Approved April 2
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Representative Turnquist at
Chairperson

3:30 ~~a.m.~~/p.m. on Thursday, March 28, 1991 in room 531 N of the Capitol.

All members were present except:

Committee staff present:

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

Conferees appearing before the committee:

Jim Yonally, National Federation of Independent Businesses
Larry Magill, Independent Insurance Agents
Dorothy Taylor, Professional Insurance Agents of Kansas
Glenda Cafer, American Insurance Association
Tom Bell Kansas Hospital Association
Daniel K. Roberts, M.D., Health Care Stabilization Fund Board of Governors
Jerry Slaughter, Kansas Medical Society
Harold Riehm, Ks Association of Osteopathic Medicine
Gary Robbins, Kansas Optometric Association
Bob Williams, Kansas Pharmacists Association
Steven Sanford, Insurance Department

Others attending: See Attached List

Representative Campbell moved for the approval of the minutes for the March 26, 1991, meeting. Representative Sawyer seconded the motion. Motion carried.

**Hearing on HB 2457 - Deductibles on workman's compensation**

Jim Yonally, representing the National Federation of Independent Businesses, testified before the committee as a proponent of the bill. He reviewed the proposed balloon amendment (See Attachment 1). Actual amounts of deductibles will not be legislated; the marketplace will be the determiner. Deductibles will not be charged or passed on to the worker but will be the fiscal responsibility of the employer.

Larry Magill, representing the Independent Insurance Agents, appeared as a proponent of the bill. Positives of the bill include: a) deductibles are in common use on most insurance policies today; b) it is generally not cost effective to "trade dollars" with insurance companies on small losses; c) workers compensation costs are increasing rapidly all across the country; d) deductibles give employers of all sizes the opportunity to absorb small losses and receive a small up-front credit or reduction in their premiums plus the employer will not have the small losses count in the calculation of their experience modification factor; e) deductibles are a proven risk management techniques and will increase the employer's involvement in loss and claims control; and f) fifteen states currently allow deductibles. (See Attachment 2).

Dorothy Taylor, Executive Director of the Professional Insurance Agents of Kansas, appeared before the committee as a proponent of HB 2457. It is generally less expensive for an insured to pay for small losses rather than transfer the risk to an insurance company and pay the higher premium. There is currently pending before the Insurance Department a 30.9% workers compensation rate increase which was requested by the National Council on Compensation Insurance. Deductibles give employers of all sizes the opportunity to absorb small losses and receive up-front discounts of their premiums. (See Attachment 3).

Glenda Cafer, Kansas Legislative Counsel of the American Insurance Association, testified before the committee as a proponent. She said the proposed deductible insurance would provide an effective tool for premium cost control by insureds. This bill can encourage self-insureds to come back into the market place which would result in greater collection of insurer taxes and assessments. (See Attachment 4).

Representative Neufeld moved for the adoption of the balloon amendment and for technical changes in HB 2457. Representative Flower seconded the motion. Motion carried.

Representative Cribbs moved for the favorable passage of HB 2457 as amended. Representative Cozine seconded the motion. Motion carried.

**Hearing on SB 38** - Health Care Stabilization Fund (Termination)

Bill Wolf of Research gave a history of the bill.

Daniel K. Roberts, M.D., Ph.D., appeared as a proponent for SB 38. He gave a video presentation from materials excerpted from the Executive Summary of the Actuarial Analysis of the Health Care Stabilization Fund as prepared by Wakely and Associations, Inc., and from the Tillinghast Actuarial Report provided to the HCSH Board of Governors. (See Attachment 5). The Health Care Stabilization Fund should be continued as it would be too expensive to phase it out and may lead to another insurance crisis with no back-up. Private insurance companies would be more expensive due to other costs involved. The market is fragile and the fund should be maintained until a suitable replacement market is guaranteed.

Jerry Slaughter of the Kansas Medical Society appeared before the committee as a proponent of SB 38. The Society recommends leaving a termination date out of this legislation, and then if conditions are favorable, the Legislature can take affirmative steps in 1993 or 1994 to terminate the fund. They recommend leaving the language in regarding tail coverage as the Fund may only be around for a few years. The Kansas Medical Society supports exemptions from tail coverage for those physicians leaving the state to participate in educational, religious, humanitarian, or governmental service programs. The proposed surcharges to protect against future insolvency are necessary to terminate the Fund in 1994. (See Attachment 6).

Harold Riehm, Kansas Association of Osteopathic Medicine, appeared before the committee as a proponent. The following amendments were proposed: a) restoration of the target date for termination; b) end to tail coverage for those who leave Kansas to practice in another state; c) exemptions to (b) for religion, education, humanitarian reasons. (See Attachment 7).

Gary Robbins, Executive Director of the Kansas Optometric Association, testified before the committee as a proponent of SB 38. Because optometrists have had only five claims involving the fund since 1976, their malpractice premiums have remained stable, over ten companies write professional liability insurance for optometrists in Kansas, they have requested to be allowed to withdraw from the Fund. They have agreed to pay for prior acts coverage in the private market or from the fund. Their withdrawal will provide experience in withdrawal for the Insurance Department and the Health Care Stabilization Fund Oversight Committee. (See Attachment 8).

Bob Williams, Executive Director of the Kansas Pharmacists Association, testified in support of SB 38. The proposed exclusion of pharmacists from the Health Care Stabilization Fund was summed up by the statement: "Let my people go." (See Attachment 9).

Cheryl DeBrot of the Kansas Society for Respiratory Care, provided written testimony in support of SB 38. (See Attachment 10).

Tom Bell, representing the Kansas Hospital Association, appeared before the committee as a proponent of SB 38. Hospitals have contributed approximately 20 percent of the monies paid into the Health Care Stabilization Fund. They recommend the phasing out of the Fund but it must be done in a way that is reasonable and efficient without inflating premiums to the point where they have an adverse effect on attracting new providers to the state. (See Attachment 11).

Steven Sanford, representing the Insurance Department, appeared as a proponent of the bill. (See Attachment 12). The major components of the bills are:

1. Collection of adequate monies to fund all anticipated liabilities based on the assumption the Fund would terminate July 1, 1994, without providing tail coverage.

2. Permit the orderly withdrawal of optometrists and pharmacists from the Health Care Provider Insurance Availability Act.

3. Extend the authority of the Health Care Stabilization Fund Oversight Committee in order to study and recommend additional steps necessary to phasing out the Fund.

Recommendations include:

1. No definite phase-out dates due to availability of insurance and need for definition of Fund's liabilities for existing claims and suits and suits filed after phase-out date.

2. Consideration be given to the availability of insurance in the private markets.

The department would not charge an additional surcharge until legislation is enacted containing standards regarding the manner in which the Fund terminates.

The Hearing on SB 38 was declared closed.

HB 2413 was discussed at length by the Committee. The proposed amendments were explained in detail by Representative Helgerson. It was suggested by Representatives Cribbs and Cornfield that HB 2502 has just recently been enacted and we should wait and see if that legislation which has passed the Kansas Supreme Court is workable before adding any new legislation to it.

Representative Sprague moved that HB 2413 be reported adversely. It was seconded by Representative Campbell. Those voting in favor of the bill were Representatives Helgerson, Cozine, Sawyer, and Welshimer. Motion did not carry.

Representative Sawyer moved that HB 2427 be reported favorably for passage. It was seconded by Representative Cozine. Motion carried.

The meeting was adjourned at 5:30 p.m.

# GUEST LIST

COMMITTEE: House Insurance DATE: March 28, 1991

| NAME (PLEASE PRINT) | ADDRESS | COMPANY/ORGANIZATION |
|---|---|---|
| Bill Sneed | TOPEKA | State Farm |
| LARRY MAGILL | " | IIAK |
| [illegible] Taylor | Topeka | PIAK |
| Dick Brock | " | Ins Dept |
| Rhonda Cofer | Topeka | AIA |
| Lee Wright | Overland Park | Farmers Ins. Group |
| Michael Kiester | Topeka | John Peterson & Associates |
| Hal BROWN | Iconic | KS Lumberdealers |
| KAREN FRANCE | TOPEKA | KAR |
| ALAN COBB | Wichita | Wichita Hosps |
| DAN Roberts | Wichita HCSF | |
| [illegible] | [illegible] | [illegible] |
| Vera Sutton | Topeka | KLTA |
| Robert A. Anderson | Topeka, | KDHR/Director Work Comp |
| BOB HAYES | TOPEKA | KS INS. DEPT. |
| Steve Sanford | Topeka | KS Ins Dept. |
| Sara F. Ullmann | Johnson Co. | Health Care Stab. Fund |
| Bob Williams | Topeka | Ks. Pharmacists Asso. |
| GARY Robbins | Topeka | Ks Optometric Assn. |
| Dave Hanson | Topeka | Ks LIFE Assoc |
| | | |
| | | |
| | | |
| | | |
| | | |

**NFIB** Kansas

National Federation of
Independent Business

TESTIMONY

on House Bill 2457

House Committee on Insurance

Mister Chairman, and members of the committee, my name is Jim Yonally, Director of the Kansas chapter of the National Federation of Independent Business. I am pleased to speak on behalf of over 7,500 small businesses in Kansas who are members of our organization, and express our support for the concepts in House Bill 2457. I would also like to express our appreciation to the committee for agreeing to introduce this bill about a month ago.

Our legislative program is determined by a vote of our membership. On the 1991 Ballot, we asked if legislation should be passed which would make workers compensation policies available with a deductible provision. The response was 57% in favor, and 30% opposed.

At the time of our request, we recommended a draft along the lines of similar legislation in other states. However, a bill on this same topic was introduced in the senate. After hearings, with input from interested parties, some amendments were offered that were designed to make the bill more workable in Kansas. Therefore, I would like to offer some amendments to HB 2457, as "ballooned" on the attached handout.

As you can see, we recommend only minor changes in lines 12 through 33 of page 1. However, we suggest the deletion of the remainder of Section 1, and the substitution of the language taken from the Senate Bill, as amended.

Let me go through these changes, and an explanation for each. (Refer to bill)

Again, we appreciate the committee's interest in this proposal, and urge you to adopt the suggested amendments and report the bill favorably.

State Office
10039 Mastin Dr.
Shawnee Mission, KS 66212
(913) 888-2235

The Guardian of
Small Business

House Insurance
March 28, 1991
Attachment 1

Session of 1991

# HOUSE BILL No. 2457

By Committee on Insurance

2-25

AN ACT relating to workers compensation insurance; requiring insurers to offer policies with deductible options.

