Approved February 7, 1991
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Representative Turnquist at
Chairperson

3:30 xa.m./p.m. on Tuesday, February 5, 1991 in room 531-N of the Capitol.

All members were present except:

Darlene Cornfield - Excused

Dale Sprague - Excused

Theo Cribbs - Excused

Committee staff present:

Bill Edds, Revisor
Chris Courtwright, Research
Nikki Feuerborn, Committee Secretary

Dr. William Wolff, Research

Conferees appearing before the committee:

Others Attending - See Attached List

Representative Hayzlett moved that the minutes for the January 31, 1991, meeting be approved. Motion seconded by Representative Welshimer. Motion carried.

Dr. William G. Wolff of Research gave an overview and history of the medical malpractice insurance mandate which was enacted by the state in 1972. This was followed by the work of the 1975 Interim Committee whose recommendations to the 1976 Legislature were enacted by that body. Primary among those new laws were the creation of a joint underwriting authority (JUA); the creation of a Health Care Stabilization Fund; and the requirement that all health care providers carry a statutorily established minimum amount of professional liability insurance. See Attachment 1.

While the Legislature has broadened its approach to addressing medical malpractice issues through tort reform, the three basic statutory under-pinnings of the Legislature's approach to malpractice summarized above became the focus of the 1988 Interim Committee's consideration. The 1988 Committee recommended the phasing out and eventual abolition of the Fund. The 1989 Legislature created the Health Care Stabilization Fund Oversight Committee to make recommendations to the Legislative Coordinating Council and to the 1991 Legislature. The Health Care Stabilization Fund Oversight Committee concludes that, with some important exceptions, most parties to the Fund, insurers and providers, favor the phase out of the Fund. A majority of the Committee agrees with that conclusion and recommends that the phase out of the Fund be targeted for June 30, 1994.

To initiate the phase out the Committee recommends that the Commissioner of Insurance "shall fix annually" (beginning in 1991-92), and collect a surcharge that would finance the termination of the Fund on June 30, 1994. This is to be based on an excess coverage basis with no tail coverage for active providers on and after the termination date. There is to be a creation of a "margin" fund that will cover any adverse deviations that might occur during the period of the phase out. No health care provider leaving the state to practice elsewhere will receive tail coverage from the Health Care Stabilization Fund. Pharmacists and Optometrists may leave the Fund effective July 1, 1991. An actuary is to be retained on an on-going basis to monitor the phase out and make recommendation of the Health Care Stabilization Fund Oversight Committee. Also the Committee recommends that upon the termination of the Fund, the statutory mandate that all health care providers maintain professional liability insurance be revoked. The Committee makes no recommendation concerning the regulation of attorney fees.

The meeting adjourned at 4:30 p.m.

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.

GUEST LIST

COMMITTEE: Insurance DATE: 2-5-91

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
LISA GETZ	WICHITA	WICHITA Hospitals
Jerry W. Cole	Wichita	Cole Consultants/ Wichita Chamber
Dave Hanson	Topeka	KS INSUR. ASSOCS.
Glenda Cafer	"	AIA
R.G. Frey	"	KTLA

MEMORANDUM

Kansas Legislative Research Department

Room 545-N -- Statehouse
Topeka, Kansas 66612-1586
(913) 296-3181

January 31, 1991

To: Representative Larry Turnquist, Chairman
Members, House Committee on Insurance

From: William G. Wolff, Principal Analyst

Re: S.B. 38 -- Amending the Health Care Provider Insurance Availability Act

In 1989, the Legislature created the Health Care Stabilization Fund Oversight Committee and charged it to study the feasibility of phasing out the Health Care Stabilization Fund. The Committee has completed its assigned task and recommends S.B. 38 to the 1991 Legislature. (See attached Committee report and bill.)

Section 1, page 1, lines 37-39: deletes pharmacists and optometrists from the definition section of the Health Care Provider Insurance Availability Act. (The deletion causes problems, not in letting out the two professional groups from the Act, but the way in which it is accomplished. The bill can be amended to exempt the two in such a way as to limit the exemption to payment of the surcharge and payment of claims from the Health Care Stabilization Fund.)

Section 2, page 6, line 31: repeals (expires) the statutory provision for mandatory professional liability insurance effective July 1, 1994.

Section 3, page 13, lines 23-31: absolves the Fund of any liability to pay for a claim against a pharmacist or optometrist after July 1, 1991, unless they have paid for "tail coverage" under the Fund.

Section 3, pages 13-14, lines 32 through 2: absolves the Fund of liability to pay for a claim against an inactive health care provider on or after July 1, 1991, if the health care providers leave the state, practice in another state, and do not purchase "tail coverage" from the Fund.

Section 4, page 15, lines 41-43: continues the Health Care Stabilization Fund Oversight Committee until July 1, 1994.

Section 4, page 14, lines 32-34: continues the present membership on the Committee at the pleasure of their individual appointing authorities.

Section 4, page 14, lines 37-41: requires an annual report of the Committee to the Legislative Coordinating Council.

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Section 4, page 14, lines 9-14: continues actuarial services to the Committee (the Committee recommends a continuation of the services of Wakely and Associates, Inc.).

Section 5, page 17, lines 8-24: directs that the Insurance Commissioner establish and collect an annual surcharge to be made on and after July 1, 1991, in an amount to fund the total of any existing deficiencies in the Fund and all anticipated claims to be made before July 1, 1994, for which the Fund will be liable.

Section 7, page 17, lines 27-28: establishes the effective date of the bill as July 1, 1991.

91-99/WGW

COMMITTEE REPORT

TO: Legislative Coordinating Council

FROM: Health Care Stabilization Fund Oversight Committee

RE: PHASE OUT OF THE HEALTH CARE STABILIZATION FUND*

The Health Care Stabilization Fund Oversight Committee was created by the 1989 Legislature through passage of S.B. 18 (K.S.A. 1989 Supp. 40-3403b). The 11-member Committee consisted of four legislators, four health care providers, one insurance industry representative, one person from the public at large with no affiliation with health care providers or with the insurance industry, and the Insurance Commissioner or the Commissioner's designee. The law charged the Committee to report to the Legislative Coordinating Council and to the Legislature by September 1, 1990. The deadline for filing this report was extended to December 15, 1990, by action of the Council. The report required to be made to the Legislative Coordinating Council shall include:

- recommendations to the Legislature for commencing the phase-out of the Health Care Stabilization Fund (HCSF) on July 1, 1991;
- an analysis of the impact and recommendations on the advisability of the imposition of limitations on attorney fees involving actions arising out of the rendering or failure to render professional services by a health care provider for which HCSF has liability; and
- recommendations for legislation necessary to implement or alter the phase-out of HCSF.

