Approved 2/11/91
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS & INSURANCE.

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

9:00 a.m./~~pm~~ on THURSDAY FEBRUARY 7, 1991 in room 529-S of the Capitol.

All members were present ~~except~~

Committee staff present:
Bill Wolff, Legislative Research
Bill Edds, Revisors Office
Fred Carman, Revisors Office
Louise Bobo, Secretary

Conferees appearing before the committee:
Tom Bell, Kansas Hospital Association
Harold E. Riehm, Kansas Association of Osteopathic Medicine
Ted Fay, Kansas Insurance Department
Daniel K. Roberts, Health Care Stabilization Fund, Wichita
Bob Frey, Kansas Trial Lawyers Association

Chairman Bond called the meeting to order at 9:10 a.m.

Tom Bell, Kansas Hospital Association, informed the committee that his membership agreed with the stand of the Kansas Medical Society--they are in agreement with the phase-out of the Fund but think it should be actuarially sound and that the termination date should be flexible. Mr. Bell stated that the main issue of hospitals is how the phaseout of the Fund will affect recruitment of doctors and, thus, the service the hospitals are able to offer. (Attachment 1)

Harold Riehm, Kansas Assocition of Osteopathic Medicine, informed the committee that his organization supported SB 38 with minor exceptions. He supports termination at the earliest time practical and also supports an end to "tail coverage" for doctors who leave the state after 6/30/91, with several exceptions. Mr. Riehm proposed a conceptual amendment to SB 38 to specifically exempt those leaving the state to engage in a medical education program, religious pursuits, or military service. (Attachment 2)

Chairman Bond requested of Mr. Riehm that he get together with Jerry Slaughter, Kansas Medical Society, and Bill Edds, Revisors Office, to work out the language concerning the amendment he suggested.

Ted Fay, Kansas Insurance Department, informed the committee that his Department intended to support the phaseout of the Health Care Stabilization Fund if that is the wish of most health care providers and if a viable source for coverage can be found. However, he added, there does not seem to be a consensus concerning this issue. Mr. Fay stressed that the Fund should not be eliminated without assurance that high limits coverage will be available. He said there was no assurance of available coverage in the private market because Kansas has a small population and a poor claims atmosphere. (Attachment 3) Mr. Fay suggested several changes on SB 38. The first amendment would retain the original language defining health care providers but allow pharmacists and optometrists to remove themselves from the Fund after 7/1/91. Also, the Insurance Department suggest clarifying the language on p. 13, subsection (o) to reflect the Oversight Committee's intent not to provide free tail coverage to providers who leave Kansas to practice in other states. (Attachment 4)

During a brief discussion, Mr. Fay assured committee members that the Fund has worked and has done what it was expected to do. He reemphasized that it was hard to get coverage in Kansas, not because we have a Fund but because Kansas is a small market and it is not worth the company's time.

Dr. Daniel Roberts, Health Care Stabilization Fund, appeared before the committee in opposition to SB 38. Dr. Roberts provided written testimony and a slide presentation to support his contention that the Fund should continue. He stated that the Fund was on a sound fiscal basis, that surcharge rates could be lowered even further, and that the cost of the phaseout would make surcharges almost unbearable. Mr. Roberts said that the HCSF was mandatory and monopolistic and if it were done away with we run the risk of selective pooling and a residual market. (Attachment 5)

Bob Frey, Kansas Trial Lawyers, informed the committee that his membership could not support SB 38 in its present form. He added that most of the testifiers had qualified their support in one way or another. Mr. Frey advised that even though they would like to see the HCSF eliminated, they would also like to have the mandatory insurance provision remain in the law. He said the Legislature should consider the constitutional implications of eliminating mandatory coverage. He suggested that some providers would go uninsured if SB 38 becomes law and that the SRS would be asked to pay medical bills and provide other services. (Attachment 6)

A brief discussion followed. A committee member inquired how the Fund had served injured people. Mr. Frey said that the system had worked in providing a defense for the providers and had assisted in paying off judgments. A committee member inquired why the committee has not heard from the insurance industry. The committee chairman agreed that they should be here.

Katherine Clark, Kansas Association of Nurse Anesthetists, in absentia, provided written testimony which was given to each committee member. (Attachment 7)

Senator Francisco requested the committee to allow introduction of a bill almost idential to HB 2321 introduced during the 1990 session and relating to "Truth in Saving."

