicians who would devote a certain amount of time to charity clinics or other situations providing medical care to indigent patients, were it not for the fact that these physicians do not have liability insurance to protect them in the event of an unsatisfactory medical outcome. Because of the very expensive premiums, neither the charity clinics nor the retired physicians can afford to purchase professional liability insurance to cover this exposure.

We believe that enactment of SB 736 will accomplish two major objectives. First, it will allow a significant number of retired physicians to provide charity care on a part-time or intermittent basis. Second, it will encourage actively practicing physicians to provide more charity care than they would otherwise. This second category of physician is one who does have professional liability insurance, but chooses not to donate professional services to indigent patients, because of the liability exposure. We frequently hear these physicians comment that they would render care to Medicaid patients if it were not for two things; the extensive paperwork and the exposure to liability.

Senate Judiciary Committee
3-14-90
Attachment IX page 1 of 4

You will note that Senate Bill 736 allows the Secretary of SRS to enter into agreements with health care providers which stipulate that the health care provider will not charge any fee when he or she renders care to a medically indigent patient. The bill also allows the Secretary of SRS to adopt eligibility criteria for purposes of determining medical indigency status. This means that the scope of the program could initially be restricted to certain categories of health care providers. Furthermore, the Secretary of SRS could choose to limit the number of indigent patients who would expose the state to a certain amount of liability. The bill also allows the Secretary of SRS to expand the scope of the program by simply redefining who might be considered a charitable health care provider and who might be eligible for medical indigency status.

We recognize that such legislation immediately raises two major questions. First, does application of the Tort Claims Act, in this instance, limit the ability of the patient to recover damages in the event of negligence on the part of a charitable health care provider? The answer is yes, the Kansas Tort Claims Act does include limitations on ability to recover, specifically, a half million dollars. The important point to keep in mind in this context is that the patient might not have received medical care otherwise. The second major question pertains to whether or not the State would be exposed to unreasonable liability. The available studies indicate that the notion that indigent patients are more likely to sue than other patients, is not the case. Attached to this testimony is a copy of an article printed in the September 8, 1989 edition of the "Journal of the American Medical Association" which summarizes a number of studies which have determined that poor patients are less likely to sue than more fortunate people.

We believe that passage of SB 736 will improve access to health care for the people of Kansas. If indeed the Executive Branch and the Legislature intend to restrain spending for programs delivering health care to medically indigent Kansans, then it is essential that other measures be taken in order to continue providing access to health care for needy individuals and families, particularly the children.

It is for these reasons that we urge you to recommend passage of SB 736. Thank you for your consideration.

CW:lg

(3-14-90)
IX 2/4

Are Poor Patients Likely to Sue for Malpractice?

Q As I try to interest other physicians in providing medical care for the poor, I am finding that almost all physicians assume that their risk of being sued for malpractice will be higher if they take such patients into their practice, that is, they believe that the poor are more likely to sue physicians than are more affluent patients. Has this issue been studied? Are there data to substantiate whether the risk of suit is different in a practice among the poor than among the financially secure? If a physician takes poor people into his or her practice, is there a greater risk of suit?

David Hilfiker, MD
Washington, DC

A The perception that poor patients sue more for medical malpractice is a damaging myth. This myth hurts access to health care for indigent people by decreasing physician acceptance of Medicaid patients.

Until very recently, there were no data either to support or refute the assertion by insurance companies and doctors that indigent patients were more likely to sue for medical malpractice than were privately insured patients. However, current studies now universally demonstrate what common sense told us all along: poor people do not account for disproportionate numbers of malpractice suits—in fact, they are *less likely to sue* than are middle-class or privately insured patients. The fear of malpractice suits by indigent patients, therefore, is not a legitimate reason for denying patients health care. A brief summary of these studies follows.

A 1988 study conducted by the Texas Medical Association found that indigent and Medicaid/Medicare patients do not account for disproportionate numbers of suits and claims.[1] The proportion of lawsuits filed by indigent patients does not vary significantly from their proportions in the overall patient population, and suits filed by Medicaid patients are disproportionately low. Medicaid patients and indigents (or those without medical insurance coverage) each account for about 12% of patients seen by Texas physicians. The reported incidence of suits filed by indigent patients is 13.4%, and for Medicaid patients it is only 3.5%. Medicare patients account for 5.9% of lawsuits and patients with acquired immunodeficiency syndrome for less than 1% of the suits.