This Committee report begins by tracing the Legislature's involvement with the medical malpractice insurance issue including tort reform initiatives, interim studies, and legislative action. Next is an overview of the Health Care Stabilization Fund Oversight Committee's activities including a review of the actuarial study's scope and findings, discussion of the attorneys' fees issue, and review of reactions of health care providers to the actuarial finds. Finally, the report contains a section dealing with the conclusions and recommendations of the Oversight Committee.

Tort Reform Efforts in Kansas

Kansas has been a leader among the states in enacting tort reform measures over the past 20 years. The incentive for a large portion of these reforms has been to try and alleviate the problems of availability of medical malpractice insurance which has occurred at different periods as well as address problems of affordability. The following is a brief summary of some of the major aspects of these reforms.

Comparative Fault. Kansas adopted the comparative fault system in 1974 and thereby abolished the joint and several liability system that existed prior to that time. The Kansas system bars plaintiffs from recovery if their own fault exceeds 49 percent.

Caps on Damages. A 1986 law placed a $1 million cap on medical malpractice recoveries. Included within this overall cap was a $250,000 cap on noneconomic damages. This law was declared unconstitutional in *Medical Malpractice Victims Coalition v. Bell*, 243 Kan 333 (1988).

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* S.B. 38 accompanies this report.

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A 1987 law, however, which placed a $250,000 cap on awards for pain and suffering in all personal injury actions except for medical malpractice was upheld in *Samsel v. Wheeler*, 246 Kan 336 (1990). The case likewise upheld a 1988 law imposing a $250,000 cap on noneconomic loss for all personal injury actions.

Punitive Damages Cap. The Legislature in 1988 enacted a cap on punitive damages in all personal injury actions of the lesser of either the annual gross income of the defendant or $5 million. If the profit of the defendant exceeds this cap, the cap then is one and one-half times the profit realized. A standard of willful or wanton conduct or fraud or malice is created. A special procedure is established which requires plaintiffs alleging punitive damages to assert these damages as an amendment to their pleadings on or before the pretrial conference. The amount of punitive damages is determined at a separate proceeding before the court. Punitive damage caps were originally enacted in 1985 just for medical malpractice actions and in 1987 for all personal injury actions other than medical malpractice.

Collateral Source Rule. A law enacted in 1988 abolished the collateral source rule in actions where the damages request exceeds $150,000. The law permits evidence to be admitted to the trier of fact (jury or judge) of any collateral source benefits received or which are reasonably expected to be received by the plaintiff in any action for personal injury or death when the plaintiff asks for damages over $150,000. The cost of obtaining these benefits also is admissible. Collateral source benefits do not include life or disability insurance, gratuitous benefits, services, or benefits for which a valid lien or subrogation interest exists or crime victims assistance or restitution.

A 1985 law abolishing the collateral source rule just in medical malpractice cases was found unconstitutional in *Farley* v. *Engelken*, 241 Kan 663 (1987).

Screening Panels. Screening panels for medical malpractice actions were made permissive in 1976. Amendments in 1986 among other things permitted the introduction of screening panel findings in court actions. A 1987 law permits screening panels for certain other professions such as certified public accountants, lawyers, engineers, and architects.

Statute of Limitations. A 1976 law established an overall ten-year statute of limitations from the time of the injury for bringing a medical malpractice action.

Attorney Fees. Attorneys' fees in medical malpractice actions must be approved by the judge at an evidentiary hearing. The reasonableness of the fee must be evaluated in light of eight factors which appear in the lawyer canon of ethics.

The Kansas Supreme Court in 1988 adopted a court rule dealing with contingency fee arrangements. It provides that the contingency fee agreement be in writing and that it contain a statement of the method by which the fee will be determined and the amount that accrue to the lawyer as a result of settlement, trial, or appeal. Further, litigation and other expenses must be deducted from the recovery before computation of the fee. The attorney must provide the client with a written statement showing the outcome of the matter, the client's share, and the method of determination. The state next must advise the client of the right to have the fee reviewed by an appropriate court; and the court has the authority to determine whether the contract is reasonable. If the court makes the finding that the fee is not reasonable then the court must set a reasonable fee.

Other Tort Reform Measures. Various other tort reform measures have been enacted in Kansas including a no-fault automobile insurance law; a product liability insurance law; sanctions against frivolous lawsuits; mandatory settlement conferences in medical malpractice cases; itemized jury verdicts; immunity for nonprofit organization volunteers; indemnity authorization for corporate officers and directors; and a modification of *ad damnum* clause to prohibit pleadings from listing a specific amount of damages if the amount exceeds $10,000.

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Prior Legislative Studies Addressing the HCSF – 1975 Interim

The Kansas Legislature, for the first time, addressed the issues associated with the availability and cost of professional liability insurance for health care providers in 1975. The driving force for the interim study in that year was the lack of availability of insurance for certain categories of providers. Pressed particularly hard in 1975 were orthopedic surgeons, anesthesiologists, and obstetrician/gynecologists. The report of the Special Committee on Medical Malpractice suggested several reasons for the problem: rapid social and technological changes; patient expectations; increased numbers of patients seeing providers because of reimbursement by third party payers, *e.g.*, Medicare, Medicaid, and private insurance; changing of the doctor-patient relationship; judicial decisions resulting in expanded rules of law in cases of medical professional negligence; and consumerism. Compounding the identified contributors to the so-called medical malpractice "crisis," the interim committee report noted, was the polarization of the positions of the interest groups associated with the causative factors.

Recommendations. The 1975 interim Committee made numerous recommendations to the 1976 Legislature which were enacted by that body. Primary among those new laws were the creation of a joint underwriting authority (JUA); the creation of a Health Care Stabilization Fund (Fund); and the requirement that all health care providers, as that term was especially defined in the new law, carry a statutorily established minimum amount of professional liability insurance.

1. **JUA.** The purpose of the JUA was to make professional liability insurance available to any provider who could not purchase such insurance in the private insurance market. Costs associated with the administration of the plan of the JUA were not to be assessed to either the providers or the insurers; rather, the operational costs were to be assessed to and paid by the Fund out of moneys collected from the providers and interest income earned on those dollars.