Senator Strick made a motion to allow this bill introduction. Senator Parrish seconded the motion and the motion carried.

The meeting adjourned at 10:00 a.m.

GUEST LIST

COMMITTEE: FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE DATE: Thurs. Feb. 7, 91

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
L.M. Cornish	Topeka	Ks P/C Ins Comp.
Kurt Scott	Topeka	KaMMCO
Steve Sanford	Topeka	Ks Ins. Dept
DAN Roberts, M.D.	Wichita	Bd of Gov. HCSP
Ted Fully	Topeka	KMD
Bob Hayes	TOPEKA	KMD
Arnold Kiehm	TOPEKA	KAOM
Lori Callahan	Topeka	kammco
Chip Wheelen	Topeka	Ks Medical Soc.
Marta Greenberg	Topeka	kammco
Charles Walker	Topeka	SRS
Mark Hatch	TOPEKA	INTERN/McCLURE
R C Frey	TOPEKA	KTLA
Gary Robbins	11	KsOpt assn
Bob Clawson	✓	SRS
Melinda Conard	KC MO	INTERN / Anderson

KANSAS HOSPITAL ASSOCIATION

Donald A. Wilson
President

Testimony of the Kansas
Hospital Association Before
the Senate Committee on
Financial Institutions
and Insurance

February 5, 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;

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Attachment 1

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. That actuarial basis has helped form the recommendation to commence the Fund's phase out in 1994.

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.

Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

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

February 6, 1991

To: Members, Senate Financial Institutions & Insurance Committee

From: Harold Riehm, Ks. Assn. of Osteopathic Medicine

Subject: Senate Bill 68 - Planned Termination of the "Fund"

I appear today in support of S.B. 38, with minor exceptions. Most of my testimony will address two major changes encompassed in the Bill. Other than that, KAOM offers these brief observations.

(1) KAOM expresses its appreciation to those who served on the Fund Oversight Committee. It was a positive example of the merits of "mixed Committee" operation, including representation from the insurance industry, the Insurance Department, legislators and providers. KAOM offered specific recommendations to the Committee on two occasions.

(2) We concur with provisions in the Bill that would end mandatory professional liability insurance for providers, the termination of tail coverage except for inactive providers already in the system on June 30, 1994 (target date of Fund termination), and the continuation of the Oversight Committee to make periodic reviews of progress toward Fund termination in light of future developments.

(3) We also are aware that a number of very important matters remain to be addressed. Certainly among the most complex of these are how to restructure the JUA and the administration of the Fund liabilities after 1994 (for providers inactive prior to the date of termination).

KAOM now offers its views on two key provisions of the Bill.

KAOM SUPPORTS TERMINATION OF THE FUND AT THE EARLIEST TIME PRACTICAL. WE VIEW THE JUNE 30, 1994 TARGET DATE AS A REASONABLE OBJECTIVE

KAOM continues to strongly support termination of the Fund.

Even though, as the actuary suggests, the Fund is approaching, or is at a position of actuarial soundness, and, even though some remedial changes have been made in recent years to correct features of Fund operation to preclude previous pitfalls from reocurring, WE THINK

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Attachment 2

THAT THE PRESENT FAVORABLE CONDITION OF THE FUND OFFERS THE WINDOW OF OPPORTUNITY FOR TERMINATION THAT HAS OFTEN BEEN DISCUSSED THROUGHOUT RECENT YEARS. The "softness" of the professional liability milieu at the present time, is subject to rapid change--a fact we know all too well. Most all observers of professional liability trends suggest a cyclical progression. Now we appear to be in a part of the cycle favorable to providers and consumers in the market. Five years ago that was not the case; FIVE YEARS FROM NOW it well could not be the case. It is tempting for current favor to shorten the memory of the lamentable past!

Kansas, we think, can take pride in having established a Fund to meet a set of specific problems--initially those of availability of an insurance product. We can also take pride, that through some sacrifices by provider participants, we weathered another major problem--insurance cost. We think we now need to take pride that we seized upon the window of opportunity apparently not present in any other State that has experimented with a "Fund", and to terminate this experiment with a minimum of disruption to the insurance coverage of participating providers.

We think it important that we keep in mind that as valid as is the question of how the Fund contributed to solving a set of problems, so also is the question of the impact the existence of the Fund had on the market correcting itself. If indeed there was a negative impact upon, for example, companies' willingness to enter the Kansas market because of the Fund, might not this again be true were conditional to repeat and the Fund remain in existence? We can only speculate with might happen. We think it is time to return to the private market for providing insurance products to health care providers.