Similar perceptions and findings have been reported from Michigan. A survey there found that Medicaid recipients are significantly underrepresented in malpractice litigation. In 1988, the Michigan Department of Licensing and Regulation reviewed the Insurance Bureau's medical malpractice closed-claim database for the years 1985 through 1987.[2] They found that Medicaid-related closed claims accounted for only 6.23% of all closed claims, while the Medicaid-eligible population for that period ranged from 10% to 11%.

Other studies have reached similar conclusions.[3] A study of medical malpractice conducted by the National Association of Community Health Centers in 1986 showed that health center obstetricians (virtually all of whose patients have incomes that are <200% of the federal poverty level, and 25% to 40% of whom are eligible for Medicaid) have malpractice claim profiles approximately one fifth as great as those of office-based obstetricians.[4]

A 1987 report by the US General Accounting Office[5] found that Medicaid patients accounted for 5.8% of the closed claims for which insurance status was known, while Medicaid recipients total about 9% of the US population.[6]

Unpublished data on malpractice claims in Maryland from 1977 through 1985 showed that Medicaid patients accounted for 9.6% of all claims for which insurance status was known; recipients represent about 9% of the state population.[7] Self-pay patients filed 17.1% of the malpractice claims, about the same proportion estimated to be uninsured in the state. Medicaid recipients accounted for 13% of obstetric-gynecologic claims for which insurance status was known. In 1986, Medicaid recipients accounted for about 19% of admissions to Maryland hospitals.[8]

A 1988 article[9] examined malpractice experience associated with fertility-control services among a national sample of obstetricians-gynecologists. This study found no significant correlation between Medicaid participation and threatened or actual malpractice litigation.

The foregoing studies reinforce what logic tells us: for a variety of reasons, poor people are the most unlikely patients to sue.[10] The primary reason is that the poor are even less likely than the general population to perceive that any type of wrong has occurred or to assert their rights,[11] and much less likely to obtain legal counsel. Contrary to what many may think, there is not an "ambulance chaser" on every block, and indigent people have virtually no access to legal representation for malpractice suits. As a general rule, only members of the private bar can take malpractice cases, and, for economic reasons, hardly any take them for the indigent.

There are two reasons for the private bar's refusal to provide legal services in malpractice cases brought by low-income clients. First, malpractice plaintiff lawyers are usually paid on contingency; that is, the lawyer will get a percentage of the award if the plaintiff wins. Since malpractice awards are based largely on future earnings, and since poor people obviously have very low future earning potential, poor plaintiffs are unlikely to get large financial awards. In fact, a study showed that a Medicaid plaintiff's average malpractice award is approximately $50 000, compared with an average $250 000 award for privately insured patients.[12] Since the economic award probably will be small, private bar lawyers do not like to represent poor people; representation of the poor is not economically profitable.

If a private bar attorney is not available, the only other way for a low-income person to get legal representation is to qualify for a Legal Services lawyer. However, federal law prohibits Legal Services lawyers, the primary providers of free legal assistance to the poor, from taking malpractice cases unless that client first has been turned away by two private attorneys. Furthermore, the eligibility requirements for Legal Services are quite strict: a client's income must be under approximately $7000 per year to qualify.[13] Thus, as a practical matter, Legal Services lawyers virtually never take

Edited by Helene M. Cole, MD, Senior Editor.

Every letter must contain the writer's name and address, but these will be omitted on request. Questions are submitted to consultants at the discretion of the editor and published as space permits.

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malpractice cases, and private bar lawyers virtually never take on a malpractice case for an indigent patient.

The same poverty that discourages lawyers from representing the poor likewise removes economic incentives for the poor to sue. In many states, Medicaid recipients must turn over to the state Medicaid agency their right to collect the money awarded by the court for medical care,[14] so the "successful" plaintiff may not get to keep any compensation. Another disincentive to poor people is the long delays in settlement of litigation. Finally, when compensation ultimately is received, it may be in the form of a lump-sum payment. Lump-sum payments usually disqualify the recipient from Aid to Families With Dependent Children, and therefore also disqualify the recipient from Medicaid. Thus, indigent plaintiffs who won their malpractice claim probably would lose their Medicaid coverage for other illnesses, preventive medical care, and their families' medical expenses as a result of receiving compensation for malpractice.