2. **HCSF.** The Fund was created to provide excess coverage over the basic coverage required of all providers. In brief, the providers were required to purchase basic coverage in the amount of not less than $100,000 per occurrence, subject to a $300,000 annual aggregate ($100,000/$300,000), from private insurers or from the JUA. Then, for the payment of a surcharge on the premium for the basic coverage, providers purchased "umbrella" coverage over the basic amount from the Fund to an unlimited amount. The initial surcharge was established in statute at 40 percent, and a $10 million cap was placed on the ultimate amount the Fund could collect. Once the Fund reached the cap, no new surcharges were collected for several years until the Legislature was made aware of the liabilities of the Fund.

3. **Mandatory Insurance.** Finally, the mandated insurance requirement imposed by the earlier legislation, in part, was to insure a sufficient number of providers paying into the Fund to guarantee accumulation of the $10 million level in the shortest amount of time. While a number of the providers required by the act to purchase coverage were not having problems acquiring insurance at reasonable rates, some speculated that their cost would rise in the future just as the cost for persons licensed to practice medicine and surgery had risen and, therefore, willingly joined in the requirement for insurance and agreed to make the required payments into the Fund. Under the law, authorization to practice specific health care professions was made contingent upon the purchase and maintenance of professional liability insurance at the levels established in the law and upon the payment of levied surcharges based upon the basic premium.

While the Legislature has broadened its approach to addressing medical malpractice issues through tort reform, the three basic statutory under-pinnings of the Legislature's approach to malpractice summarized above became the focus of the 1988 interim Committee's consideration.

Prior Legislative Studies – 1988 Interim

The 1988 interim Special Committee on Commercial and Financial Institutions was directed to study the desirability of abolishing the HCSF and the implications such an abolition would have on health care and on health care providers who are covered by the Fund. In concert, the health care providers asked the Committee to recommend abolition of the Fund and supported the recommendations of the Group, *i.e.*, all liabilities of the Fund be financed in advance of its termination date. In that regard, July 1, 1994, was a date often cited as the most feasible time for ending the Fund. Additionally, and in the interim, the provider representatives recommended that the maximum liability of the Fund be reduced, for example, to $1 million per claim, and that providers be allowed to purchase optional levels of coverage recognizing that not all providers have the same level of exposure to malpractice claims. There was unanimity among the providers that, upon the abolition of the Fund, the mandatory insurance requirement should be terminated. Many providers reminded the Committee that no other professional group was required by state law to carry such insurance as a condition to practicing its profession. Finally, providers reflected the skepticism of the Insurance Department in their belief that implementation of the proposed changes would solve the root cause of the malpractice insurance problem. A part of any solution, some argued, must be tort reform.

The legal profession, too, was in agreement that the Fund should be systematically phased out of operation. However, in contrast to the position of the Kansas Bar Association, the representative of the Kansas Trial Lawyers Association made it clear that the Association's position is that the mandatory insurance requirement should be retained. The Association expressed the hope that, upon termination of the Fund, private carriers would be encouraged to enter the Kansas market. On this point the insurance agents indicated that, with the Fund in place, some companies would not come into Kansas for fear of having to contribute toward payment of existing Fund deficits.

The insurance industry represented before the interim Committee pointed out that there would be certain ramifications from any phase out of the Fund. Most significantly, it noted fact that existing JUA expenses are covered annually by transfers from the Fund. Removing the Fund would remove the financial support of the JUA which, if it is to continue, must be provided a different mechanism for covering losses and administrative expenses. In that regard, The St. Paul Companies said it would not oppose a JUA if it were self-supporting through a surcharge or assessment mechanism against policyholders and if there were a broad insurer assessment base for any additional deficit. The Independent Insurance Agents of Kansas, too, saw the probable necessity of continuing the JUA, but offered its support contingent upon the JUA being funded by an assessment on medical malpractice insurance companies only.

Actuarial Studies. The 1988 interim Committee was aware that the Insurance Commissioner had contracted the services of an actuary to determine the liability of the Fund should the Legislature decide to terminate it as proposed in various bills introduced in the 1988 Session and by several of the interim conferees. After hearing the testimony of the conferees, the Committee requested the Commissioner to ask the actuary to furnish data for termination of the Fund based on July 1, 1989 and July 1, 1994 dates.

As reported by the Department's actuary, DANI Associates, Inc., if the Fund were terminated under option one on July 1, 1989, including all responsibility for inactive health care provider tail coverage, there would be a shortfall in the Fund's resources versus its liabilities of approximately $35.2 million. If the Fund were abolished on the same basis on July 1, 1994, the estimated balance in the Fund would cover the incurred liabilities of $391,057,000. No surcharge estimates were given to the Committee to explain how that balance would be built.

If the Fund were terminated under option two on July 1, 1989, based on claims-made excess coverage and inactive tail coverage requirements, there would be a shortfall in the Fund's resources versus its liabilities of approximately $31.4 million. If the Fund were abolished on the same basis on July 1, 1994, there would be sufficient balances in the Fund to cover all liabilities of $454,298,000. The balance of $454,298,000 would be achieved by the imposition of surcharges estimated to be 130 percent, 135 percent, 140 percent, 160 percent, and 190 percent against $200,000/$600,000 basic limit premiums for the fiscal years 1989-90, 1990-91, 1991-92, 1992-93, and 1993-94, respectively.

If the Fund were terminated under option three on July 1, 1989, but tail coverage continued for all health care providers, the total liability of the Fund would be $228,027,000. The balance in the Fund would be $87,455,000,

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for a shortfall of approximately $140 million. If the Fund were abolished on the same basis on July 1, 1994, the liabilities of the Fund would be $944,335,000. The balance in the Fund would be $454,298,000, for a shortfall of approximately $490,037,000.

The actuary's report represented the first time such projections had been made for as many years into the future. In the past, the reports covered one or two years and the data generated were used to establish the next year's surcharge on providers. The sizes of the estimated liabilities of the Fund and the estimated balances of the Fund, and the ultimate shortfall in those balances projected in the report were startling to the Committee. Explanations of the data by the actuary supported the notion that, in the future, numbers of claims and sizes of awards and settlements, in general, and the number and amount of payments from the Fund would continue to grow.