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

Section 1. (a) Each insurer issuing a policy to assure the payment of compensation under the workers compensation act ~~shall~~ may offer, as a part of the policy or as an optional endorsement to the policy, deductibles optional to the policyholder for benefits payable under the workers compensation act. ~~Deductible amounts offered shall be fully disclosed to the prospective policyholder in writing in the amount of $100, $200, $300, $400, $500, or increments of $500 up to a maximum of $2,500 per compensable claim. The policyholder exercising the deductible option shall choose only one deductible amount.~~

(b) ~~If the policyholder exercises the option and chooses a deductible, the insured employer shall be liable for the amount of the deductible for benefits paid for each compensable claim of work injury suffered by an employee.~~ The insurer shall pay all or part of the deductible amount, whichever is applicable to a compensable claim, to the person or medical provider entitled to the benefits conferred by the workers compensation act and seek reimbursement from the insured employer for the applicable deductible amount. The payment or nonpayment of deductible amounts by the insured employer to the insurer shall be treated under the policy insuring the liability for workers compensation in the same manner as payment or nonpayment of premiums. The insurer may require adequate security to provide for reimbursement of the paid deductible from the insured. An employer's failure to reimburse deductible amounts to the insurer shall not cause the deductible amount to be paid from the workers' compensation fund under K.S.A. 44-532a and amendments thereto, or any other statute. The insurer shall have the right to offset unpaid deductible amounts against unearned premium, if any, in the event of cancellation.

~~(c) Optional deductibles shall be offered in each policy insuring liability for workers compensation which is issued, delivered, issued for delivery or renewed on or after the effective date of this act, unless an insured employer and insurer agree to renegotiate a workers compensation policy in effect on June 30, 1991, so as to include a provision allowing for a deductible.~~

~~(d) Premium reduction for deductibles shall be determined before the application of any experience modification, premium surcharge or premium discounts. To the extent that an employer's experience rating or safety record is based on benefits paid, money paid by the~~

(c) Such deductible shall provide premium credits as approved by the commissioner of insurance and losses paid by the employer under the deductible shall not apply in calculating the employer's experience modification.

~~insured employer under a deductible as provided in this section shall not be included as benefits paid so as to harm the experience rating of such employer.~~

~~(e)~~ This section shall not apply to employers who self-insure against liability for workers compensation or group-funded workers compensation pool established pursuant to K.S.A. 44-581 *et seq.*, and amendments thereto.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

(d) The commissioner of insurance shall not appr any policy form that permits, directly or indir any part of the deductible to be charged to or passed on to the worker.

(e) The deductible amounts paid by an employer shall be subject to reimbursement as provided for under K.S.A. 44-567 and amendments thereto when applicable. All compensation benefits paid by the insurer including the deductible amounts shall be subject to assessments under K.S.A. 40-566a and 74-713 and amendments thereto. The Kansas workers compensation plan under K.S.A. 40-2109 and amendments thereto shall not require deductibles under policies issued by the plan.

(f)

Testimony on HB 2457
Presented to the House Insurance Committee
By: Larry W. Magill, Jr., Executive Vice President
Independent Insurance Agents of Kansas
March 28, 1991

Thank you mister chairman and members of the committee for the opportunity to appear in support of HB 2457 allowing use of employer paid deductibles on workers compensation coverage.

We feel that allowing the use of workers compensation deductibles makes good sense and good public policy for the following reasons:

- Deductibles are in common use on most insurance policies today. It is only because workers compensation is a "creature of statute" that legislation is necessary to allow their use in workers compensation.
- It is generally not cost effective to "trade dollars" with insurance companies on small losses. Insurance works best when it covers the more catastrophic or large losses. On small losses, it is generally less expensive for the customer to handle them themselves than transfer the risk to the insurance company and pay the resulting higher premiums.
- Workers compensation costs are increasing rapidly all across the country and Kansas is no exception. There is currently pending at the Insurance Department a 30.9% rate increase requested by the National Council on Workers Compensation insurance. The Insurance Department's independent actuary supports a 24.0% increase. These types of rate increases are needed primarily for two reasons:
  1. Inadequate rate increases in the past.
  2. Substantially increasing medical and indemnity (lost time) claims in Kansas. We have attached graphs depicting recent claims trends.

House Insurance
March 28, 1991
Attachment 2

The independent insurance agents of Kansas strongly support providing employers with all the cost control measures possible in the face of these rising rates.

- Deductibles give employers of all sizes the opportunity to absorb small losses and receive a small up front credit or reduction in their premium plus the employer will not have the small losses count in the calculation of their experience modification factor.
- Deductibles are a proven risk management technique and will increase the employer's involvement in loss and claims control. Employers will be more aware of the small losses and more likely to take an interest in their prevention. For example, if an employer is paying a number of eye wash claims, they are more likely to purchase goggles and enforce their use. In addition, in the insurance business there is an old adage that where there is a frequency of small claims there is more of a likelihood of having a large loss or losses. By preventing minor eye injuries, an employer may also prevent the loss of sight in a more serious accident.
- The following fifteen states currently allow deductibles:

| | | |
|---|---|---|
| Colorado | Illinois | New Mexico |
| Delaware | Maine | New York |
| Florida | Montana | Oregon |
| Georgia | Nebraska | Rhode Island |
| Hawaii | New Hampshire | South Dakota |

Most give a front end credit but include amounts paid under deductibles in calculating the experience modification. This proposal would not include amounts paid under deductibles in calculating experience modifications. With one exception, all of these states have enacted deductible legislation since 1988.



342

We encourage the committee to leave this legislation as permissive as possible to allow both large and small employers the most flexibility to use deductibles to their advantage. Since large employers may use the deductible, we support placing no maximum on the deductible amount. We would anticipate that a large number of deductibles would be offered starting at a minimum of $100.

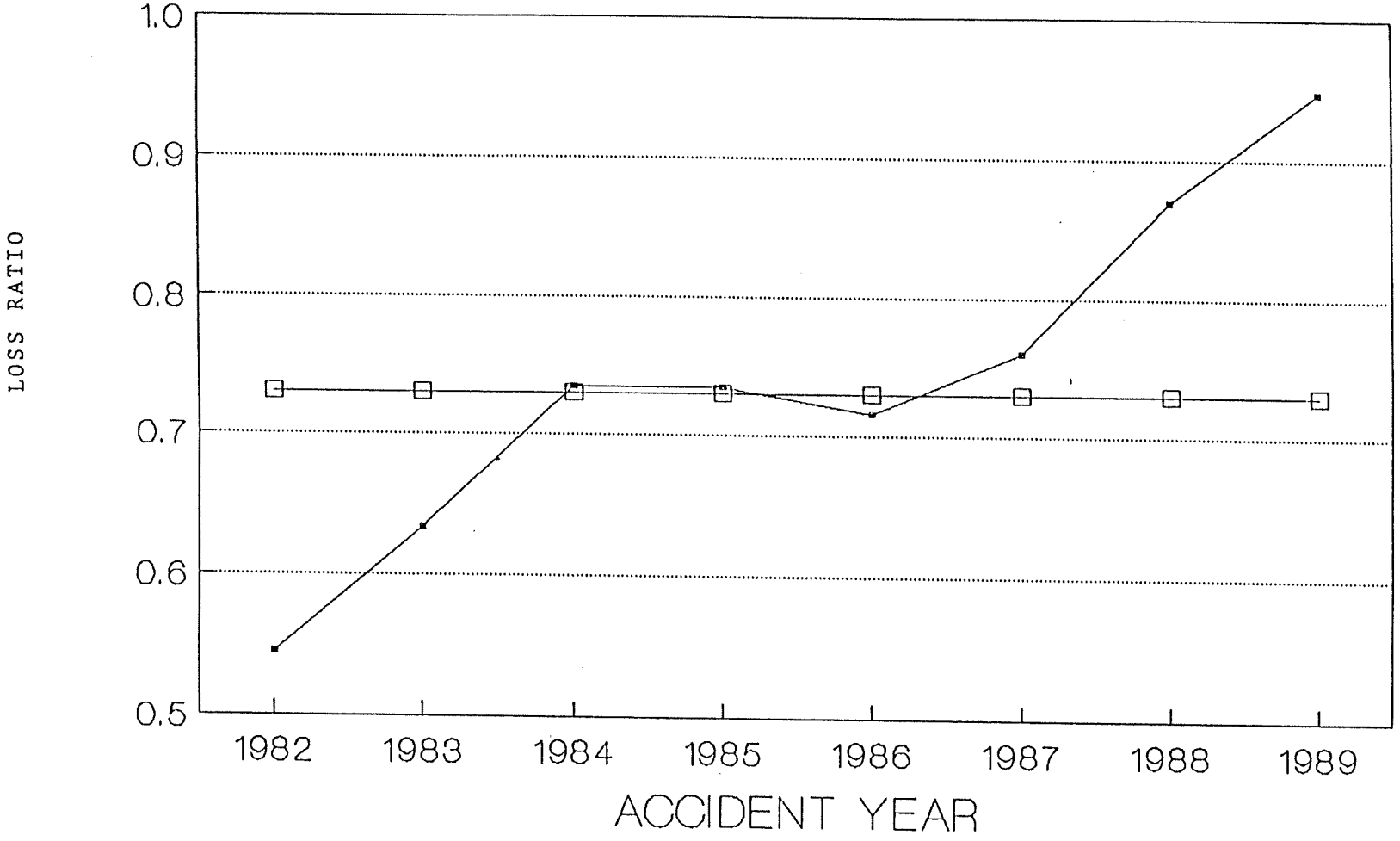
We do not feel that the bill needs to include a maximum deductible for the following reasons:

1. It will allow large employers who do not want to self-insure or who cannot qualify as an individual self-insurer an opportunity to still save substantially on their workers compensation costs.
2. It will not pose a risk to the employees' benefits since the insurer is still primarily responsible for payment of benefits to injured workers. The insurer assumes the financial risk of the employer paying amounts owed under the deductible.

Attached to our testimony is a "balloon copy" of HB 2457 with the changes agreed to by the Senate Labor and Industry Committee, plus a few additional changes. Also attached is an explanation of those changes.