Despite the studies and the commonsense reasons demonstrating the unlikelihood of increased malpractice exposure from caring for low-income patients, the pernicious myth that poor people are a "malpractice risk" persists. Perhaps one reason for the persistence of this damaging myth is that physicians confuse the distinction between the likelihood of *medically bad outcomes* and the likelihood of *malpractice suits* and paid claims.[15] It may indeed be true that indigent patients are at higher risk for poor outcomes, because their overall health is inferior to that of privately insured people. But higher risk in and of itself does not affect a physician's malpractice exposure *if the incidents do not become claims.* Insurance premiums are based on the amount of money paid out in claims, not on the number of bad outcomes. As both common sense and recent studies tell us, poor people who have been the victims of malpractice rarely pursue their right to compensation in court.

Molly McNulty, JD
National Health Law Program
Washington, DC

1. Conversation with Leslie Lanham, Children's Defense Fund, Austin, Tex (June 15, 1989), author of the Texas Medical Association Professional Liability Survey (summer 1988).
2. Michigan Dept of Social Services. *Medicaid Matters.* February 1989;3(2).
3. Two other states, Maryland and Washington, currently are studying the issue. The Institute of Medicine also is expected to issue a report by September 1989.
4. Rosenbaum S, Hughes D. The medical malpractice crisis and poor women. In: Brown S, ed. *Prenatal Care: Reaching Mothers, Reaching Infants.* Washington, DC: Institute of Medicine; 1988:229-243.
5. *Medical Malpractice: Characteristics of Claims Closed in 1984.* Washington, DC: US General Accounting Office; 1987. GAO-HRD-87-55.
6. Data recalculated by Deborah Lewis-Idema, *Increasing Provider Participation.* Washington, DC: National Governors Association; 1988:27. The recalculation corrected for the presence of closed claims for which the insurance source was not known.
7. Data provided by Laura L. Morlock, The Johns Hopkins University School of Public Health, Dept of Health Policy and Management, *cited* in Lewis-Idema, *supra* note 6, p 70.
8. *Ibid.*
9. Weisman CS, Teitelbaum MA, Morlock LL. Malpractice claims experience associated with fertility-control services among young obstetricians-gynecologists. *Med Care.* March 1988;26(3):298-306.
10. Stoll K. Don't blame the poor for the malpractice crisis. *Washington Post.* April 30, 1986. Health Section:6.
11. Dept of Health, Education, and Welfare Secretary's Commission on Medical Malpractice. *Consumer's Knowledge of and Attitudes Towards Medical Malpractice.* Washington, DC: Dept of Health, Education, and Welfare; 1973:658-694. These data do not mean that the poor experience fewer incidents of malpractice. Peterson hypothesized that low-income groups may be less likely to perceive a negative medical experience as a case of malpractice.
12. US General Accounting Office, *supra* note 5. The GAO data were retabulated by Laura L. Morlock, The Johns Hopkins University. The GAO-published report includes payout on behalf of plaintiffs in 1 year. Because large awards frequently involve payments over time, the averages in the published report understate the effect of these awards. The retabulation from the GAO database covers total expected value of the award to the patient. Reported in Lewis-Idema, *supra* note 6, note 48 on p 71.
13. A person's family income must be less than 125% of the federal poverty guidelines to be eligible for Legal Services. In 1989, these levels are as follows:

Family Size	Annual Income, $
1	7475
2	10 025
3	12 575
4	15 125

Federal Register. February 16, 1989;54:7098.
14. See, eg, *White v Sutherland,* 585 P2d 331 (NM Ct App 1978); *Brown v Stewart,* 129 Cal App 3d 331 (Calif Ct App 1981); and *Moss v Glynn,* 383 NE2d 275 (Ill App Ct 1978).
15. Rosenbaum and Hughes, *supra* note 4.