Recommendations. The 1988 interim Committee agreed with the near unanimous position of the conferees that the Health Care Stabilization Fund should be phased out and recommended that the 1989 Legislature enact legislation to affect the abolition of the Fund. The bill recommended by the Committee would have terminated the Fund on July 1, 1989. On that date no health care provider would have excess liability coverage nor would any provider have coverage for prior acts -- tail coverage, for acts or omissions committed after that date. Further, the Committee recommended that on July 1, 1989, the mandatory professional liability insurance requirement be abolished. Accordingly, all providers would be free to choose to be insured or not and, if insurance were purchased, the amount of coverage would be left to the individual providers.

The recommendations of the 1988 interim Committee did not address the questions of whether the proposed changes enhanced the availability of insurance in the private market or exacerbated the availability problem, drove current private insurers from the market or attracted new insurers into the Kansas market. Neither did the proposals address the particular circumstance of the Kansas University Medical Center and its training programs. Further, the question of whether the state should remain involved in the professional liability insurance business through operation of a JUA to make insurance available to those providers who want to be insured but could not purchase coverage in the private market, remained unresolved. The Committee commended to the appropriate standing committees its report and recommendations as points of departure for further discussion and action.

HCSF Legislation in 1989

In January, the House Committee on Insurance asked DANI Associates, Inc., to prepare a report showing the cost of phasing out the Fund under two new plans: a staged reduction in the liability of the Fund, first to $1 million, then down to $500,000 on July 1, 1990, down to $300,000 on July 1, 1991, and to zero on July 1, 1994; the second option would offer health care providers three levels of coverage from which to choose -- $800,000, $300,000, and $100,000.

Under new option one, the staged reduction plan, the actuary projected a discounted Fund liability of $354,298,000 on July 1, 1989, down from $454,298,000 -- a reduction of about 22 to 25 percent.

Under new option two, the three-level plan, the actuary projected, a discounted Fund liability of $274,298,000 on July 1, 1989, down from $454,298,000 -- a reduction of about 40 to 45 percent.

In December, 1988, the discounted liability of the Fund for tail coverage was projected to be $490,037,000 on July 1, 1994. In February, 1989, it was anticipated, but not demonstrated, that there could be a savings in the cost of tail coverage perhaps comparable to the percentage reductions noted above for each of the two plans: plan one, 22-25 percent or roughly $367,528,000 and for plan two, 40-45 percent or $220,517,000.

Senate Bill No. 18. After hearing the actuary and studying the report setting out the costs of each option, the Legislature passed S.B. 18. The bill made a number of changes in the Health Care Provider Insurance Availability Act relating to the amount of excess liability insurance coverage required to be carried by all health care providers; the reduction in liability of the Health Care Stabilization Fund (HCSF) to certain optional levels elected by the health care providers; the establishment of a date to begin the phase out of the HCSF; the coverage of

participants in residency programs approved by the Board of Healing Arts; and to self-insurance of the full-time physician faculty, the foundations, and corporations of the University of Kansas Medical Center.

Specifically, the Legislature took the following steps to address the issue of medical malpractice insurance:

- In the two-year interim, 1989-91, the Insurance Commissioner will fix the surcharge on the $800,000, $300,000, and $100,000 optional levels of coverage available to all health care providers beginning on July 1, 1989. Health care providers will be able to chose a lower option after the initial election without permission, but election of a higher option may be made only with the permission of the Board of Governors of the HCSF.

- On and after July 1, 1989, tail coverage from the HCSF will be available to all providers who have participated in the Fund for five years, unless inactive status comes about through death, retirement, disability, or circumstances beyond the control of the provider. Those providers who do not meet the five-year requirement for coverage, may purchase such coverage from the Fund within 30 days of taking inactive status. Time spent in a postgraduate program of residency training will not be included in computation of time for purposes of meeting the five-year requirement for tail coverage under the Fund.

- Regarding "self-insuring" the full-time physician faculty of the University of Kansas Medical Center and the foundations and corporations, the full-time physician faculty, foundations, and corporations will be self-insured for the basic liability coverage; however, those entities will pay $500,000 into a reserve fund from which losses will be paid, with the HCSF paying settlements and judgments which exceed the resources of the reserve fund. The State General Fund will reimburse the HCSF for any amount paid on behalf of the full-time physician faculty, foundations, and corporations of the Medical Center. Annually, the reserve fund will be replenished to its $500,000 level by those self-insured.

- The provision of tail coverage for participants in residency programs is extended to all programs approved by the Board of Healing. Currently, that would include residency programs in Wichita, Salina, and at Menningers in Topeka. The University of Kansas Medical Center program residents are already provided tail coverage under the HCSF. The election of optional coverage for persons in residency training will be made by the agency or institution paying the surcharge levied for excess coverage under the Fund.

- Municipal hospitals and their employees are placed under the Kansas Tort Claims Act on or after July 1, 1989. This provision would include city hospitals, county hospitals, district hospitals, and any clinic, school of nursing, long-term care facility, child-care facility, and emergency medical or ambulance service operated with the operation of the medical care facility (hospital).

Finally, the 1989 Legislature created the Health Care Stabilization Fund Oversight Committee to make recommendations to the Legislative Coordinating Council and to the 1991 Legislature.

HCSF Oversight Committee Activity

Under the auspices of the Legislative Coordinating Council and through the Oversight Committee, S.B. 18 directed a "second opinion" on the financial provisions of the phase out of the HCSF to include the employment of an actuary of national reputation to advise the Committee and the Legislature regarding the phase out of the HCSF. The costs associated with obtaining independent actuarial data, including services of the actuary, shall be paid by the HCSF.

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By August, 1989, the members convened to begin the work outlined in S.B. 18. An invitation for bid was developed and submitted to numerous actuaries and actuarial firms across the country. Early in its deliberations the Committee resolved to require an on-sight visit by all finalists for the actuarial assignment in the belief that not only should the winning bidder be prepared to perform the actuarial work, but be able to explain the work product to lay audiences. Four finalists were interviewed and on December 8, 1989, the Legislative Coordinating Council entered into a contract with Wakely and Associates, Inc., of Stone Mountain, Georgia, for actuarial services. Mr. Terry Biscoglia and Mr. Mark Crawshaw represented the firm, performed the work, and explained the results of their many computations to the Committee.