KAOM SUPPORTS AN END TO TAIL COVERAGE FOR PROVIDERS WHO LEAVE THE STATE TO PRACTICE ELSEWHERE AFTER JUNE 30, 1991, WITH EXCEPTIONS.

In KAOM's written and verbal presentation to the Oversight Committee on September 6, 1990, we urged an end to tail coverage effective June 30, 1991, for providers leaving the State to practice elsewhere. We reaffirm our support for this provision, with an important exception.

We made this recommendation primarily for two reasons. First, we think it important that in the interim period between now and planned Fund termination, that we take every step feasible and practical to lower Fund exposure. This, we think, contributes to that objective.

Second, and the more compelling of the reasons, we think there is a basic matter of fairness involved. We have always had reservations about doctors who remain in Kansas to practice, being assessed the costs of tail coverage for those who move to practice outside Kansas. On the one hand we were implementing numerous programs to attract physicians to the State; on the other we established favorable conditions for them to exit the State.

It has been stated that to end tail on this date for those who practice outside Kansas, would discourage persons from entering Kansas to practice. Yet such persons would not be eligible for tail coverage anyway since addition of the five year rule in 1988.

It also has been stated that this change would lead to a mass exodus prior to July 1, 1991. This may or may not be true. We think it not true. Similarly we doubt that there would be mass retirements by physicians prior to July 1, 1994, to obtain tail coverage before termination of tail as proposed in S.B. 38. It should also be noted that the time available between passage of this Bill and the June 30, 1991 date, is minimal.

A third observation we think is valid and needs attention. That is that it would be unfair to providers who seek to enhance their medical education at a location outside the State, to require them to assume tail responsibility. This could be residency training, a fellowship, etc. Therefore, we suggest that S.B. 38 be amended to cover such contingencies. Conceptually, we suggest this:

CONCEPTUAL AMENDMENT TO S.B. 38

(1) That language be inserted to specifically exempt an end to Fund tail coverage as of June 30, 1991, for those leaving the State to practice elsewhere, provided they are primarily engaged in a medical education program, religious medical pursuits, or civilian or military service to their country. Such exceptions would be submitted to The Board of Governors of the Fund for verification and approval.

If the issue is one of "fairness"--and we think it is, then we also think it more important to consider the fairness to the many physicians and other providers who remain in Kansas to practice, rather than just the fairness to those who choose to practice outside the State and think the Fund has a commitment to cover their tail responsibilities.

Again, KAOM is aware that many issues remain to be addressed. We look forward to continuing dialogue among all interested parties.

Thank you for this opportunity to testify on Senate Bill 38.

TESTIMONY

REGARDING

SENATE BILL NO. 38

BY

TED FAY

CHIEF ATTORNEY

ON BEHALF OF

RON TODD

COMMISSIONER OF INSURANCE

BEFORE

SENATE COMMITTEE ON FINANCIAL

INSTITUTIONS AND INSURANCE

FEBRUARY 6, 1991

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2/7/91
Attachment 3

I AM TED FAY, CHIEF ATTORNEY FOR THE KANSAS INSURANCE DEPARTMENT. I AM HERE TODAY TO TESTIFY ON BEHALF OF RON TODD, THE COMMISSIONER OF INSURANCE, AS TO SENATE BILL NO. 38.

THE INSURANCE DEPARTMENT, ON A NUMBER OF PRIOR OCCASIONS, HAS INDICATED ITS INTENT TO SUPPORT THE PHASEOUT OF THE HEALTH CARE STABILIZATION FUND IF THAT IS THE DESIRE OF MOST HEALTH CARE PROVIDERS. THIS WAS THE POSITION OF FLETCHER BELL AND CONTINUES TO BE THE DEPARTMENT POSITION UNDER RON TODD. THE FUND WAS ESTABLISHED IN 1976 LARGELY TO ADDRESS THE PROBLEMS WITH AVAILBILITY THAT FACED HEALTH CARE PROVIDERS IN KANSAS IN THE EARLY AND MID 1970's. IF HEALTH CARE PROVIDERS TODAY BELIEVE THE ATMOSPHERE HAS CHANGED AND THAT THE FUND HAS OUTLIVED ITS USEFULNESS, THE DEPARTMENT WILL HONOR THEIR WISHES.