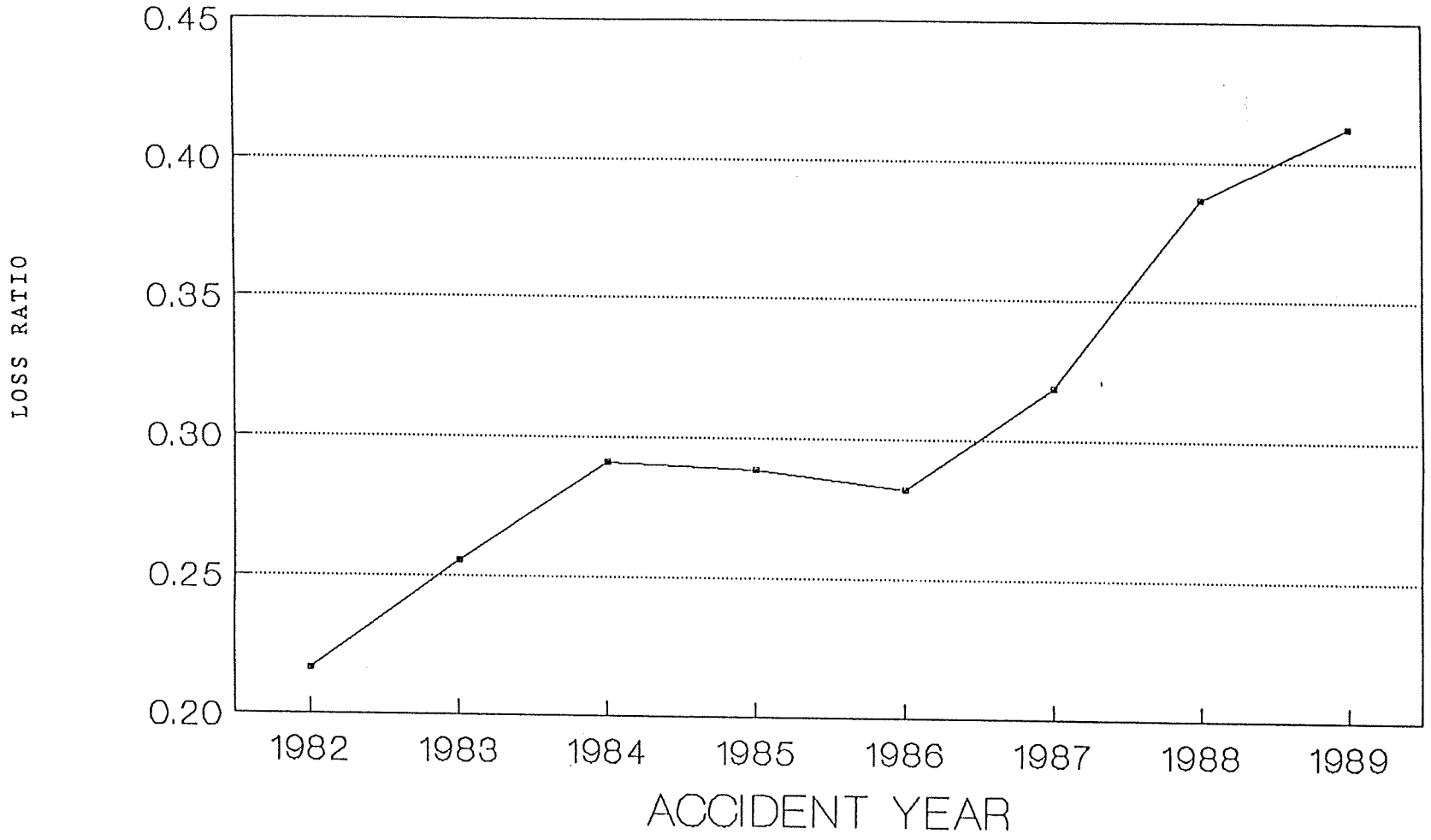
Thank you for the opportunity to appear today in support of HB 2457. We urge the committee to act favorably on the legislation. We would be happy to answer questions or provide additional information.

# KANSAS - HISTORICAL LOSS RATIOS
## INDEMNITY + MEDICAL



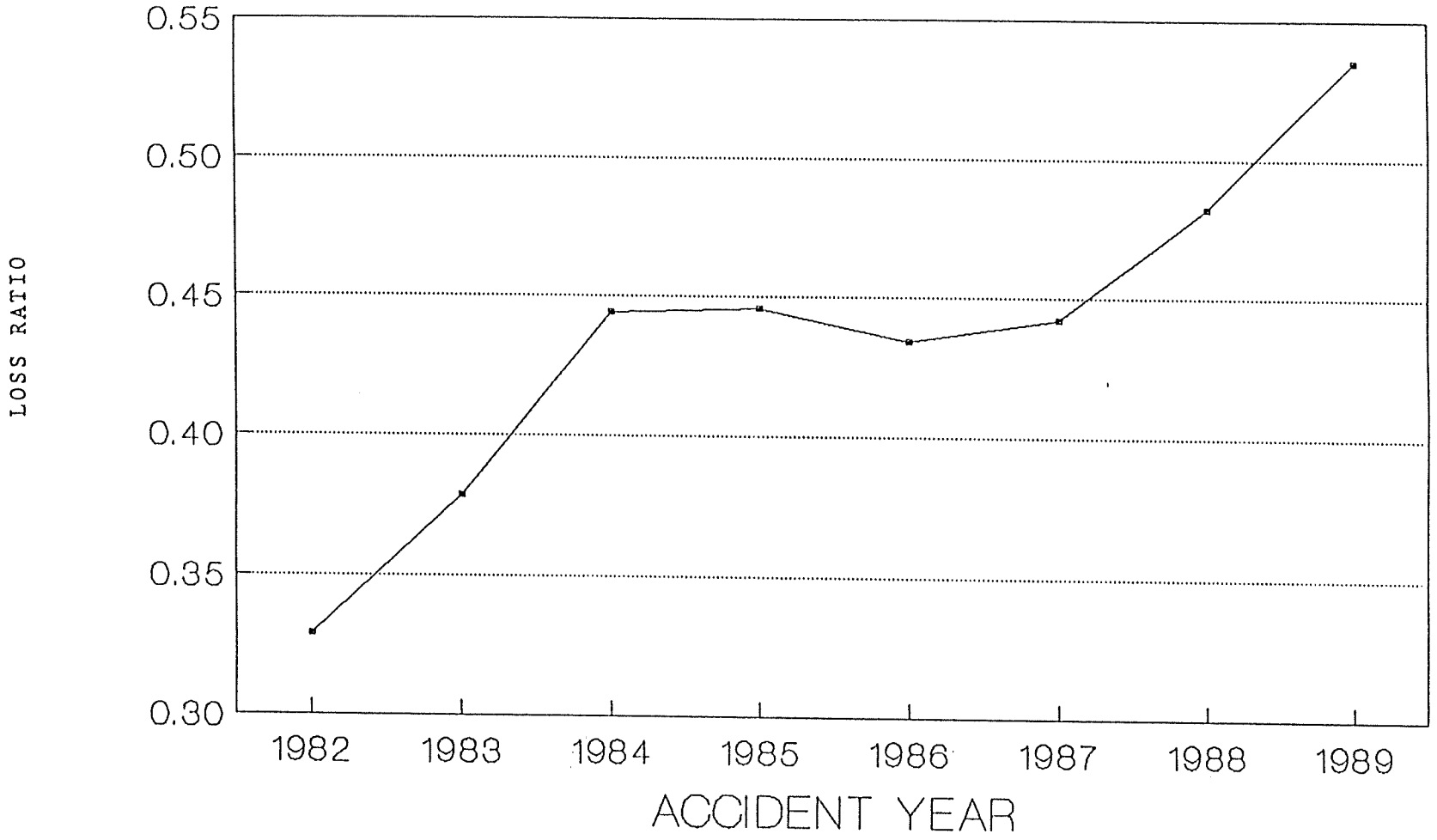

NOTES:
1. Source: filing.
2. Premiums are on current rate level.
3. Indicated losses are under current law.
4. Target loss ratio is .730 .

# KANSAS - HISTORICAL LOSS RATIOS
## MEDICAL




NOTES:
1. Source: filing.
2. Premiums are on current rate level.
3. Indicated losses are under current law.

# KANSAS - HISTORICAL LOSS RATIOS
## INDEMNITY




NOTES:
1. Source: filing.
2. Premiums are on current rate level.
3. Indicated losses are under current law.

EXPLANATION OF PROPOSED
AMENDMENTS TO HB 2457

1. Avoids a mandatory offer of a deductible to every employer and the resulting administrative expenses including the possible need for special rejections to prove the offer was made. The marketplace will assure that employers are given this option.

2. a) Allows insurance companies to financially underwrite a firm's ability to repay amounts paid by the insurer under the deductible.

   b) Prevents an insurer from seeking reimbursement for unpaid deductible amounts from the Workers Compensation Fund. The Workers Compensation Fund is intended to cover uninsured insolvent employer's employees by providing the workers compensation benefits owed.

   c) Clarifies that if there is any return premium owed an employer on a cancelled workers compensation policy, the insurance company can deduct any unpaid deductible amounts from the return premiums.

3. Clarifies that there will be both an "up-front" credit (or reduction) applied to the premium paid and that amounts paid by the employer under the deductible will not be charged against them when the National Council on Compensation Insurance calculates their experience modification. All other types of deductibles are handled in this manner. Most business owners are not going to understand being charged for amounts they paid under a deductible in the calculation of their experience modification for three years.

4. Clarification desired by the AFL-CIO.

5. a) Will allow an employer to share in any second injury fund reimbursement for a qualifying claim on a pro-rata basis with the insurance company.

   b) Includes claim amounts paid under deductibles in an insurance company's total paid claims for purposes of calculating the insurer's assessment for operation of the Director of Workers Compensation office and the operation of the Workers Compensation Fund.

   c) Prohibits the Workers Compensation Plan from requiring that employers accept deductibles since this is the market of last resort. The plan may still offer deductibles and we anticipate that they will.

Session of 1991

# HOUSE BILL No. 2457

By Committee on Insurance

2-25

AN ACT relating to workers compensation insurance; requiring insurers to offer policies with deductible options.

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

Section 1. (a) Each insurer issuing a policy to assure the payment of compensation under the workers compensation act ~~shall~~ may offer, as a part of the policy or as an optional endorsement to the policy, deductibles optional to the policyholder for benefits payable under the workers compensation act. ~~Deductible amounts offered shall be fully disclosed to the prospective policyholder in writing in the amount of $100, $200, $300, $400, $500, or increments of $500 up to a maximum of $2,500 per compensable claim. The policyholder exercising the deductible option shall choose only one deductible amount.~~

~~(b) If the policyholder exercises the option and chooses a deductible, the insured employer shall be liable for the amount of the deductible for benefits paid for each compensable claim of work injury suffered by an employee.~~ The insurer shall pay all or part of the deductible amount, whichever is applicable to a compensable claim, to the person or medical provider entitled to the benefits conferred by the workers compensation act and seek reimbursement from the insured employer for the applicable deductible amount. The payment or nonpayment of deductible amounts by the insured employer to the insurer shall be treated under the policy insuring the liability for workers compensation in the same manner as payment or nonpayment of premiums.

~~(c) Optional deductibles shall be offered in each policy insuring liability for workers compensation which is issued, delivered, issued for delivery or renewed on or after the effective date of this act, unless an insured employer and insurer agree to renegotiate a workers compensation policy in effect on June 30, 1991, so as to include a provision allowing for a deductible.~~

~~(d) Premium reduction for deductibles shall be determined before the application of any experience modification, premium surcharge or premium discounts. To the extent that an employer's experience rating or safety record is based on benefits paid, money paid by the~~

(a) The insurer may require adequate security to provide for reimbursement of the paid deductible from the insured.

(b) An employer's failure to reimburse deductible amounts to the insurer shall not cause the deductible amount to be paid from the workers' compensation fund under K.S.A. 44-532a and amendments thereto, or any other statute.

(c) The insurer shall have the right to offset unpaid deductible amounts against unearned premium, if any, in the event of cancellation.

(c) Such deductible shall provide premium credits as approved by the commissioner of insurance and losses paid by the employer under the deductible shall not apply in calculating the employer's experience modification.

~~insured employer under a deductible as provided in this section shall not be included as benefits paid so as to harm the experience rating of such employer.~~

~~(e)~~ This section shall not apply to employers who self-insure against liability for workers compensation or group-funded workers compensation pool established pursuant to K.S.A. 44-581 *et seq.*, and amendments thereto.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

(d) The commissioner of insurance shall not approve any policy form that permits, directly or indirectly, any part of the deductible to be charged to or passed on to the worker.