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State of Kansas
Mike Hayden, Governor

Department of Health and Environment
Division of Health

Stanley C. Grant, Ph.D., Secretary

Landon State Office Bldg., Topeka, KS 66612-1290

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Testimony presented to

Senate Judiciary Committee

by

The Kansas Department of Health and Environment

Senate Bill 736

The purpose of Senate Bill 736 is to allow physicians who volunteer their services to medically indigent patients to be considered as employees of the state of Kansas thereby placing them under the Kansas Tort Claims Act. The Commission on the Medically Indigent and Homeless estimates that there are a minimum of 350,000 Kansans who are medically indigent. The medical societies in Sedgwick, Shawnee and Wyandotte counties have indicated that they have a number of retired physicians ready and willing to donate time to community clinics. Senate Bill 736 would allow them to see medically indigent patients at no charge and be covered by the Kansas Tort Claims Act as charitable health care providers. This is one more reasonable though small effort to impact on the indigent care dilemma in Kansas.

Testimony presented by: Charles Konigsberg Jr., M.D.
Director
Division of Health
March 14, 1990

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Charles Konigsberg, Jr., M.D., M.P.H., Director of Health (913) 296-1343

James Power, P.E., Director of Environment (913) 296-1535

Lorne Phillips, Ph.D., Director of Information Systems (913) 296-1415

Roger Carlson, Ph.D., Director of the Kansas Health and Environmental Laboratory (913) 296-1619

STATE OF KANSAS

ROY M. EHRLICH
SENATOR, THIRTY-FIFTH DISTRICT
RICE, BARTON, RUSSELL COUNTIES
ROUTE 1, BOX 92
HOISINGTON, KANSAS 67544-0092

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS

CHAIRMAN: COMMISSION ON ACCESS SERVICES FOR THE MEDICALLY INDIGENT AND HOMELESS
CHAIRMAN: PUBLIC HEALTH AND WELFARE
MEMBER: FEDERAL AND STATE AFFAIRS
LABOR, INDUSTRY, AND SMALL BUSINESS
LOCAL GOVERNMENT
ADMINISTRATIVE RULES AND REGULATIONS
ADVISORY COMMITTEE OF STATE DEPARTMENT OF AGING
NATIONAL CONFERENCE OF STATE LEGISLATURES SPECIAL SELECTED COMMITTEE—HEALTH CARE
NATIONAL SPECIAL SELECT STANDING COMMITTEE OF THE MENTAL HEALTH ASSOCIATION

March 14, 1990

Senator Wint Winters
Chairman, Senate Judiciary Committee
Room 120S, Statehouse
Topeka, KS 66612

Dear Senator Winters:

In reference to Senate Bill 736, I want to express my support of passage of this important legislation.

As Chairman of the Commission on Access to Services for the Medically Indigent and Homeless, I have come across many medical doctors who would willing give of their time if they didn't have the obligation of medical liability insurance.

It is a shame to waste the much needed talent of these valuable retired medical doctors, when all we have to do is to provide a way for them to be free of the need of medical liability insurance which is preventing them from volunteering their abilities where needed.

I would appreciate your favorable consideration of Senate Bill 736, and thereby giving Kansas another source to provide help to the medically indigent and homeless in Kansas.

Thank you.

Sincerely,

Roy M. Ehrlich/sn

Roy M. Ehrlich
State Senator
Thirty-Fifth District

RME:sn

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STATE OF KANSAS

OFFICE OF THE ATTORNEY GENERAL

2ND FLOOR, KANSAS JUDICIAL CENTER, TOPEKA 66612-1597

ROBERT T. STEPHAN
ATTORNEY GENERAL

MAIN PHONE: (913) 296-2215
CONSUMER PROTECTION: 296-3751
TELECOPIER: 296-6296

March 14, 1990

The Honorable Wint Winter, Jr.
Chairman of the Senate Judiciary Committee
State Capitol
Topeka, Kansas

Re: Senate Bill No. 736

Dear Senator Winter:

I am writing on behalf of Attorney General Bob Stephan in support of Senate Bill 736.

As you know, there are many people in Kansas who cannot afford adequate health care. Most of these unfortunate individuals turn to the state for assistance. But in a time of tight budgets, even the public sector can not always provide the money for needed medical services.