WE MUST NOTE, HOWEVER, THAT THE HEALTH CARE PROVIDERS ARE NOT OF ONE VOICE CONCERNING THIS ISSUE. THERE IS A SPLIT OF OPINION AMONG HEALTH CARE PROVIDERS, PARTICULARLY AMONG PHYSICIANS. WHILE IT IS

PERHAPS AN OVERSIMPLIFICATION, HIGH RISK PROVIDERS SEEM CONCERNED THAT WITHOUT THE FUND, THE AVAILABILITY PROBLEMS OF THE 1970's MAY REAPPEAR, ONLY THIS TIME THEY MAY ALSO BE ACCOMPANIED BY AFFORDABILITY PROBLEMS AS WELL. THOSE PHYSICIANS IN HIGH RISK SPECIALTIES WHO WERE IN PRACTICE BACK IN 1976 REMEMBER THE TERRIBLE PROBLEMS THAT EXISTED AT THAT TIME AND SEEM RELUCTANT TO ELIMINATE THE HEALTH CARE STABILIZATION FUND BEFORE THE ALTERNATIVES ARE KNOWN.

IT MAY APPEAR THAT WE ARE BRINGING UP THESE POINTS TO PROTECT OUR BUREAUCRATIC TURF. NOTHING IS FURTHER FROM THE TRUTH. OUR DEPARTMENT HOSTED SOME OF THE EARLY MEETINGS HELD WITH REPRESENTATIVES OF HEALTH CARE PROVIDER GROUPS, WHEN IT APPEARED THAT NONE OF THE LEGISLATIVE TORT REFORM MEASURES WOULD BE UPHELD BY THE SUPREME COURT. IN THOSE EARLY MEETINGS, HEALTH CARE PROVIDERS FEARED THAT THE SYSTEM WAS OUT OF CONTROL AS JUDGMENTS SPIRALED EVER HIGHER. HEALTH CARE PROVIDERS WERE LOCKED INTO A MANDATORY PROFESSIONAL LIABILITY SYSTEM THAT REQUIRED THEM TO CONTINUE TO PURCHASE COVERAGE REGARDLESS OF COST OR, ALTERNATIVELY, TO TERMINATE

THE SERVICES THAT CAUSED THE HIGH MEDICAL MALPRACTICE COVERAGE COSTS. COMMUNITIES WERE OFTEN LEFT WITHOUT ESSENTIAL MEDICAL SERVICES. THERE WAS A CONSIDERABLE AMOUNT OF PESSIMISM BY ALL PARTIES DURING THOSE EARLY MEETINGS. THE ONLY SOLUTION SEEMED TO REQUIRE THE ELIMINATION OF MANDATORY INSURANCE SO THAT FAMILY PRACTICE PHYSICIANS IN SMALL TOWNS COULD ELECT TO PRACTICE WITHOUT INSURANCE IF THE COST OF INSURANCE AND HEALTH CARE STABILIZATION FUND COVERAGE CONTINUED TO SOAR. FLETCHER BELL AND RON TODD WERE OF THE OPINION THAT THE FUND COULD NOT CONTINUE ON A SOUND FOOTING WITHOUT MANDATORY INSURANCE, AND IF MANDATORY INSURANCE WAS ELIMINATED, THE FUND ALSO NEEDED TO BE PHASED OUT. OTHER SOLUTIONS ADDRESSED IN THOSE EARLY MEETINGS INCLUDED A CONSTITUTIONAL AMENDMENT TO ESTABLISH MINIMUM TORT REFORM MEASURES IN KANSAS. AS IT TURNED OUT, AFTER THE MEETINGS IN THE DEPARTMENT BUT BEFORE THE SENATE TOOK ACTION ON A CONSTITUTIONAL MEASURE, THE SUPREME COURT REVERSED ITS EARLIER POSITION ON ONE OF THE CAPS AND THE AMENDMENT PROVED TO BE UNNECESSARY.

DURING THESE MEETINGS, THE DEPARTMENT'S POSITION NEVER WAIVERED. IF THE PROVIDERS WISHED TO ELIMINATE THE FUND, WE WOULD HONOR THEIR DESIRES PROVIDED THERE WAS SOME PROOF THAT INSURANCE WOULD BE AVAILABLE TO REPLACE FUND COVERAGE AND IF THE FUND COULD BE TERMINATED IN AN ORDERLY FASHION AND WITHOUT ADDITIONAL COST TO THE GENERAL PUBLIC.