(e) The deductible amounts paid by an employer shall be subject to reimbursement as provided for under K.S.A. 44-567 and amendments thereto when applicable. (b) All compensation benefits paid by the insurer including the deductible amounts shall be subject to assessments under K.S.A. 40-566a and 74-713 and amendments thereto. (c) The Kansas workers compensation plan under K.S.A. 40-2109 and amendments thereto shall not require deductibles under policies issued by the plan.

(f)

KANSAS

PROFESSIONAL
INSURANCE
AGENTS

DOROTHY M. TAYLOR
EXECUTIVE DIRECTOR

214 W. 7th
Topeka, KS 66603
913/233-4286
FAX 913/234-3713

# TESTIMONY
# ON
# HOUSE BILL NO. 2457

Presented to: HOUSE INSURANCE
COMMITTEE

By
Dorothy Taylor, Executive Director
Professional Insurance Agents of Kansas

House Insurance
Attachment 3
March 28, 1991

KANSAS

PROFESSIONAL INSURANCE AGENTS

DOROTHY M. TAYLOR
EXECUTIVE DIRECTOR

214 W. 7th
Topeka, KS 66603
913/233-4286
FAX 913/234-3713

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE.

MY NAME IS DOROTHY TAYLOR, EXECUTIVE DIRECTOR OF THE PROFESSIONAL INSURANCE AGENTS OF KANSAS REPRESENTING SOME 500 AGENCIES EMPLOYING SOME 3,000 EMPLOYEES ACROSS THE STATE WHO BELIEVE THAT ALLOWING THE USE OF DEDUCTIBLES FOR BENEFITS PAYABLE UNDER THE WORKERS COMPENSATION ACT MAKES GOOD PUBLIC POLICY AND GOOD SENSE.

DEDUCTIBLES ARE IN COMMON USE IN MANY OTHER TYPES OF INSURANCE POLICIES BOTH IN THE PERSONAL LINES AS WELL AS IN COMMERCIAL LINES. IT IS GENERALLY LESS EXPENSIVE FOR AN INSURED TO PAY FOR SMALL LOSSES RATHER THAN TRANSFER THE RISK TO AN INSURANCE COMPANY AND PAY THE RESULTING HIGHER PREMIUM.

THERE IS CURRENTLY PENDING BEFORE THE INSURANCE DEPARTMENT A 30.9% WORKERS COMPENSATION RATE INCREASE WHICH WAS REQUESTED BY THE NATIONAL COUNCIL ON COMPENSATION INSURANCE, THE INDUSTRY'S NATIONAL RATING ORGANIZATION FOR WORKERS COMPENSATION. THE RATE INCREASE IS STATISTICALLY JUSTIFIED AND IS NEEDED BECAUSE OF INADEQUATE RATES OVER THE PAST SEVERAL YEARS, BECAUSE OF CONTINUING INCREASES IN MEDICAL AND TIME LOSS CLAIMS, AND BECAUSE THE BENEFITS UNDER WORKERS COMPENSATION HAVE BEEN INCREASED.

WE SUPPORT THIS BILL WHICH WILL PROVIDE EMPLOYERS WITH ANOTHER COST CONTROL MEASURE NEEDED IN THE FACE OF RISING INSURANCE COSTS.

DEDUCTIBLES GIVE EMPLOYERS OF ALL SIZES THE OPPORTUNITY TO ABSORB SMALL LOSSES AND RECEIVE UP-FRONT DISCOUNTS OF THEIR PREMIUMS, PLUS THE ADVANTAGE OF REDUCING THEIR EXPERIENCE MODIFICATION FACTOR/A TWO-PRONGED COST SAVING MEASURE. DEDUCTIBLES ARE A PROVEN RISK MANAGEMENT TECHNIQUE WHICH WILL INCREASE THE EMPLOYER'S INVOLVEMENT IN LOSS AND CLAIMS CONTROL.

THE PRESENT BILL WOULD PERMIT BOTH LARGE AND SMALL EMPLOYERS TO USE DEDUCTIBLES TO THEIR ADVANTAGE AS INSURANCE COMPANIES WILL OFFER DEDUCTIBLES FROM $100 TO $5,000.

THANK YOU FOR THE OPPORTUNITY TO TESTIFY IN SUPPORT OF OUR CUSTOMERS WHO BUY WORKERS COMPENSATION. WE URGE THE COMMITTEE TO ACT FAVORABLY ON THIS LEGISLATION.

2-3

LAW OFFICES
BENNETT, DILLON & CALLAHAN
1605 S.W. 37TH STREET
TOPEKA, KANSAS 66611
(913) 267-5063

MARK L. BENNETT, JR.
WILBURN DILLON, JR.
LORI M. CALLAHAN

GLENDA L. CAFER

FAX (913) 267-2652

TO: House Insurance Committee

FROM: Lori M. Callahan, Kansas Legislative Counsel
American Insurance Association

SUBJECT: H.B. 2457

DATE: March 28, 1991

The American Insurance Association is a national trade organization representing more than 280 companies who write property and casualty insurance. I appreciate the opportunity to testify today.

The American Insurance Association supports H.B. 2457 in the balloon version as proposed by the National Federation of Independent Business represented by Mr. Jim Yonelly. We feel that deductibles in workers' compensation insurance, if properly written, provide an effective tool for premium cost control by insureds. In order to assure that such a deductible program would be attractive to insurers, as well as insureds, the language as proposed by the National Federation of Independent Business in their balloon must be included in H.B. 2457. If adopted as proposed, it is our opinion that H.B. 2457 can encourage self insureds to come back into the market place, which

House Insurance
Attachment 4
March 28, 1991

results in greater collection of insurer taxes and assessments and helps all Kansas businesses, as well as the state of Kansas. The potential cost savings from deductibles would result in reduced premiums, which would be a further advantage to Kansas businesses. Accordingly, as proposed to be amended, H.B. 2457 is an effective tool for both Kansas businesses, the state of Kansas, as well as the insurance market. For this reason, we support H.B. 2457.

# Evaluation of the Health Care Stabilization Fund Oversight Committee Actuarial Report from Wakely et. al.

by
Daniel K. Roberts, M.D., Ph.D.
August 23, 1990

Data for this response are acquired from the Executive Summary of the Actuarial Analysis of the Health Care Stabilization Fund (HCSF) done by Wakely and Associates, Inc. for the Oversight Committee and the minimal summary of the Tillinghast Actuarial Report provided to the HCSF Board of Governors. I shall utilize the Recommendations and Conclusions of the Wakely report as a structural guideline. (See attached.)

(1) The estimated discounted liability (EDL) is $113 million by Wakely and $138 million by Tillinghast. This is obtained by first projecting total liabilities associated with surcharges through June 30, 1990. The liability is then reduced to reflect the fact that liabilities are paid out over many years and that, in the meantime, reserve funds will earn interest. The current fund balance is $110 million. The difference between the two EDL's by the two actuaries is, in reality, minimal. The difference between the actual fund balance on 6/30/90 of $110 million and the two EDL's of $113 + 138 million is similarly minimal. Considering the uncertainties in liability projections and the fact that only a 7.5% interest rate is projected, this should be no cause for alarm. If one were to assume a 10% interest rate, the extra 2.5% on $110 million would, over time, make up any difference. The bottom line is that the HCSF +/- its past is on a sound basis.

(2) Estimated overall surcharge rate for the current fiscal year by Tillinghast is set at 111%. According to the Wakely report, it should be 88%. (91% if we lost the cap on non-economic damages.) See Exhibit III, Sheet 1. The Tillinghast surcharge rate is higher than the Wakely rate because Tillinghast includes a portion to recoup the deficiency in the Fund that they estimate currently exists. Without this, the two rates are approximately equal. I believe an appropriate, prudent reduction in surcharge is in order. We do not have a discounted liability problem. Nor do we have a cash flow problem. If we wait until 1991-92 we will be better off and the estimated surcharge figures in III-1 would probably be even less.

(3-4-5-6-7) These data deal with the phase-out. The figures necessary to do this depend on three factors. First is time, i.e. 1994 or 1996. Second is coverage, i.e. excess only or 1st dollar coverage. Third is with or without the cap on non-economic damages. (Exhibit IV).

Health Insurance
Attachment 5
March 28, 1991

If we are to supply funds for the phase out we will have to add to our surcharge that amount to cover the additional discounted tail liabilities. If one adds 1% to the surcharge, one will generate $1.8 million plus interest by 1994 and $3 million + interest by 1996. Let us compute the cost of buyout on 1st dollar coverage, non-economic cap present, by 1994 and 1996.

1994 - $89.5 million needed / $1.8 million = 49.32%
1996 - $108.1 million needed / $3.0 million = 36.03%

Therefore, to arrange for a 1994 phase out, one would have to add on top of regular surcharge a minimum of 50% and for a 1996 phase out, a minimum of 36%. This would have to start immediately to be valid. For a 1996 phase out one would add 36% to the current surcharge at each level. For example, at the $1/3 million level, it would be (120 + 36 = 156% Tillinghast) or (90 + 36 = 126% Wakely).

Further, #5 speaks to the variability of projections which may be high or low. They suggest adding an "explicit margin in the carried liabilities to reduce the possibility of an inadequacy of funds and to establish a mechanism by which any excess funds may eventually be returned to health care providers". It is recommended that the "explicit margin ..." be 5% annually (therefore for a $1/3 million level we are now at 156 + 5 = 161% Tillinghast or 126 + 5 = 131% Wakely). Fortunately, with the current and continued operation, these variabilities in our existing plan can be adjusted for on a yearly basis.

(8&9) The legislative committee ask them to speak toward restricting attorney fees. I have no comment.

(10) The debate between claims made and occurrence basis of the fund is a legal and interpretation issue to which I don't intend to speak.

(11) Having seen the operation first hand, I would certainly have to concur that there is no economic incentive to the basic policy providers to defend claims that are covered by the HCSF. Duplication of effort is also present. If the above cannot be corrected and, since "...in most states the defense cost included in the rate for primary coverage typically contemplates defense of all claims, no matter how large ...," then an offset or payment to the HCSF by base policy providers should occur to ..."reflect the portion of defense costs assumed by the HCSF".

(12) No comment.

## MISCELLANEOUS

(A) The method of payment on large judgements is set forth as follows: "...limited to $300,000 or 10% of the judgement including interest, whichever is greater." I can see this potentially being a problem. With any claim greater than $3 million, neither method would likely allow one to pay off the claim with the current interest rates. It would seem to be prudent to at least have someone look at this. Also if one were to lump a combined set of claims into one this would not handle the circumstances. Whatever might be changed should stay as an option of the HCSF.

(B) I would only comment that the current legislation on the tail coverage is questionable. It may keep some physicians in Kansas for five years but I suspect it keeps an equal or greater number out of our state.

(C) The one hooker in all of this is the current situation with the HCPIAP. I am not impressed with the past efficiency of the operation of this entity and I hope there are no skeletons in the closet.

## OPINION AND RECOMMENDATIONS

I. KEEP THE H.C.S.F.!

A. Despite early difficulties, through changes and adjustments the Commissioner has put the fund on a current sound fiscal basis.
- EDL and current balance are quite compatible
- Cash flow is not a problem

B. The surcharge rates can be safely lowered even further.

C. Phase Out Cost

- The annual addition of 55% for 1994 or 41% for 1996 would make surcharges almost unbearable. Doctors would not only not come to Kansas but also recent graduates would not enter practice here. No one wants to pay for someone else's past.