While the search for an actuary proceeded in the background, the Committee solicited the comments and suggestions of interested parties to the study. Health care providers; insurers; and interested parties providing comments included: Kansas Medical Society; Kansas Medical Mutual Insurance Company; Kansas Association of Osteopathic Medicine; Kansas Hospital Association; Kansas Trial Lawyers Association; Kansas Insurance Department; Independent Insurance Agents of Kansas; The St. Paul Companies; Kansas Association of Nurse Anesthetists; Kansas Chapter, American College of Surgeons; Kansas Pharmacists Association; the Kansas Bar Association; The Medical Protective Company; the Kansas Optometric Association; the Kansas Chiropractic Association; and the Board of Governors of the Health Care Stabilization Fund. A representative of Physicians National Risk Retention Group, Inc., had followed with interest the passage of S.B. 18, but chose not to pursue its interest with the Committee.

From the initial testimony received by the Committee it was obvious that not all parties to the study were in agreement on all aspects of the study. The Kansas Association of Osteopathic Medicine, the Kansas Chapter of the American College of Surgeons, and the Kansas Trial Lawyers Association were fixed in their opinions that the Fund should be phased out. The opinion of the Kansas Medical Society was less certain at the outset of the study and the Kansas Hospital Association and the Kansas Association of Nurse Anesthetist suggested that the Committee approach consideration of a phase out of the Fund with considerable caution. Similarly, divisions among the conferees existed on the question of regulating attorney fees paid out of Fund proceeds. The Kansas Medical Society and the Insurance Department presented strong argument in favor of limitations on such fees. The Kansas Hospital Association thought some limitation of fees during the phase out of the Fund could be beneficial but any final decision to regulate attorney fees should be based on findings of the Committee's actuary. Holding views in opposition to fee regulation were the Kansas Bar Association and the Kansas Trial Lawyers Association neither of whom could find precedent for the regulation of fees charged by other professionals in the state. As was anticipated by the Legislature as it deliberated the creation of the Committee, resolution of the two major issues, a phase-out of the Fund, and limitation of attorney fees, could only be addressed based upon actuarial data.

Scope of Actuarial Study

As set out in the invitation for bid, the contract for services, and later, in explicit requests of the Committee, specific objectives of the actuarial study were defined as follows:

- estimation of the liabilities of the HCSF at the end of fiscal years 1990 through 1995 under existing coverage provisions (*i.e.*, excess professional liability coverage for active health care providers on a claims-made basis, with provision for continuing HCSF coverage for providers who become inactive during each fiscal year);

- estimation of the liabilities of the HCSF under prospective revisions of the Act which would phase out the HCSF either as of July 1, 1994 or alternatively as of July 1, 1996. These prospective revisions would provide for all liabilities for both active and inactive health care providers, subject to the HCSF coverage limits in effect at the time an incident leading to a claim occurred;

- estimation of the demands on the HCSF from the Health Care Provider Insurance Availability Plan (JUA);

- estimation of the necessary surcharge to be levied on the basic ($200,000/$600,000) premium for professional liability coverage for health care providers for fiscal years ending June 30, 1991 through 1996;

- estimation of the cash flow of the HCSF for fiscal years ending June 30, 1991 through 1996 in accordance with existing statutes and proposed legislative provisions;

- estimates are to be evaluated assuming the following limitations on losses and attorney fees are, or are not, effective:

    - noneconomic damages are limited to $250,000 on judgments and settlements after July 1, 1988; and

    - plaintiff attorney fees (contingent) payable from the HCSF are capped according to one of three options:

        Option 1: 35 percent of the first $100,000 recovered from the HCSF, 25 percent of the next $100,000 and 10 percent of the remainder.

        Option 2: 25 percent of the first $500,000 recovered from the HCSF, 20 percent of the next $500,000 and 15 percent of the remainder.

        Option 3: 40 percent of the first $200,000 recovered from the HCSF, 25 percent of the next $800,000 and 15 percent of the remainder.

(These provisions do not apply to the first $200,000 paid from the HCSF if the HCSF is liable for first-dollar coverage (it is noted that none of the limitations are to apply to amounts recovered from basic coverage)):

- presentation of a summary of paid and outstanding losses by report year; and

- review of any HCSF legislative proposals being considered by the HCSF Oversight Committee.

Attorney Fees

Addressing the issue of regulating attorney fees, Wakely and Associates, Inc., "determined that each alternative [option] is likely to prove ineffective at reducing losses." As explained in the actuary's report:

> This is because each alternative excluded from regulation the first $200,000 recoverable. Considering this exclusion, the relatively low coverage limits currently offered by the HCSF, and the fact that many medical professional liability claims involve multiple defendants, plaintiff attorneys would be able to maintain current contingency rates simply by rewording contingency contracts.

While the exclusion of the first $200,000 recoverable would have little effect on rates, the actuary explored the possibility of regulating attorney fees on the entire medical professional liability awards and settlements:

> Such an approach, if effectively implemented, is likely to decrease overall losses. In determining policy in this area it is important to note that this decrease in costs does not occur because "excess" attorney fees are removed. Rather, losses are likely to decrease as it becomes no longer economically viable for attorneys to pursue cases aggressively. This reduction in activity in turn results in decreased net compensation to plaintiffs. In determining the practical implications of implementing a fee limitation, the major issue for policymakers to consider is not the determination of "fair" rates of contingency fees but rather the balance of the conflicting goals of minimizing medical professional liability losses while maintaining adequate levels of compensation to injured plaintiffs and maintaining deterrence effects the tort system.

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Actuarial Report and Findings

Early in 1990, Wakely and Associates, Inc., began gathering data necessary to complete the study contracted by the Legislative Coordinating Council and by September, was ready to makes its preliminary report to the Health Care Stabilization Fund Oversight Committee. That report, in two volumes (an executive summary and a technical appendix), is on file in the Legislative Research Department and also is available through the Division of Legislative Administrative Services.

Based on its analysis of the experiences of the HCSF through June 30, 1990, the actuary submitted the following conclusions:

1. The estimated discounted liability of the HCSF associated with surcharges received through June 30, 1990, is approximately $113 million. The actual Fund balance as of that date was $110 million. "Considering the uncertainties inherent in actuarial projections," the actuary concluded that "the fund balance as of June 30, 1990 is reasonable."

   (The actuary for the Insurance Department, employed to assist the Insurance Commissioner in determining the surcharge to be imposed beginning on July 1, 1990, Tillinghast, estimated the liability associated with surcharges receivable through June 30, 1990, to be $137 million with an actual Fund balance of $110. Wakely's liability was based on surcharges received, which accounts for approximately $8 million of the difference between the two actuaries. Tillinghast's report then indicated a Fund deficit of about $19 million and Wakely reports about a $3 million deficit. The difference between the two actuaries is thus $16 million.)