What makes this situation all the harder to hear is the fact that there are some physicians and other health care providers who would be willing to donate their services to the poor, if it were not for the need to pay malpractice premiums. There are other physicians who are in semi-retirement and have very limited practices. These "exempt" doctors are not required to maintain malpractice insurance. These doctors could help the poor, but they are fearful of expanding their practice without protection.

Senate Bill 736 could help alleviate this situation. This bill allows the Secretary of SRS to enter into agreements with charitable health care providers. These agreements would allow physicians to provide services to the poor free of charge. This would be made possible by providing this limited number of health care providers with the protection of the Kansas Tort Claims Act, KS.A. 75-6101 et seq.

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The up front expense of such a program would be limited. The primary concern would, of course, be the potential liability of the Tort Claims Fund to cover malpractice claims. I can not tell you what that liability would be. We are exploring new ground with this legislation. Attorney General Stephan recommends that the Secretary start slowly with this program and that it be evaluated annually. However, he does believe it is a worthy program. It is one that deserves a chance.

Attorney General Stephan believes that benefit of free medical services to the poor would outweigh the liability of malpractice claims. This belief is founded on the fact that indigent medical recipients have been found less likely to bring legal actions against health care providers than the public at large. Further, it should be recognized that if the state does not accept these donated services, it will have to pay for at least some of these services.

Attorney General Bob Stephan urges you to support Senate Bill 736.

Sincerely,

OFFICE OF THE ATTORNEY GENERAL
ROBERT T. STEPHAN

John W. Campbell
Deputy Attorney General

JWC/mb

cc: Reid Stacey

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TESTIMONY OF THE STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Re: Senate Bill 736

SB 736 calls upon SRS to enter into agreements with interested health care providers which would recognize them as "charitable health care providers". Such a provider would agree to provide free medical care to people SRS defined as "medically indigent". In return for this care the provider would be covered under the Kansas Tort Claims Act for any damage claims arising from this medical care. The Secretary of SRS is given the discretion to define medical indigence.

There are two methods by which SRS might implement the provisions of Senate Bill 736. One method would be for SRS to merely define the term "medically indigent" and publish guidelines by which individual charitable health care providers would determine whether to provide free health care services. Under this method, the cost to SRS would be minimal. The second method would be for SRS to determine who among Kansas residents will be defined as being "medically indigent" and to certify such status to the charitable health care providers. The estimated cost of this second method would be $8,000,000.00 in state funds per year.

Under either method, another cost of the program would be the expenses of development and monitoring of the contracts between SRS and the charitable health care providers, communications with providers over the interpretation of the definition of "medically indigent," and keeping current provider enrollment lists available within each community. This would require a one-half time position with few administrative expenses, for a cost of approximately $16,000.00 per year.

One important expense would be the cost to the Kansas Tort Claims Fund for the defense, settlement and payment of judgments arising out of claims filed against charitable health care providers. Last year, the Health Care Stabilization Fund paid $18,313,000.00 in settlements and judgments. It is estimated that the medical malpractice insurance carriers paid approximately $34,000,000.00 last year in settlements and judgments. Comparing the total payout to the population of Kansas (1987 figures), the average payout for medical malpractice per Kansas resident was $21.25.

Health Care Fund	$18,313,000.00
Insurance payments	+34,000,000.00
Total Payout	$52,313,000.00

Total Payout	$52,313,000.00	
Kansas Population	2,461,000	= $21.25 per person

Using an estimated population of medically indigent persons numbering 18,191, it may be extrapolated that the payout of settlements and judgments would be $386,558.00 annually. (18,191 X $21.25 = $386,558.00.) An additional cost, not included in this figure would be the cost of defending the claims. It is unknown whether the defense of claims against charitable health care providers would be provided by the office of the Attorney General or by the SRS Legal Division Staff. Either way, it must entail some extra expense by either staff. This figure assumes that claims will be somewhat comparable to doctors in ordinary non-charitable practice. There are some factors which might increase the number of claims, but there are some factors which may decrease the number of claims. Some factors which might increase the number of claims are:

retired doctors may not keep up on latest technology and fall short of the standard of care; charitable clinics may not have the diagnostic equipment that a regular clinic may have; the indigent population may have generally poorer health than the general population; a charitable health care provider may not have a long history of dealing with the patient; and charitable health care providers may be overworked. Some factors which might decrease the number and quality of claims include: limited access of poor people to legal assistance; and the relative value of the case before a jury or judge (i.e., if the patient has not had a good work history, there is not as good a case for large damage awards for diminished earning capacity). In any case, medical malpractice liability exposure is a highly variable cost. For example, the Health Care Stabilization Fund is currently involved in a case involving a single man with no dependents who was injured in a doctor's care, where the fund is presently faced with a judgment of $6,000,000.00.