- At the level necessary to accomplish this phase out some on-going practices might move elsewhere.

- Granted the cost of malpractice immediately following would be significantly less on the 5 step scenario of claims-made. However, $1/3 million may or may not be available. Overall the cost would be more expensive.

- Remember this is claims made. Occurrence policies would not only be more expensive, but would not likely be available. If the claims made excess policies went away the same crisis would exist as existed before.

- Current Fund acts like an occurrence policy even though legally it is not. One cannot get dependable occurrence rates or policies to match.

D. If HCSF is put to rest we are sewing the seeds for another insurance crisis with no back-up.

II. Summary

A. COST IS COST and in the real world whatever it costs if left to private insurance companies will have the following additions:

- Commission on sales (7% ?)
- Insurance company profit (?)
- Premium Tax
- Federal Tax

B. The HCSF is Mandatory and Monopolistic. If it goes away we run the risk of selective pooling and a residual market and an even greater problem with an entity such as the HCPIAP.

C. We are dealing with a Fragile market and the fund should exist until a suitable replacement market could be guaranteed. This will be tough to find.

D. Past debts are essentially paid off and we have optimized on minimizing other costs.

## III Final Analysis

A. Keep the Fund.

B. Convert the oversight committee to a permanent structure, with a primary responsibility of independently examining the actuarial soundness of the HCSF. Such a system would allow for responsible checks and balances against the pricing structure and reserving practices established by the actuary representing the Commissioner's office.

C. If the HCSF becomes unmanageable because of governmental bureaucracy, one may need to accomplish a joint venture between government and private insurance company.

Enclosures: ACTUARIAL ANALYSIS OF THE KANSAS HEALTH CARE STABILIZATION FUND EXECUTIVE SUMMARY, Wakely and Associates, Inc.
Pages 1-5
Exhibits: III-1, IV

# ACTUARIAL ANALYSIS OF THE

# KANSAS HEALTH CARE STABILIZATION FUND

# EXECUTIVE SUMMARY

# ACTUARIAL ANALYSIS OF THE

# KANSAS HEALTH CARE STABILIZATION FUND

## EXECUTIVE SUMMARY

At the request of the Kansas Legislative Coordinating Council and the Health Care Stabilization Fund (HCSF) Oversight Committee, Wakely and Associates, Inc. has performed a funding analysis of the HCSF as of June 30, 1990. Due to the complexity and multi-dimensional nature of the HCSF, we have separated our analysis into two sections. This section represents the executive summary portion of our analysis, including recommendations and conclusions, and our understanding of this history and structure of the HCSF and related entities.

The accompanying report includes the technical appendix and sets forth the detail of our analysis which supports the recommendations and conclusions set forth below.

## RECOMMENDATIONS AND CONCLUSIONS

Based on our analysis of the experience of the HCSF through June 30, 1990 we have the following recommendations and conclusions.

(1) The estimated discounted liability of the HCSF associated with surcharges received through June 30, 1990 is approximately $113 million, assuming a 7.5% annual investment return (see Exhibit I, Sheet 1, Item 13 for fiscal year 1989-1990). The actual fund balance as of June 30, 1990 is $110 million. Considering the uncertainties inherent in actuarial projections of HCSF's liability, it is concluded that the fund balance as of June 30, 1990 is reasonable.

(2) The estimated surcharge rate for the 1990 - 1991 fiscal year for coverage under existing law is 88% of basic premium (see Exhibit I, Sheet 1, Item 24). This is significantly less than the estimated 111% surcharge rate that is currently being used.

(3) If current law is revised to provide for the phase out of the HCSF with provision for all liabilities of active and inactive providers (i.e., tail coverage) then a substantial amount of funds beyond those contemplated in the surcharge rates above would need to be accumulated. There are two distinct coverage strategies which could be used to phase out the HCSF. 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 are $90 million and $108 million for phase-out dates of June 30, 1994 and June 30, 1996, respectively.

The second alternative is to extend coverage on an excess basis, consistent with coverage currently offered to active providers. The costs under this approach are $46 million and $58 million for phase-out dates of June 30, 1994 and June 30, 1996, respectively. These and other values are summarized in Exhibit IV.

(4) To determine the magnitude of the increase in surcharge rate required to generate funds for these liabilities, it is noted that a 1% increase in the surcharge rate is expected to generate about $1.8 million plus interest through June 30, 1994 or about $3 million plus interest through June 30, 1996.

(5) Any actuarial estimates of future medical professional liabilities involve the projection of future contingent events and are therefore subject to variability. 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. It may, therefore, be 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. It is noted that provided the HCSF continues its current mode of operation and coverage remains compulsory, the financial integrity of the HCSF can be maintained without a risk margin as any fluctuation from projected values can be reflected properly in future surcharges.

(6) If the HCSF is to be phased out, it will be necessary to decide exactly how coverage will be discontinued. In the analysis, we have assumed that coverage will be discontinued for all occurrences after the phase out date even though existing basic policies would provide coverage beyond this date.

(7) All the estimates discussed above were determined based on the assumption that current law limiting recoveries on non-economic damages to $250,000 is upheld. As is apparent later in this report, this assumption resulted in lower projections than would have been obtained otherwise.

(8) Wakely and Associates was requested to estimate the impact of three alternative potential prospective law changes limiting plaintiff attorney contingency fees recoverable from the HCSF. We have determined that each alternative is likely to prove ineffective at reducing losses. 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.

(9) In view of (8), the possibility of regulating attorney fees on entire medical professional liability awards and settlements may be considered. 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 policy makers 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 of the tort system.

(10) There is currently an ambiguity in the coverage that should be clarified by the HCSF. Specifically, in cases where health care providers have purchased basic occurrence policies it has been argued in a recent court case the HCSF coverage is also provided on an occurrence basis. This interpretation is different from that of the HCSF, which argues that coverage for active providers is on a claims-made basis, regardless of the underlying coverage.

(11) The current system has a potential weakness in that commercial insurers writing basic policies have no economic incentive to defend claims that are covered by the HCSF. In a traditional reinsurance arrangement such incentives are likely to be included either through a financial arrangement or as a condition for a continued business relationship. There is also the potential of duplication of effort by the HCSF and carriers' attorneys that could increase overall defense costs. These issues may become even more significant given the reduction in coverage available from the HCSF and possible involvement of excess commercial insurers.

We stress that these potential deficiencies are based on general considerations of structure and we have made no analysis to determine whether any problems currently exist. Additionally, it is noted that in most states the defense cost included in the rate for primary coverage typically contemplates defense of all claims, no matter how large. Thus, any Kansas rate filing by medical professional liability carriers that includes defense costs based on countrywide experience should include an offset to reflect the portion of defense costs assumed by the HCSF.



945

WSA

(12) Certain of the prior law revisions impacting the HCSF and the coverage it provides have introduced, from an actuarial perspective, complications that do not appear necessary relative to the aims of the program. These complications introduce additional uncertainties in determining the present and future financial condition of the fund and, in addition, are likely to cause confusion to health care providers. It is recommended that any future revisions recognize, to the extent possible, the values of simplicity and adherence to sound insurance principles.

A specific example of such a complication is the method by which the recent change in policy limits has been phased in, whereby coverage is provided on a claims-made basis but coverage limits are determined on an occurrence basis. This has resulted in a situation where new entrants to the program are essentially contributing funds for prior exposures of old members. A second example is the method by which the new coverage limits were introduced at policy renewal. This resulted in incentives for providers to change policy renewal dates in order to optimize available HCSF coverage.

ACKNOWLEDGEMENT

We acknowledge the cooperation and assistance of Dr. William G. Wolff, Principal Analyst at the Legislative Research Department and Mr. Robert D. Hayes, Fire and Casualty Policy Examiner at the Insurance Department, in providing and clarifying the data for this analysis.

DISTRIBUTION AND USE

This report is intended for the use of the HCSF Oversight Committee in fulfilling its statutory duties under K.S.A. 40-3401, et seq. It is our understanding that this report may become public record. It is requested that, in instances where this report is made public, that it be distributed only in its entirety, including both the Executive Summary and the Technical Appendix.



1075

# HCSF OVERSIGHT COMMITTEE

## SUMMARY OF INDICATED SURCHARGES

### Cap on Non-Economic Damages Effective

| Coverage Limits | 90 - 91 | 91 - 92 | 92 - 93 | 93 - 94 | 94 - 95 | 95 - 96 |
|---|---|---|---|---|---|---|
| $100,000 | 82% | 62% | 40% | 33% | 29% | 29% |
| $300,000 | 86 | 70 | 54 | 49 | 46 | 48 |
| $800,000 | 90 | 82 | 73 | 71 | 71 | 74 |
| Overall | 88% | 77% | 65% | 62% | 61% | 63% |

### Cap On Non-Economic Damages Ineffective

| Coverage Limits | 90 - 91 | 91 - 92 | 92 - 93 | 93 - 94 | 94 - 95 | 95 - 96 |
|---|---|---|---|---|---|---|
| $100,000 | 85% | 64% | 42% | 35% | 31% | 31% |
| $300,000 | 88 | 73 | 57 | 53 | 51 | 51 |
| $800,000 | 93 | 86 | 79 | 79 | 80 | 81 |
| Overall | 91% | 81% | 71% | 68% | 68% | 69% |

Notes: The overall surcharge is calculated assuming a 16% ($100,000), 14% ($300,000) and 70% ($800,000) distribution of basic premium by policy limits (based on HCSF experience). The overall surcharges reconcile to Exhibit I, Sheets 1 and 2, Line (23).

1175

WSA

# HCSF OVERSIGHT COMMITTEE

## SUMMARY OF ADDITIONAL DISCOUNTED TAIL LIABILITIES FOR PHASE OUT OF THE HCSF

($MILLIONS OMITTED)

### Present Value of Additional Liabilities at June 30, 1994

| | Coverage Provided on: Excess Basis | First Dollar |
|---|---|---|
| Cap on Non-Economic Damages Effective | $ 45.6 | $ 89.5 |
| Cap on Non-Economic Damages Ineffective | 49.9 | 95.5 |

### Present Value of Additional Liabilities at June 30, 1996

| | Coverage Provided on: Excess Basis | First Dollar |
|---|---|---|
| Cap on Non-Economic Damages Effective | $ 58.3 | $108.1 |
| Cap on Non-Economic Damages Ineffective | 64.3 | 112.1 |

Note: Based on projected liabilities for active providers under current coverage provisions and Kansas claim lag reporting patterns.

gether with undiscounted HCPIAP transfers and miscellaneous expenses of $2.[illegible] million and $0.469 million, respectively, total disbursements for the year are expected to be approximately $22.2 million.

The following tables display by quarter the estimated growth in the Fund's liabilities over the next year. An interest rate of 7.5% was utilized for purposes of discounting. Liabilities are distinguished between those funded on a prospective basis arising after July 1, 1984, and those funded on a retrospective basis arising prior to July 1, 1984.