2. The estimated surcharge rate for the 1990-91 year for coverage under existing law was projected to be 88 percent of basic premium. (The average actual surcharge of 111 percent levied by the Insurance Commissioner was based on the Tillinghast report.)

3. If the Fund is phased out, there are two distinct coverage strategies which could be used. Under the first, all coverage would be extended on a first-dollar basis, consistent with coverage currently offered to inactive providers. The costs associated with phasing out the HCSF under this approach would be $90 million and $108 million for phase out dates of June 30, 1994, and June 30, 1996. The second alternative is to extend coverage on an excess basis consistent with coverage currently offered to active providers. The costs under this approach would be $46 million and $58 million for phase out dates of June 30, 1994, and June 30, 1996, respectively.

4. Any actuarial estimates of future medical professional liabilities involve the projection of future contingent events and are subject to variability. It is desirable to include an explicit margin in the carried liabilities to reduce the possibility of an inadequacy and to establish a mechanism by which any excess funds may eventually be returned to health care providers.

5. If the Fund is phased out, it will be necessary to decide exactly how coverage will be discontinued. (Wakely assumed that coverage would be discontinued for all occurrences after the phase out date even though existing basic policies would provide coverage beyond that date.)

6. All estimates discussed in the report were determined based on the assumption that current law limiting recoveries on noneconomic damages to $250,000. (This assumption resulted in lower projections than would have been obtained otherwise.)

After reviewing the preliminary findings and conclusions of the actuary, the Committee accepted the report for final preparation and submission to the Legislative Coordinating Council (filed September 17, 1990 and accepted by the Council at its October meeting). Having seen the costs associated with a phase out and having heard other considerations it should make if the Fund were to be phased out, the Committee requested the actuary, among other things, to prepare exhibits that set out surcharges applicable to phasing out the Fund based on different

termination dates, *i.e.*, June 30 of years 1991 through 1996. Further, the actuary was directed to prepare a projection that would include tail coverage and one that would exclude such coverage.

The information requested by the Committee was presented as an addendum to the actuary's final report and is on file in the Legislative Research Department. The following exhibits are taken from that addendum. Exhibit A provides a summary of the surcharges that would be associated with a phase out of the Fund with no tail coverage to active providers. The second column of the exhibit shows the surcharge for current operations and is the surcharge required assuming the Fund is not to be phased out. The third through sixth columns show the indicated surcharge rates should the Fund be phased out at the various dates. The surcharges in these columns exceed those for ongoing operations because they include provision to fund a margin for adverse deviation. (As noted earlier, the surcharge for the current fiscal year was set at 111 percent and so that figure is shown in the exhibit.)

EXHIBIT A

SUMMARY OF ESTIMATED SURCHARGE RATES FOR PHASE-OUT EXCLUDING TAIL COVERAGE

Fiscal Year	Surcharge for Ongoing Operation	Total Surcharge for Phase-Out as of: July 1, 1992	July 1, 1993	July 1, 1994	July 1, 1996
1990-91	88%	111%	111%	111%	111%
1991-92	77	131	103	94	87
1992-93	65	--	84	79	73
1993-94	62	--	--	75	70
1994-95	61	--	--	--	69
1995-96	63	--	--	--	71

Exhibit B is similar to Exhibit A except that the surcharge rates assuming phase out have been adjusted to exclude the component attributable to ongoing operations. For example, the surcharge rate for 1990-91 is shown as 111 percent on Exhibit A while the additional surcharge rate is shown as 23 percent (=111 percent - 88 percent) on Exhibit B. These additional surcharges represent the cost of phasing out the Fund.

EXHIBIT B

SUMMARY OF ESTIMATED SURCHARGE RATES FOR PHASE-OUT EXCLUDING TAIL COVERAGE

Fiscal Year	Surcharge for Ongoing Operation	Additional Surcharge for Phase-Out as of:			
		July 1, 1992	July 1, 1993	July 1, 1994	July 1, 1996
1990-91	88%	23%	23%	23%	23%
1991-92	77	54	26	17	10
1992-93	65	--	22	14	8
1993-94	62	--	--	13	8
1994-95	61	--	--	--	8
1995-96	63	--	--	--	8

Exhibits C and D are similar to Exhibit B but show surcharge rates assuming the HCSF is phased out with tail coverage for active providers. Exhibit C assumes tail coverage will be provided on a first dollar basis, *i.e.,* for the portion of losses below $200,000. Exhibit D assumes tail coverage will be provided on an excess basis, *i.e.*, for the portion of losses in excess of $200,000. The additional surcharge rates on Exhibits C and D represent the costs of phasing out the Fund and include provision for tail coverage and a margin for adverse deviation.

EXHIBIT C

SUMMARY OF ESTIMATED SURCHARGE RATES FOR PHASE-OUT EXCLUDING TAIL COVERAGE

First Dollar Coverage

Fiscal Year	Surcharge for Ongoing Operation	Additional Surcharge for Phase-Out as of:			
		July 1, 1992	July 1, 1993	July 1, 1994	July 1, 1996
1990-91	88%	23%	23%	23%	23%
1991-92	77	312	137	89	55
1992-93	65	--	116	75	46
1993-94	62	--	--	71	44
1994-95	61	--	--	--	45
1995-96	63	--	--	--	43

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EXHIBIT D

SUMMARY OF ESTIMATED SURCHARGE RATES FOR PHASE-OUT EXCLUDING TAIL COVERAGE

Excess Coverage Only

Fiscal Year	Surcharge for Ongoing Operation	Additional Surcharge for Phase-Out as of:			
		July 1, 1992	July 1, 1993	July 1, 1994	July 1, 1996
1990-91	88%	23%	23%	23%	23%
1991-92	77	172	77	50	32
1992-93	65	--	65	42	27
1993-94	62	--	--	40	26
1994-95	61	--	--	--	27
1995-96	63	--	--	--	25

Early in its study, the Committee was made aware that certain professionals included within the statutory definition of "health care provider" would like to be removed from the definition which would remove them from the Health Care Provider Insurance Availability Act. Particularly, optometrists and pharmacists asked for such consideration. Before making any recommendation on the release of any professional from the Act, the Committee asked the actuary to review the distribution of losses and surcharges by type of provider and also of the distribution of losses and surcharges by type of provider. Exhibits E and F provided the information sought by the Committee.