WE ALSO STRONGLY RECOMMENDED THE ESTABLISHMENT OF AN INSURANCE COMPANY BY THE MEMBERS OF THE KANSAS MEDICAL SOCIETY OR BY ANY OTHER HEALTH CARE PROVIDER GROUP. IT WAS THE DEPARTMENT'S BELIEF THAT A PROVIDER OWNED COMPANYWOULD HELP ADDRESS FUTURE INSURANCE AVAILABILITY PROBLEMS IN KANSAS. WE ARE EXTREMELY PLEASED THAT SUCH A COMPANY IS NOW IN PLACE AND APPEARS TO BE GAINING AN IMPORTANT POSITION IN THIS STATE. UNFORTUNATELY, WE ARE NOT CONVINCED THAT THE PRESENCE OF KAMMCO NECESSARILY SOLVES THE AVAILABILITY QUESTION FOR HIGH RISK PROVIDERS NEEDING HIGH LIMITS COVERAGE.

WE WANT TO MAKE CERTAIN THAT IF THE FUND IS ELIMINATED, HEALTH CARE PROVIDERS UNDERSTAND THE RISKS INVOLVED. TO THIS END, THE DEPARTMENT BELIEVES THAT HEALTH CARE PROVIDERS NEED TO KNOW EXACTLY WHAT WILL REPLACE THE FUND. AS YOU KNOW, THE FUND NOT ONLY PROVIDES EXCESS COVAREGE, BUT ALSO UNDERWRITES THE HEALTH CARE PROVIDER AVAILABILITY PLAN (THE PLAN). THE PLAN PROVIDES THE PRIMARY, $200,000, COVERAGE FOR ANY PROVIDER UNABLE TO OBTAIN COVERAGE IN THE PRIVATE MARKETS. IF THE FUND IS ELIMINATED, THE FUND CANNOT UNDERWRITE THE PLAN. ONE OF THE MOST DIFFICULT PROBLEMS WILL BE WHETHER TO RETAIN THE PLAN, AND IF RETAINED, HOW TO UNDERWRITE IT IN THE FUTURE. BEFORE PROVIDERS CAN MAKE AN INTELLIGENT DECISION ABOUT THE PHASEOUT OF THE FUND, IT IS IMPORTANT THEY KNOW WHETHER THE PLAN WILL ALSO BE ELIMINATED. IT IS IMPORTANT THAT THE PUBLIC BE INFORMED WHO WILL BEAR THE COSTS OF FUNDING THE NEW PLAN. IN OUR OPINION, IF THERE IS TO BE A NEW PLAN, IT WILL HAVE TO BE UNDERWRITTEN EITHER BY THE TAXPAYERS OR BY THE ENTIRE FIRE & CASUALTY INSURANCE INDUSTRY. THE MALPRACTICE WRITERS IN KANSAS ARE SIMPLY TOO SMALL TO PRATICABLY FUND POTENTIAL LOSSES BY THE PLAN. WE ASSUME THAT THE LEGISLATURE

DOES NOT WANT THE COST OF THE PLAN TO BE FUNDED, DIRECTLY OR INDIRECTLY, BY TAX REVENUES.

COMMISSIONER TODD IS VIRTUALLY CERTAIN THAT HIGH LIMITS MEDICAL MALPRACTICE COVERAGE WILL NOT BE IMMEDIATELY AVAILABLE IN THE PRIVATE MARKETS FOR MANY KANSAS HEALTH CARE PROVIDERS. IT IS TRUE THAT OTHER STATES WITHOUT FUNDS SEEM TO SURVIVE, BUT KANSAS HAS A MUCH SMALLER POPULATION AND A WORSE CLAIMS ATMOSPHERE. THIS COMBINATION WILL MOST LIKELY DISCOURAGE HIGH LIMIT MARKETS FROM DEVELOPING QUICKLY IN KANSAS FOR MANY PROVIDERS, PARTICULARLY THOSE PRACTICING IN HIGH RISK SPECIALTIES.