**Undiscounted Liabilities**

| Evaluation Date | 7/1/89 | 10/1/89 | 1/1/90 | 4/1/90 | 7/1/90 |
|---|---|---|---|---|---|
| 1. Post 7/1/84 | $ 137,832 | $ 146,699 | $ 155,567 | $ 164,434 | $ 173,301 |
| 2. Pre 7/1/84 | 14,633 | 13,661 | 12,690 | 11,718 | 10,746 |
| 3. Total Liabilities | 152,465 | 160,360 | 168,257 | 176,152 | 184,047 |

**Discounted Liabilities**

| Evaluation Date | 7/1/89 | 10/1/89 | 1/1/90 | 4/1/90 | 7/1/90 |
|---|---|---|---|---|---|
| 1. Post 7/1/84 | $ 102 746 | $ 109,478 | $ 116,210 | $ 122,941 | $ 129,673 |
| 2. Pre 7/1/84 | 11,810 | 11,023 | 10,237 | 9,450 | 8,663 |
| 3. Required Reserves | 114,556 | 120,501 | 126,447 | 132,391 | 138,336 |
| 4. Foregone Savings | 11,625 | 11,125 | 10,625 | 10,124 | 9,624 |
| 5. Accrual Out of Balance | 3,310 | 3,098 | 2,887 | 2,675 | 2,463 |
| 6. Unfunded Liabilities (2)+(4)+(5) | 26,745 | 25,246 | 23,749 | 22,249 | 20,750 |
| 7. Funded Liabilities (3)-(6) | 87,811 | 95,255 | 102,698 | 110,142 | 117,586 |

Expected revenues, disbursements, and liabilities for the fiscal years 1990/91 through 1993/94 are summarized in the following table.



HZAD Associates

1375

## HEALTH CARE STABILIZATION FUND

### Cash Balance Plus Investments

| | |
|---|---|
| 02-28-91 | $139,176,291 |
| 12-31-90 | $132,000,000 |
| 06-30-90* | $110,000,000 |
| 12-31-89 | $101,000,000 |
| 06-30-89 | $ 77,000,000 |
| 12-31-88 | $ 66,000,000 |

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

March 27, 1991

TO: House Insurance Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: SB 38; Concerning the Health Care Stabilization Fund

The Kansas Medical Society appreciates the opportunity to present comments on SB 38, relating to the eventual termination of the Health Care Stabilization Fund. We participated in the interim hearings by the Health Care Stabilization Fund Oversight Committee, and we would like to compliment them on the effort expended to deal with this difficult problem. We support SB 38, as amended by the Senate.

While we do support SB 38, we urge the Legislature to move carefully. No state, as far as we know, has terminated such a fund, and there are certain to be complications, questions and inequities presented which we are unable to anticipate in advance. While the insurance market is competitive and strong at the present time, there is no assurance that such will be the case in 1994, and we could be right back where we were in the mid-70s when excess insurance was simply not available. Due to the volatile nature of this market, and the many uncertainties inherent in terminating the Fund, we believe it is prudent to move deliberately and cautiously towards its termination.

To that end, we supported the Senate amendment which deleted the provision on page 6, line 37, which would have ended the mandatory insurance requirement on July 1, 1994. In fact, we believe the recommendation of the Oversight Committee was not to set such a date in stone, but to remain flexible in case conditions in the future change. If the excess limits insurance market goes sour again (as many think it will) it might be necessary to continue the Fund past 1994. Therefore, it would seem more prudent to us to leave a specific termination date out of this legislation, and then if conditions are favorable the Legislature can take affirmative steps in 1993 or 1994 to terminate the Fund.

I should point out that, while a majority of physicians at the present time appear to support the termination of the Fund, there is certainly not unanimity. Generally, physicians in higher risk specialties tend to believe the Fund should be retained, while those in lower risk specialties tend to seek termination of the Fund. In fact, in recent weeks we have observed a noticable shift in opinion among physicians of all specialties, towards retaining the Fund. While it is too early to tell if this represents a significant shift in opinion or not, I believe it is a recognition among many physicians that in spite of the tumultuous decade we have just been through in liability terms, the Fund, by and large, has done its job and is working well.

House Insurance
March 28, 1991
Attachment 6

There is another issue in the bill which we wish to comment upon. It is the provision concerning "tail" coverage on page 4, lines 12-26. We support the Senate amendment which deleted this language. This provision would have imposed a requirement to purchase tail coverage on a physician who leaves the state to practice elsewhere, regardless of how long he or she has practiced in Kansas. Proponents of the tail provision argue that it is needed to provide a disincentive for physicians to leave Kansas to practice elsewhere, and it does not saddle remaining physicians with unfunded tail obligations for those who leave. We would argue that it only complicates an already complicated situation, and may prevent just as many physicians from locating in Kansas. In 1989 the Legislature enacted a five year tail coverage provision found at subsection (m) of K.S.A. 40-3403. This provision represents a significant compromise which was hammered out in 1989, and we believe it is preferable to the stricken language, especially in view of the fact that the Fund may only be around for another three years.

There is another Senate amendment on a related issue which we supported. On page 7, lines 23-27, the Senate inserted language which would grant the Health Care Stabilization Fund Board of Governors some latitude in granting exemptions from the five year tail provision to health care providers who leave the state to obtain additional education, or to participate in religious, humanitarian or government service programs. We believe it is important to give the Board of Governors of the Fund some flexibility, although limited, to grant exemptions in certain, deserving instances.

We also support the Senate amendments on page 15, lines 33-36, which restates the charge to the Health Care Stabilization Fund Oversight Committee. We believe this language is consistent with the future responsibilities of the Oversight Committee.

Finally, we recognize that in order to terminate the Fund in 1994, it will be necessary to collect additional surcharge dollars as a sort of "margin" to protect against future insolvency. The actuary for the Oversight Committee has outlined a recommendation which indicates surcharges would be on average about 15% higher (than actually indicated) each year for the next three to fund this margin. While we hope surcharges can be reduced as much as possible, we realize it is preferable to provide a cushion in advance, as opposed to assessing physicians for a deficiency at some point in the future.

In summary, we support SB 38, as amended by the Senate. We pledge our continued cooperation with the Oversight Committee as it continues its deliberations over the next couple of years, and we appreciate the opportunity to present these comments.

JS:ns

# Kansas Association of Osteopathic Medicine

*Harold E. Riehm, Executive Director*

*1260 S.W. Topeka*
*Topeka, Kansas 66612*
*(913) 234-5563*

March 27, 1991

To: Chairman Turnquist and Members, House Insurance Committee

From: Harold Riehm, Kansas Association of Osteopathic Medicine

Subject: Support for S.B. 38, But With Suggested Amendments.

Thank you for this opportunity to express our views on S.B. 38, and to suggest Amendments to that Bill. At the start, we want to express our thanks to two members of this Committee for serving, with distinction, on the Health Care Stabilization Oversight Committee.

---

KAOM SUPPORTED THE RECOMMENDATIONS OF THE OVERSIGHT COMMITTEE AS THEY APPEARED IN S.B. 38. HOWEVER, WE HAVE RESERVATIONS ABOUT SENATE AMENDMENTS TO THE ORIGINAL BILL.

---

First, some general comments:

(1) Even though the Fund is not actuarially sound and even though some remedial changes have been made to correct previous Fund pitfalls, WE THINK THAT THE PRESENT FAVORABLE CONDITION OF THE FUND OFFERS THE WINDOW OF OPPORTUNITY FOR TERMINATION, THAT HAS OFTEN BEEN DISCUSSED IN RECENT YEARS. We know from experience that the malpractice milieu runs in cycles. The "current softness" of the market should not clous the fact that conditions five years from now could be as serious as they were five years ago.

(2) We can take pride in Kansas that we structured a Fund to meet a specific set of problems, that providers were willing to make financial sacrifices to keep the Fund operative, and that we now have the only "sound" Fund in the country. We think we now need to take pride in being the first to successfully terminate the Fund, while conditions are most favorable to accomplishing that.

(3) We support the end of mandatory professional liability insurance for Fund participants, once the Fund is terminated.

(4) We support an end to all tail coverage upon Fund termination, planned for June 30, 1994. A three year interim offers time for private carriers to work with providers to develop solutions to tail coverage at the time of termination.

(5) We support the efforts of the optometrists and pharmacists to extricate themselves from Fund coverage.

---

ON THE FOLLOWING PAGES WE SUGGEST THREE AMENDMENTS, AND OFFER COMMENTS ON EACH.

(1) Restoration of the target date for termination.

(2) An end to tail coverage for those who leave to practice in another State, effective June 30, 1991.

(3) Exemptions to (2) for religion, education, humanitarian reasons.

House Insurance
Attachment 1
March 28, 1991

prescribed by the commissioner declaring that its professional liability insurance policies, wherever issued, shall be deemed to provide at least the insurance required by this subsection when the insured is rendering professional services as a nonresident health care provider in this state. Any nonadmitted insurer may file such a form.

(2) Every nonresident health care provider who is required to maintain basic coverage pursuant to this subsection shall pay the surcharge levied by the commissioner pursuant to subsection (a) of K.S.A. 40-3404 and amendments thereto directly to the commissioner and shall furnish to the commissioner the information required in subsection (a)(1).

(c) Every health care provider that is a self-insurer, the university of Kansas medical center for persons engaged in residency training, as described in subsection (r)(1) of K.S.A. 40-3401 and amendments thereto, the employers of persons engaged in residency training, as described in subsection (r)(2) of K.S.A. 40-3401 and amendments thereto, the private practice corporations or foundations and their full-time physician faculty employed by the university of Kansas medical center or a medical care facility or mental health center for self-insurers under subsection (e) of K.S.A. 40-3414 and amendments thereto shall pay the surcharge levied by the commissioner pursuant to subsection (a) of K.S.A. 40-3404 and amendments thereto directly to the commissioner and shall furnish to the commissioner the information required in subsection (a)(1) and (a)(2).

(d) In lieu of a claims made policy otherwise required under this section, a person engaged in residency training who is providing services as a health care provider but while providing such services is not covered by the self-insurance provisions of subsection (d) of K.S.A. 40-3414 and amendments thereto may obtain basic coverage under an occurrence form policy if such policy provides professional liability insurance coverage and limits which are substantially the same as the professional liability insurance coverage and limits required by subsection (a) of K.S.A. 40-3402 and amendments thereto. Where such occurrence form policy is in effect, the provisions of the health care provider insurance availability act referring to claims made policies shall be construed to mean occurrence form policies.

~~*(e) The provisions of this section shall expire on July 1, 1994.*~~

Sec. 3. K.S.A. 1990 Supp. 40-3403 is hereby amended to read as follows: 40-3403. (a) For the purpose of paying damages for personal injury or death arising out of the rendering of or the failure to render professional services by a health care provider, self-insurer or inactive health care provider subsequent to the time that such

AMENDMENT NO. 1 - PAGE 6 - LINES 37-38

REINSERT LANGUAGE REMOVED BY THE SENATE, IN SEC 2 (3)(b)(2)(e)

REASONS:

(1) Stating a date gives added force to the move for termination and retains an incentive for the Oversight Committee to pursue its work toward resolving troublesome questions, like what to do with the JUA.

(2) This makes it consistent with provisions retained that provide that the surcharge shall be computed in a manner to insure sufficient fund balances on June 30, 1994, to terminate the Fund.