EXHIBIT E

SUMMARY OF DISTRIBUTION OF LOSSES AND SURCHARGES BY TYPE OF PROVIDER

	Distribution of:	
	Losses	Surcharges
Physicians and Surgeons	76.9%	72.9%
Professional Associations, Partnerships	6.7	7.5
Hospitals	9.5	18.1
Other Providers	6.9	5.0
TOTAL	100.0%	100.0%

EXHIBIT F

REVIEW OF DISTRIBUTION OF LOSSES AND SURCHARGES BY TYPE OF PROVIDER

	Distribution of Loss Incurred through 12/31/89	Distribution of Surcharges through 12/31/89
M.D.'s	72.7%	69.5%
D.O.'s	4.2	3.4
Subtotal	76.9%	72.9%
Professional Associations, Partnerships	6.7%	7.5%
Acute Care Hospitals	9.3%	17.0%
Psychiatric Hospitals	0.2	1.1
Subtotal	9.5%	18.1%
Chiropractors	2.2%	1.1%
Podiatrists	0.0	0.2
Physical Therapists	0.0	0.1
Dental Anesthetists	0.0	0.1
H.M.O.'s	0.0	0.5
Pharmacists	0.2	0.1
Optometrists	0.0	0.2
Registered Nurse Anesthetists	4.5	2.7
Subtotal	6.9%	5.0%

Reactions of Health Care Providers

Having before them data regarding the status of the Health Care Stabilization Fund (its liabilities and its balance), as well as an array of possible phase out plans with their associated costs (including the creation of a margin fund), the Committee again solicited the health care providers for their opinions on the phase out of the Fund. The Board of Governors of the Health Care Stabilization Fund argued to keep the Fund. Acknowledging early difficulties, they noted that the Fund is currently on a sound fiscal basis, has estimated discounted liabilities and a current balance that are "quite compatible," and has no cash flow problem. Further, they pointed out that there are additional costs associated with a phase out of the Fund that could have a negative impact on providers; that cost of insurance "in the real world" will be higher because of company profits, agents' commissions, and taxes; and, if the HCSF is phased out, the seeds for another insurance crisis are sewn with no back-up. The Board of Governors also recommended that the Oversight Committee be made permanent with the primary responsibility of independently examining the actuarial soundness of the HCSF; and, if the Fund becomes unmanageable because of government bureaucracy, it could be converted to a joint venture between government and the private insurance industry.

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The Kansas Medical Society reported that it supports the termination of the HCSF, but urged caution in the dismantling process. Since no state has phased out a fund, the Society believed that there would be complications and inequities to be addressed that are unknown at the time the phase out begins. Included among the "unknowns" is the nature of the insurance market. There are no assurances that, upon a phase out, the current competitive and strong market will exist. The Kansas Medical Society recommended that the Fund be phased out on June 30, 1994, without ongoing tail coverage. On this point the Society clearly stated that the agreement to terminate the Fund without tail coverage comes with great reluctance and does not come as the Kansas Medical Society's first choice. However, there is the recognition that the Fund balance does not include tail coverage and the surcharges necessary to generate sufficient moneys to provide tail coverage are "unacceptable in the current environment." Finally, the Medical Society expressed the strong conviction that the mandatory insurance requirement must be repealed effective July 1, 1994.

The Kansas Association of Osteopathic Medicine urged that the Fund be ended "at the earliest practical point in time consistent with acceptable negative financial repercussions to its contributors." That date they believed to be June 30, 1994. The Association, too, agreed that tail coverage would cease for all providers except those in the system on July 1, 1994, *i.e.*, inactive providers. With the end of the Fund, the Association recommended an end to the mandatory insurance for providers. On the issue of regulating attorney fees paid from the Fund, the Kansas Association of Osteopathic Medicine restated its support for such limitations but did not suggest that the Committee including limitations in its recommendations to the 1991 Legislature, recognizing that the question of attorney fees could be a "deterrent to the orderly consideration of important changes in the Fund . . . ."

The Kansas Pharmacists Association and the Kansas Optometric Association did not comment directly on the question of phasing out the Fund. Rather, both groups requested that whether the Fund is terminated or not, the Committee recommend an amendment to the definition of "health care provider" in the Health Care Provider Insurance Availability Act to delete inclusion of their professions.

Finally, the University of Kansas Medical Center identified numerous areas wherein the elimination of the Health Care Stabilization Fund would effect the Medical Center, its residents, the full-time teaching faculty, and the professional practice corporations associated with the Medical Center. Currently, the state "self-insures" residents for basic coverage; however, excess coverage for those residents is provided from the Fund. Phase out of the Fund removes the source of excess coverage for residents. Additionally, the Fund is the source for tail coverage for residents employed by the Medical Center and for residents in programs operated in Wichita, Salina, and at the Menninger Foundation. Phase out of the Fund removes the source of such coverage. Further, the private practice corporations or foundations and their full time faculty are deemed self-insured for basic coverage. These same entities contribute to a special fund of $500,000 from which claims above basic coverage are paid. Phase out of the Fund would remove the source of payments which exceed the $500,000 fund in an single year.

The University of Kansas Medical Center made specific recommendations for dealing with each of the problem areas created by the phase out of the Fund. Regarding residents, it was recommended that the state self-insure the residents based in Kansas City for an amount up to $1 million per claim, or, as an alternative, continue the policy of self-insuring against claims up to $200,000, with the provision that the Legislature appropriate funds to the University for the purchase of excess coverage. For residents in Wichita, the University proposed that they be handled in the same manner as proposed for Kansas City residents. Given that residents in Wichita are employed by private hospitals who currently have responsibility to fund a portion of the cost of professional liability insurance for these residents, the University recommended that these employers be required to purchase excess coverage for residents up to $1 million per incident. The same proposal should be made applicable to residents in Salina. To address the impact on the faculty and private foundations or corporations, the University recommended the continuation of self-insurance for primary coverage in an amount of at least $200,000 per incident and that second source of payment be from the fund in the State Treasury established by the foundations or corporations in the amount of $500,000. The University did not express an opinion as to the basic question of whether the Fund should be terminated.

Conclusions and Recommendations

The Health Care Stabilization Fund Oversight Committee concludes that, with some important exceptions, most parties to the Fund, insurers and providers, favor the phase out of the Fund. A majority of the Committee agrees with that conclusion and recommends that the phase out of the Fund be targeted for June 30, 1994. Included in this decision is a large measure of caution to be exercised in the implementation of the phase out. All members of the Committee are in agreement that the phase out must be undertaken in a manner that is flexible enough to allow for modification or, if necessary, abandonment, so that the Fund can continue to operate if that becomes necessary.