Another way to analyze this is to look at the cost of insurance if purchased on the open market. For a medical doctor with a full license, with $500,000.00 worth of coverage, in a Class 2 category, which would entail some minor procedures but no surgery, the approximate medical malpractice premium is $15,000.00 per year. It can probably be assumed that the $15,000.00 figure includes a profit for the insurance company. If it can be estimated how many physicians would be serving as charitable health care providers, one might estimate the amount it would cost the Tort Claims Fund by multiplying the number of doctors times $10,000.00. (The figure of $10,000.00 discounts from the cost of the premiums some of the administrative and profits which, presumably, may be included in the cost of the insurance.) If it is assumed that 40 charitable health care providers would enroll in the program and contract with SRS, the estimated cost, by the method of approximating the premium cost, would be $400,000.00, annually. To summarize the liability portion of the cost of the bill, the following two figures are submitted:

Estimated claim payments by liability history: $386,558.00
or
Estimated claim payments by premium estimate: $400,000.00

This is an extremely difficult bill to analyze. It is not apparent from the bill whether it is intended that SRS merely define the term "medically indigent" or whether, as discussed in the second method, SRS would actually make an eligibility determination.

Senate Bill 736's intent is a commendable one. It would be of benefit to the residents of Kansas to have a program whereby retired doctors or those not in active practice would be able to serve as volunteers or good samaritans to the medically indigent without fear of personal liability in the event that something goes wrong. Florida has a similar program, called the "Medivan" program. In that case the physicians are agents of the state, and are covered by Florida's Risk Management Malpractice Insurance. This bill is an insurance issue. It is unnecessary to have the State Department of Social and Rehabilitation Services involved in contracting with doctors or other health care providers merely to ensure that claims are covered and the doctors are free from personal liability. If, as under the current language of the bill, the Secretary of Social and Rehabilitation Services is to contract with charitable health care providers, it is quite probable that in the event of a malpractice suit, not only the doctor would be named as a defendant, but the Secretary of Social and Rehabilitation Services would be named as well.

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KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

March 14, 1990

TO: Senate Judiciary Committee

FROM: Kansas Hospital Association

RE: SENATE BILL 736

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of Senate Bill 736. This bill would set up a system whereby health care providers could be classified as a "charitable health care provider" and included within the meaning of "employee" under the Kansas Tort Claims Act. To qualify as a charitable health care provider, the health care provider would have to enter into an agreement with the Secretary of SRS to render free care to medically indigent persons.

The Commission on Access to Services for the Medically Indigent and Homeless has studied many difficult and complex issues for over two years now. The Commission has made a number of recommendations to deal with these problems, including expansion of services available to low-income individuals and expansion of insurance coverage for those individuals. In addition, however, the Commission has recommended that "health care providers should be encouraged to assume a share of the responsibility for indigent care in their regular practice settings and in clinics and health departments across the State." We feel Senate Bill 736 is a good example of legislation that would provide such encouragement. If successful, this program could make much-needed primary and preventative services available to individuals who currently enter the system in a more acute condition and, therefore, are more expensive to treat.

We also think this is a good example of a public/private partnership to provide care for the medically indigent. Through the provision of free care to individuals and the application of the Tort Claims Act, the governmental and private sectors are both assuming responsibility for caring for the medically indigent. This is an important recognition that the State has a role to play in this area.

Finally, we also wish to point out that although Senate Bill 736 is a very helpful piece of legislation, it is by no means a panacea to end the problems of care for the medically indigent. A large number of persons are still uninsured. They wait as long as possible to seek medical care, and often their entry point to the health care system is the hospital emergency room. There are many aspects to this problem and they must all be considered.

Thank you for your consideration of our comments.

Senate Judiciary Committee
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TLB:pj

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