(3) It is true that the date may have to be changed. It can be changed to a new date as easily as a new date being inserted.

(4) It has parallels to many present statutory provisions that sunset state agencies, with those dates always subject to being moved up when and if necessary and/or desired.

(5) There is evidence that there are companies ready to write at levels of one million or more coverag and it appears that there are solutions to coveri.. tail when it lapses upon Fund termination.

ADD NEW SUBSECTION (e):

(e) The provisions of this section shall expire on July 1, 1994.

SB 38—Am.

14

*macist prior to July 1, 1991, unless such optometrist or pharmacist ~~procured coverage therefor in the same manner as provided for inactive health care providers in subsection (m)~~ qualified as an inactive health care provider prior to July 1, 1991, and obtained coverage pursuant to subsection (m). Optometrists and pharmacists not qualified as inactive providers prior to July 1, 1991, may purchase coverage from the fund for periods of prior compliance by making application prior to August 1, 1991, and payment within 30 days from notice of the calculated amount as determined by the commissioner to be sufficient to fund anticipated claims based on reasonably prudent actuarial principles.*

*~~(o) Notwithstanding the provisions of subsection (m) or any other provision in article 34 of chapter 40 of the Kansas Statutes Annotated to the contrary, the fund shall not be liable for any claim against an inactive health care provider relating to any injury or death arising out of the rendering of or failure to render professional services by such inactive health care provider in circumstances where: (1) Such individual became an inactive health care provider on or after July 1, 1991, (2) such individual departed this state, (3) such individual rendered professional services in another state subsequent to the time that such individual became an inactive health care provider, and (4) such claim was made subsequent to the time that such individual became an inactive health care provider unless such inactive health care provider procured coverage therefor in the same manner as provided for in subsection (m).~~*

~~(n)~~ *~~(p)~~* ~~(o)~~ Notwithstanding anything in article 34 of chapter 40 of the Kansas Statutes Annotated to the contrary, the fund shall in no event be liable for any claims against any health care provider based upon or relating to the health care provider's sexual acts or activity, but in such cases the fund may pay reasonable and necessary expenses for attorney fees incurred in defending the fund against such claim. The fund may recover all or a portion of such expenses for attorney fees if an adverse judgment is returned against the health care provider for damages resulting from the health care provider's sexual acts or activity.

Sec. 4. K.S.A. 1990 Supp. 40-3403b is hereby amended to read as follows: 40-3403b. (a) There is hereby created a health care stabilization fund oversight committee to consist of eleven members, one of whom shall be the commissioner of insurance or the commissioner's designee, one of whom shall be appointed by the president of the state senate, one of whom shall be appointed by the minority leader of the state senate, one of whom shall be appointed

(p)

AMENDMENT NO. 2 - PAGE 14, LINES 12-27

REINSERT SEC. 3, SUBSECTION (o) IN REVISED FORM, AND REDESIGNATE THE SUBSECTION STARTING LINE 27, AS (p)

Note: The Senate amended out original Subsection (o). This reinstates the Subsection, but with clarifying language as suggested by the Insurance Department. The meaning is the same.

(o) Notwithstanding the provisions of subsection (m) or any other provisions in article 34 of chapter 40 of the Kansas Statutes Annotated to the contrary, the fund shall not be liable for any claim against an inactive health care provider relating to any injury or death arising out of the rendering of or failure to render professional services by such inactive health care provider in circumstances where such individual became an inactive health care provider on or after July 1, 1991, and rendered professional services in another state subsequent to the time that such individual became an inactive health care provider, unless such health care provider purchased coverage therefore in the same manner as provided in subsection (m).

REASONS:

(1) Reinstating this paragraph would end Fund tail coverage on July 1, 1991, only for those providers who leave Kansas to practice in another state. IT WOULD NOT effect tail coverage for those who remain in Kansas and retire, become disabled, or die. Their tail coverage would remain in place.

(2) This would not violate any contractual agreement of those who leave. Each year a part of the Fund Surcharge is to cover tail coverage obligations for just that year. No provider has paid for future tail coverage. There exists no contractual agreement that tail will always be covered for participating providers.

(3) Providers leaving the State to practice elsewhere, start out at immature rates (lower premiums on claims made policies) because they have no tail coverage liability--the doctors remaining in Kansas are paying for that Tail!

(4) KAOM has, for some time, questioned that provision. Now that a plan is in place to end the Fund, we think it important to lower Fund liability exposure as much as possible. This is moving toward that end.

(5) It seems inconsistent to us that, on the one hand we undertake programs to attract and keep doctors in rural areas, and on the other, make financially attractive to leave the State to practice in another state.

SB 38—Am.

7

health care provider or self-insurer has qualified for coverage under the provisions of this act, there is hereby established the health care stabilization fund. The fund shall be held in trust in a segregated fund in the state treasury. The commissioner shall administer the fund or contract for the administration of the fund with an insurance company authorized to do business in this state.

(b) (1) There is hereby created a board of governors. The board of governors shall:

(A) Provide technical assistance with respect to administration of the fund;

(B) provide such expertise as the commissioner may reasonably request with respect to evaluation of claims or potential claims;

(C) provide advice, information and testimony to the appropriate licensing or disciplinary authority regarding the qualifications of a health care provider; ~~and~~

(D) prepare and publish, on or before October 1 of each year, a summary of the fund's activity during the preceding fiscal year, including but not limited to the amount collected from surcharges, the highest and lowest surcharges assessed, the amount paid from the fund, the number of judgments paid from the fund, the number of settlements paid from the fund and the amount in the fund at the end of the fiscal year~~;~~ *and*

*(E) have the authority to grant exemptions from the provisions of subsection (m) of this section when a health care provider temporarily leaves the state for the purpose of obtaining additional education or training or to participate in religious, humanitarian or government service programs.*

(2) The board shall consist of 14 persons appointed by the commissioner of insurance, as follows: (A) The commissioner of insurance, or the designee of the commissioner, who shall act as chairperson; (B) two members appointed from the public at large who are not affiliated with any health care provider; (C) three members licensed to practice medicine and surgery in Kansas who are doctors of medicine; (D) three members who are representatives of Kansas hospitals; (E) two members licensed to practice medicine and surgery in Kansas who are doctors of osteopathic medicine; (F) one member licensed to practice chiropractic in Kansas; (G) one member who is a licensed professional nurse authorized to practice as a registered nurse anesthetist; and (H) one member of another category of health care providers. Meetings shall be called by the chairperson or by a written notice signed by three members of the board. The board, in addition to other duties imposed by this act, shall study and evaluate the operation of the fund and make such recommendations to the leg-

AMENDMENT NO. 3 - PAGE 7 - STARTING LINE 28
ADD A NEW SEC. 3(b)(1)(F)

REASONS:

(1) Chairman Bond of the Senate Committee, noted that perhaps exceptions should be made for removing tail coverage when a provider leaves the State to practice for religious, humantarian, or to further his or her education reasons--or to practice in the service of his or her countr

(2) This Amendment makes these exceptions. Tail coverage would not terminate after July 1, 1991, if providers leaving Kansas to practice in another State (or country) did so for these reasons.

(3) The Senate inserted the language in new "(E)", on Page 7 (see at left). Here it would apply to the five year Fund coverage requirement before Fund tail coverage is available.

(4) This proposed amendment would permit the Board of Governors to grant exemptions from tail termination, for leaving the state to practice elsewhere for these reasons.

KAOM SUPPORTS THESE EXEMPTIONS, AS CONSISTENT WITH OUR SEARCH FOR FAIRNESS.

New Subsection (F)

(F) have the authority to grant exemptions from the provisions of subsection (o) of this section when a health care provider leaves the state for the purpose of obtaining additional education or training or to participate in religious, humanitarian or government service programs.

**TESTIMONY**

**HOUSE INSURANCE COMMITTEE**

**MARCH 27, 1991**

I am Gary Robbins, Executive Director of the Kansas Optometric Association. Before I start my remarks, I want to acknowledge the hard work of the Health Care Stabilization Fund Oversight Committee in developing Senate Bill 38. I am appearing in support of Senate Bill 38. During the interim, we appeared before the Health Care Stabilization Fund Oversight Committee. We requested that we be able to withdraw from the Health Care Stabilization Fund for four reasons. First, we have experienced only five claims involving the fund since the inception of the fund in 1976. Second, our malpractice premiums have remained stable in the range of $150 to $500 for basic coverage under the fund. Third, we have over ten companies writing professional liability insurance for optometrists in Kansas. In addition, we are aware of additional companies that will enter the market if we are allowed to withdraw from the fund, including the plan endorsed by the American Optometric Association which is available in the other forty-nine states. If we are allowed to withdraw from the fund, several companies, including the AOA-endorsed plan, will offer occurrence coverage. Fourth, we have not had an availability problem, a high frequency of claims, or a severity of claims which we had feared when the fund was started. Since these problems haven't developed, the Health Care Stabilization Fund Oversight Committee recommended that we be allowed to withdraw from the fund based upon the considerations outlined above. To facilitate our withdrawal from the fund, we agree to pay for prior acts coverage in the private

House Insurance
Attachment 8
March 28, 1991

market or from the fund. From an actuarial standpoint, the impact of allowing optometrists and pharmacists to withdraw from the fund appears to be insignificant and will not impact the solvency of the fund.

In conclusion, we would encourage you to pass Senate Bill 38 for two additional reasons. First, it is important to continue the Health Care Stabilization Fund Oversight Committee and to provide for an actuarial firm which Senate Bill 38 allows. Second, allowing optometrists and pharmacists to withdraw from the fund, will provide valuable experience to the Insurance Department and the Health Care Stabilization Fund Oversight Committee. This process will provide vital information which will assist in the phase-out of the fund at some future date if deemed appropriate.

Thank you for allowing me to appear in support of this legislation.

THE KANSAS PHARMACISTS ASSOCIATION
1308 WEST 10TH
PHONE (913) 232-0439
TOPEKA, KANSAS 66604
ROBERT R. (BOB) WILLIAMS, M.S., C.A.E.
EXECUTIVE DIRECTOR

# TESTIMONY

SB38
House Committee on Insurance

March 27, 1991

My name is Bob Williams, I am the Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address the committee.

Since 1989 the Kansas Pharmacists Association has been working with the Kansas Legislature to exempt pharmacists from the Health Care Stabilization Fund. Actuarial data indicates our absence would have no impact on the funds actuarial soundness.

We, therefore, support the recommended changes found on page 4 (lines 32 and 33); page 5 (lines 38 and 39); page 8 (lines 26, 27, 31 and 32); page 13 (lines 30 through 43); page 9 (line 1); page 16 (lines 35 and 36); and on page 19 (lines 22 through 24) which excludes pharmacists from the Health Care Stabilization Fund.

Additionally, a new subsection (n) would be added to 40-3403 which would allow pharmacists the option to purchase tail coverage from the Fund.

We encourage the committee to support the above-mentioned provisions.

Thank you.

March 28, 1991
House Insurance
Attachment 9

Testimony of Cheryl DeBrot
Representing the Kansas Society for
Respiratory Care (KSRC)
Wednesday, March 27, 1991
before the House Insurance Committee

Relating to the Provisions of SB-38 as amended by the Senate Committee on Financial Institutions and Insurance.