To initiate the phase out, the Committee recommends S.B. 38 directing that the Commissioner of Insurance "shall fix annually" (beginning in 1991-92), and collect a surcharge that would finance the termination of the Fund on June 30, 1994. Explicit in this directive to the Commissioner is the Committee's conclusion that the phase out be based on an excess coverage basis with no tail coverage for active providers on and after the termination date. Also a part of this directive is the creation of a "margin" fund that will cover any adverse deviations that might occur during the period of the phase out. The Committee is cognizant of its actuary's comment made early on in the study that "It should be recognized that if the HCSF is phased out, there is the likelihood that projected liabilities at the time of phase out will prove either inadequate or excessive."

Recognizing that the Insurance Commissioner will employ an actuary to assist in determining annually the surcharge to be levied on health care providers, Wakely and Associates, Inc., has provided, from a 1990 vantage point, projected costs for the phase out as set out in Exhibit G.

EXHIBIT G

SUMMARY OF ESTIMATED SURCHARGE RATES
($ Millions Omitted)

Estimated Fund Balance at Phase-Out

Liabilities (Ongoing) -- $126 Margin (Ongoing) -- $25 Total -- $151

Estimated Surcharge Rates

Fiscal Year	Liabilities (Ongoing)	Margin (Ongoing)	Total
1990-91	88%	4%	92%
1991-92	77	17	94
1992-93	65	14	79
1993-94	62	13	75

In addition to setting in motion the phase out of the Fund, the Committee concluded that certain actions should be undertaken prior to the phase out date. In that regard, S.B. 38 will provide that no health care provider leaving the state to practice elsewhere will receive tail coverage from the Health Care Stabilization Fund. Several members spoke to the issue of fairness when providers who stay in the state are assessed the cost of tail coverage for those who leave their practice in Kansas for another practice site. Some members, expressed the concern that

enactment of this provision may have the effect of discouraging providers from coming to Kansas or, perhaps drive some from the state. The legislative committees are encouraged to look closely at the potential impact of this particular recommendation.

At the request of the pharmacists and the optometrists, the Committee recommends that the definition of the term "health care provider" in K.S.A. 1989 Supp. 40-3401 be amended to delete optometrists licensed by the Board of Examiners in Optometry and pharmacists licensed by the Board of Pharmacy. The Committee concluded, based upon information disclosed in Exhibits E and F, that no damage would be done to the Fund by allowing these two professional groups to exit. Both the pharmacists and the optometrists will be liable to pay the cost of tail coverage if they should chose such coverage upon their departure from the Fund. S.B. 38 would accomplish this objective effective July 1, 1991.

Understanding the important role actuarial services play in the preparations for phasing out the Fund, the Committee concludes that those services should be continued through July 1, 1994. The Committee recommends that Wakely and Associates, Inc., the current actuary, be retained on an ongoing basis to monitor the phase out and make recommendations to the Health Care Stabilization Fund Oversight Committee which the Committee recommends be continued in its current form and make up for the duration of the phase out period. Based upon the work of the actuary and data from provider and insurer sources, it would be the function of the renewed committee to make recommendations on an annual basis to the Legislature as to whether the phase out of the Fund should be continued, modified, or canceled and the Fund continued.

As its last recommendation, the Committee recommends that, upon the termination of the Fund, projected for July 1, 1994, the statutory mandate that all health care providers maintain professional liability insurance be revoked. This provision in S.B. 38 would return health care professionals to the status they held prior to imposition of the mandatory insurance in 1977 and which, in their estimation, they accepted only because the collection of sufficient funds to support the HCSF required as many providers as possible be covered and, therefore, pay the annual surcharge.

The Committee makes no recommendation concerning the regulation of attorney fees. The Committee recalls the work of the actuary on this point and notes that no savings to the Fund is attributable to such regulation. Further, since the Committee is recommending the beginning of a phase out of the Fund, there seems little merit to the imposition of a regulation when the duration of its applicability is potentially very short.

Unresolved Matters

The proposed phase out of the Fund includes the collection of sufficient moneys to finance the liability the Fund has incurred through June 30, 1994, and for a "margin" amount to cover the contingency that projections of actual liabilities were in error. Since it is possible that more money than is necessary to cover liabilities will be collected, some mechanism should be put in place to return the excess. The Committee has not determined how any such funds should be returned or to whom the funds should be returned and, therefore, recommends that this issue be addressed during the period of the phase out of the Fund.

While the Committee recommends legislation to address five issues, it realizes that several other important issues remain to be further studied and acted upon. Specifically, the Committee is aware that a phase out of the Fund will have an impact on the manner in which residents, faculty, and the corporations at the University of Kansas Medical Center are covered with professional liability insurance. The record of the Committee contains an explanation of that impact and suggests varies courses of action; nevertheless, it will be necessary for the Legislature to review those proposals as each one results in some exposure of loss to the State General Fund. It is proposed that the Health Care Stabilization Fund Oversight Committee continue to study this issue and to make recommendations to the House Appropriations Committee and to the Senate Committee on Ways and Means as well as to accept suggestions from those two committees, should they have some, as it formulates final recommendations to the Legislature.

Finally, the Committee recognizes that removing the mandatory insurance coverage and phasing out the Fund effectively removes the state from the professional liability insurance business. However, the question of what

to do with the Health Care Provider Insurance Availability Plan (JUA) is unresolved. Since the JUA operates with no profit and no losses as the Fund absorbs both, repeal of the Fund undercuts the financial support of the JUA. If the Legislature determines that the state has some responsibility, after phase out and repeal of the mandatory insurance requirement, for making liability insurance available to those who cannot obtain it in the private marketplace, how should the JUA be restructured and financed? The Committee recommends that this issue be addressed in the intervening time to the phase out date by the renewed Oversight Committee with input from providers, the insurance industry (agents and companies), and from operators of the current JUA.

Respectfully submitted,

12/17, 1990

Frank Lowman, Chairperson
Health Care Stabilization Fund
Oversight Committee

Rep. Dale Sprague	Richard L. Rajewski, M.D.
Rep. Larry Turnquist	James V. Rider, D.O.
Sen. Richard Bond	Paul H. Kindling, M.D.
Sen. Richard Rock	Gene E. Schmidt
Ron Todd	Homer Cowan