THE HEALTH CARE STABILIZATION FUND HAS SERVED KANSAS VERY WELL SINCE 1976. THE FUND PRESENTLY HAS MORE THAN $130 MILLION IN ASSETS, MAKING THE FUND ONE OF THE FEW FUNDS IN THE UNITED STATES WHICH DEMONSTRATE ANY DEGREE OF SOLVENCY. THIS HAS BEEN ACCOMPLISHED THROUGH THE COOPERATIVE EFFORTS OF HEALTH CARE PROVIDERS, THE INSURANCE DEPARTMENT, AND THE LEGISLATURE. THE SOLVENCY OF THE FUND

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IS PARTICULARLY NOTABLE WHEN IT IS ONCE AGAIN REMEMBERED THAT THE FUND ALSO UNDERWRITES THE PLAN, AND THAT THE PLAN IS ALSO ONE OF THE ONLY PLANS IN THE UNITED STATES THAT IS SOLVENT.

THERE IS NO DISAGREEMENT, HEALTH CARE PROVIDERS WILL NOT BE ABLE TO REPLACE FUND COVERAGE FOR LESS MONEY OVER THE LONG TERM. THE FUND HAS OPERATED WITH VERY LOW OVERHEAD. ALMOST ALL OF THE FUND ASSETS ARE USED TO PAY CLAIMS. UNLESS THERE IS A MARKED IMPROVEMENT IN THE CLAIMS CLIMATE IN KANSAS, THERE IS NO REASON TO BELIEVE CLAIM COSTS CAN BE REDUCED. INDEED, THERE IS EVERY REASON TO BELIEVE THAT CLAIM COSTS WILL PUSH EVEN HIGHER WITHOUT THE FUND. THE COURTS WENT THROUGH A PERIOD WHEN LITTLE CONSIDERATION WAS PAID TO THE MALPRACTICE CLIMATE AND HOW THAT WAS AFFECTING HEALTH CARE COSTS IN KANSAS. RECENTLY, THERE HAS BEEN SOME IMPROVEMENT IN THE JUDICIAL ATMOSPHERE. THE COURTS SEEM TO BE STRIVING MORE AND MORE FOR A REASONABLE BALANCE, AND IN A FEW AREAS THE FUND -- AS A STATUTORY CREATION -- RECEIVES SOME BENEFITS NOT AVAILABLE TO PRIVATE INSURERS.

SINCE THE COST OF INSURANCE COVERAGE IS SURE TO INCREASE IF THE FUND IS ELIMINATED, AND SINCE INSURANCE IS LIKELY TO BE UNAVAILABLE TO SOME HIGH RISK PROVIDERS, AND SINCE THERE HAS BEEN NO DECISION AS TO HOW AVAILABILITY PROBLEMS WILL BE FINANCED IN THE FUTURE, THIS COMMITTEE MAY WISH TO BE CAUTIOUS AS IT SETS INTO MOTION A STATUTE TERMINATING THE FUND WITHOUT REGARD TO THE CONSEQUENCES OF THAT ACTION.

IN SUMMARY,

1. THE WISHES OF HEALTH CARE PROVIDERS CONCERNING THE TERMINATION OF THE FUND ARE IMPORTANT. THERE IS, HOWEVER, A DIVISION AMONG HEALTH CARE PROVIDERS, AND THE FUND SHOULD NOT BE ELIMINATED WITHOUT CAREFUL CONSIDERATION OF ALL HEALTH CARE PROVIDERS' CONCERNS.

2. A NUMBER OF IMPORTANT DECISIONS, SUCH AS THE FUTURE STATUS OF THE PLAN, ARE YET TO BE DECIDED. UNTIL THESE IMPORTANT QUESTIONS ARE DETERMINED, THERE IS NOT SUFFICIENT INFORMATION AVAILABLE FOR EITHER

HEALTH CARE PROVIDERS OR THE LEGISLATURE TO DETERMINE THE FULL IMPACT OF THE ELIMINATION OF THE FUND.

3. ALTHOUGH KAMMCO HAS GREATLY IMPROVED THE AVAILABILITY OF MARKETS IN KANSAS, THERE IS NO EVIDENCE THAT HIGH LIMITS COVERAGE WILL BE AVAILABLE TO ALL HEALTH CARE PROVIDERS SHOULD THE FUND BE ELIMINATED.