Mr. Chairman, members of the committee, the Kansas Society for Respiratory Care (KSRC) while in general support of the provisions of SB 38 would like to request the addition of language specifically exempting health care providers registered with the State Board of Healing Arts as Respiratory Care Practitioners (RCPs).

Our reasons for this request are threefold:

1. Approximately 95% of our practitioners are hospital based. They are therefore covered by their employers professional liability coverage.

2. Litigation involving Respiratory Care Practitioners in the State of Kansas is essentially non-existent. No cases are known to the KSRC.

3. We believe that inclusion of RCPs under the auspices of this act will result in increased threats of litigation under the concept of the 'deep pockets' theory.

Mr. Chairman, the Kansas Society for Respiratory Care would also like to go on record as joining with our colleagues in the Kansas Medical Society, the Kansas Hospital Association and the Kansas Association of Osteopathic Medicine in support of the cautious approach of preparing for the phase out of the Health Care Stabilization Fund. We believe that a gradual, well thought-out process is mandated when dealing with issues of this import on the parts of the state, the medical health care community and the public.

Mr. Chairman, the Kansas Society for Respiratory Therapy appreciates the opportunity to state our views on these important matters. I am available to answer questions or provide further information at your request.

Thank you.

Insurance
March 28, 1991
Attachment 1

KANSAS HOSPITAL ASSOCIATION

**Donald A. Wilson**
President

Testimony of the Kansas
Hospital Association Before
the House Insurance Committee

March 27, 1991

The Kansas Hospital Association appreciates the opportunity to comment briefly regarding Senate Bill 38. There are currently 137 community hospitals in Kansas. Of that total amount, approximately one-half are government hospitals--owned or operated by a city, county or hospital district. Traditionally, hospitals have contributed approximately 20 percent of the monies paid into the Health Care Stabilization Fund.

Hospitals must maintain a broad perspective when it comes to medical malpractice insurance issues. First, hospitals are obviously directly affected by the cost of their own insurance rates. These costs are part of the hospital's overall financial picture and, therefore, play a big part in the institution's well-being. Second, however, hospitals are just as concerned about how these issues affect individual health care providers. The ability to recruit and retain private practitioners is crucial to the viability of the hospital. Most importantly, these issues have a direct bearing on the level of services a given hospital is able to offer to its patients.

Because of the fact that most members of the committee are already somewhat familiar with these issues, it is not necessary to go into much historical detail. It might be helpful, however, to review several of the recommendations made by Commissioner Bell's Health Care Stabilization Fund Study Group in August of 1988. That group included representatives of both providers and insurers. It was the consensus of the group that:

1) Any plan for Fund termination must be developed on an actuarialy sound basis;

House Insurance
March 28, 1991
Attachment 11

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

2) Any termination plan must coincide with the availability of a reasonable and adequate source of insurance that is available; and
3) Any termination plan must be based on reliable actuarial projections of the Fund's liability.

We think those recommendations remain viable today. The Health Care Stabilization Fund Oversight Committee has worked hard since its inception to make this process an orderly and reasonable one. Because of that committee's work, there is currently much more actuarial data available.

As the committee considers its options with regard to the Health Care Stabilization Fund, we ask that it keep in mind the fact that the Fund was not designed to be easily dismantled. Therefore, Fund termination cannot occur overnight. In fact, a phase-out plan that is too hasty might create more problems than it solves. As the committee is certainly aware, many difficult and complicated issues must be addressed.

No matter what course of action is taken, there will be some problems and some unhappy providers. The Kansas Hospital Association supports the phasing out of the Health Care Stabilization Fund, but it must be done in a way that is reasonable and efficient without inflating premiums to the point where they have an adverse effect on attracting new providers to our state.

Thank you for your consideration of our comments.



2-11

TESTIMONY

REGARDING

SENATE BILL NO. 38

BY

STEVEN SANFORD

SENIOR COUNSEL

HEALTH CARE STABILIZATION FUND

ON BEHALF OF

RON TODD

COMMISSIONER OF INSURANCE

BEFORE

HOUSE COMMITTEE ON INSURANCE

MARCH 27, 1991

House Insurance
March 28, 1991
Attachment 12

I AM STEVEN SANFORD, ATTORNEY FOR THE HEALTH CARE STABILIZATION FUND. THIS TESTIMONY IS PRESENTED ON BEHALF OF RON TODD, COMMISSIONER OF INSURANCE.

SENATE BILL NO. 38 ORIGINATED THROUGH THE WORK OF THE HEALTH CARE STABILIZATION FUND OVERSIGHT COMMITTEE. THE PURPOSE OF THE BILL IS TO FACILITATE THE ORDERLY DISSOLUTION OF THE HEALTH CARE STABILIZATION FUND. ITS MAJOR COMPONENTS ARE AS FOLLOWS:

1. COLLECTION OF ADEQUATE MONIES TO FUND ALL ANTICIPATED LIABILITIES BASED ON THE ASSUMPTION THAT THE FUND WOULD TERMINATE ON JULY 1, 1994 AND WITHOUT PROVIDING TAIL COVERAGE AFTER THAT DATE.

2. PERMIT THE ORDERLY WITHDRAWAL OF OPTOMETRISTS AND PHARMACISTS FROM THE HEALTH CARE PROVIDER INSURANCE AVAILABILITY ACT. THESE TWO PROVIDER GROUPS REQUESTED PERMISSION TO WITHDRAW BECAUSE THEY BELIEVE ADEQUATE COVERAGE IN THE PRIVATE MARKET IS AVAILABLE.

3. EXTEND THE AUTHORITY OF THE HEALTH CARE STABILIZATION FUND OVERSIGHT COMMITTEE IN ORDER TO STUDY AND RECOMMEND ADDITIONAL STEPS NECESSARY TO PHASING OUT THE HEALTH CARE STABILIZATION FUND. IN THIS REGARD, SENATE BILL NO. 38 MERELY SETS THE STAGE FOR PHASING OUT THE FUND. A NUMBER OF SIGNIFICANT ISSUES HAVE YET TO BE ADDRESSED.

SENATE BILL NO. 38, AS AMENDED BY SENATE COMMITTEE, CONFORMS TO THESE OBJECTIVES. THE SENATE COMMITTEE DID DELETE THE OVERSIGHT COMMITTEE'S RECOMMENDATION REGARDING TAIL COVERAGE AND THE REFERENCE TO A SPECIFIC DATE FOR ENDING MANDATORY INSURANCE COVERAGE WAS REMOVED. THE REMAINING AMENDMENTS TO THE BILL WERE TECHNICAL IN NATURE AND WERE DRAFTED BY, OR AT THE REQUEST OF, THE KANSAS INSURANCE DEPARTMENT.

IN OUR TESTIMONY TO THE SENATE COMMITTEE THE KANSAS INSURANCE DEPARTMENT MADE THE FOLLOWING RECOMMENDATIONS.

1. INCLUSION OF A DEFINITE PHASE-OUT DATE SHOULD BE AVOIDED UNTIL THE FOLLOWING ISSUES ARE STUDIED AND RESOLVED.

   A. THE STATUS OF THE HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN. UPON TERMINATION OF THE HEALTH CARE STABILIZATION FUND, THE PLAN EITHER WILL HAVE TO BE DISCONTINUED OR RESTRUCTURED.

   B. LEGISLATION MUST BE DRAFTED TO DEFINE THE HEALTH CARE STABILIZATION FUND'S LIABILITIES FOR EXISTING CLAIMS AND SUITS, AND FOR CLAIMS AND SUITS FILED AFTER THE PHASE-OUT DATE BUT ARISING OUT OF INCIDENTS PRIOR TO THIS DATE.

C. LEGISLATION WILL ALSO BE REQUIRED TO REPLACE THE CURRENT METHOD OF INSURING RESIDENCY AND FACULTY PROGRAMS.

2. CONSIDERATION SHOULD ALSO BE GIVEN TO THE AVAILABILITY OF INSURANCE IN THE PRIVATE MARKETS. AT THE PRESENT TIME THE DEPARTMENT CAN NEITHER PREDICT NOR ASSURE HEALTH CARE PROVIDERS THAT INSURANCE WILL BE AVAILABLE FROM THE PRIVATE MARKETS.

FINALLY, THE DEPARTMENT WOULD CALL THE COMMITTEE'S ATTENTION TO THE LANGUAGE ON PAGES 17 AND 18 OF THE BILL REGARDING SURCHARGE COLLECTION. THE PURPOSE OF THE AMENDED LANGUAGE AS INDICATED BY THE OVERSIGHT COMMITTEE IS TO PERMIT THE DEPARTMENT TO COLLECT ADEQUATE SURCHARGE REVENUE TO COVER ALL FUND LIABILITIES AS OF JULY 1, 1994. THE LANGUAGE USED SEEMS TO CONTEMPLATE INCLUDING THE COLLECTION OF A "MARGIN" OR "CUSHION" TO MAKE CERTAIN ADEQUATE FUNDS ARE ON HAND WITHOUT THE NEED TO COLLECT ADDITIONAL REVENUE AFTER JULY 1, 1994. THE OVERSIGHT COMMITTEE CONCLUDED THAT IT WOULD BE INAPPROPRIATE TO COLLECT ADDITIONAL REVENUE FROM PROVIDERS NO LONGER BENEFITTING FROM THE FUND.

THE DEPARTMENT NOTES THAT THE LANGUAGE OF THIS SECTION DOES NOT EXPRESSLY REFER TO THE COLLECTION OF A MARGIN OR CUSHION AND THEREFORE THIS COMMITTEE MAY WISH TO CLARIFY THIS ISSUE. OUR CONCERN IS BASED ON THE FACT THAT EVEN THOUGH THE INFERENCE OF ASSESSING A HIGHER SURCHARGE THAN IS IMMEDIATELY NECESSARY IS CONTAINED IN THE BILL, NO STANDARDS OR REQUIREMENTS ARE PROVIDED AS

TO HOW THE ADDITIONAL AMOUNT IS TO BE DETERMINED OR WHAT ITS SPECIFIC PURPOSE IS. FOR EXAMPLE, IF COLLECTION OF THIS MARGIN OR CUSHION IS PREDICATED ON THE ASSUMPTION THAT THE FUND WILL TERMINATE WITHOUT PROVIDING TAIL COVERAGE AND IF SUBSEQUENT LEGISLATION DOES NOT MAINTAIN THIS ASSUMPTION, THE NECESSARY MONEY TO TERMINATE THE FUND ON JULY 1, 1994 WILL NOT BE AVAILABLE BECAUSE THE DEPARTMENT WILL NOT BE ABLE TO PREDICT THIS LEGISLATIVE CHANGE. UNTIL LEGISLATION IS ENACTED CONTAINING STANDARDS REGARDING THE MANNER IN WHICH THE FUND TERMINATES, THE DEPARTMENT DOES NOT INTEND TO COLLECT AN ADDITIONAL SURCHARGE.

I APPRECIATE THE OPPORTUNITY TO COME BEFORE THE COMMITTEE AND WILL STAND FOR QUESTIONS.



5713