4. WHATEVER ELSE IS DECIDED, THE COST TO PROVIDERS TO REPLACE FUND COVERAGE WILL BE HIGHER.

5. SOME PROVIDERS, SUCH AS OPTOMETRISTS AND PHARMACISTS, APPEAR TO HAVE NO AVAILABILITY OR AFFORDABILITY PROBLEMS, AND SHOULD BE ALLOWED TO WITHDRAW FROM THE FUND IF THEY CAN DO SO WITHOUT INCREASING THE LIABILITIES OF ANY OF THE REMAINING MEMBERS OF THE FUND. BY PREVIOUS LETTER, THE DEPARTMENT HAS SUGGESTED SOME TECHNICAL CHANGES TO SENATE BILL NO. 38 TO CLARIFY THE WITHDRAWAL OF OPTOMETRISTS AND PHARMACISTS. WE HAVE ALSO SUGGESTED A TECHNICAL CHANGE IN THE LANGUAGE ALTERING THE TAIL COVERAGE PROVISIONS.

STATE OF KANSAS

KANSAS
INSURANCE DEPARTMENT

420 S.W. 9th
Topeka 66612-1678 913-296-3071

1-800-432-2484
Consumer Assistance
Division calls only

RON TODD
Commissioner

February 4, 1991

The Honorable Richard L. Bond
Senator, Eighth District
State of Kansas
Capitol, 128-S

RE: Senate Bill No. 38

Dear Senator Bond:

Please find enclosed our suggested changes on Senate Bill No. 38.

On page 1, we suggest that the original language defining health care providers be retained in order to preserve our authority to continue providing coverage to optometrists and pharmacists who become inactive prior to July 1, 1991. In order to accomplish the removal of optometrists and pharmacists after July 1, 1991, we have added appropriate language to the mandatory insurance provisions, pp. 4-5; liability provision, p. 13, subsection (n); and fund compliance provisions, p. 16.

Finally, we suggest that the language on p. 13, subsection (o) be clarified to reflect the Oversight Committee's intent not to provide free tail coverage to providers who leave Kansas to practice in other states.

Please let me know if this language is not satisfactory.

Very truly yours,

Ron Todd
Commissioner of Insurance

Steven R. Sanford, Attorney
Health Care Stabilization Fund

SRS:jc
cc: Dr. William Wolff, Legislative Analyst
Jerry Slaughter, Executive Director
Kansas Medical Society

LE/4218

H + T
2/7/91
Attachment 4

Session of 1991

SENATE BILL No. 38

By Senators Bond and Rock

1-16

AN ACT amending the health care provider insurance availability act; concerning liability of the health care stabilization fund; amending K.S.A. 1990 Supp. 40-3401, 40-3402, 40-3403, 40-3403b and 40-3404 and repealing the existing sections.

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

Section 1. K.S.A. 1990 Supp. 40-3401 is hereby amended to read as follows: 40-3401. As used in this act the following terms shall have the meanings respectively ascribed to them herein.

(a) "Applicant" means any health care provider.

(b) "Basic coverage" means a policy of professional liability insurance required to be maintained by each health care provider pursuant to the provisions of subsection (a) or (b) of K.S.A. 40-3402 and amendments thereto.

(c) "Commissioner" means the commissioner of insurance.

(d) "Fiscal year" means the year commencing on the effective date of this act and each year, commencing on the first day of that month, thereafter.

(e) "Fund" means the health care stabilization fund established pursuant to subsection (a) of K.S.A. 40-3403 and amendments thereto.

(f) "Health care provider" means a person licensed to practice any branch of the healing arts by the state board of healing arts, a person who holds a temporary permit to practice any branch of the healing arts issued by the state board of healing arts, a person engaged in a postgraduate training program approved by the state board of healing arts, a medical care facility licensed by the department of health and environment, a health maintenance organization issued a certificate of authority by the commissioner of insurance, ~~an optometrist licensed by the board of examiners in optometry,~~ a podiatrist licensed by the state board of healing arts, ~~a pharmacist licensed by the state board of pharmacy,~~ a licensed professional nurse who is authorized to practice as a registered nurse anesthetist, a licensed professional nurse who has been granted a temporary authorization to practice nurse anesthesia under K.S.A. 1989 Supp. 65-1153 and amendments thereto, a professional

(Restore the original language of this subsection in order to retain authority to provide coverage to optometrists and pharmacists who qualify as inactive providers prior to July 1, 1991)

corporation organized pursuant to the professional corporation law of Kansas by persons who are authorized by such law to form such a corporation and who are health care providers as defined by this subsection, a partnership of persons who are health care providers under this subsection, a Kansas not-for-profit corporation organized for the purpose of rendering professional services by persons who are health care providers as defined by this subsection, a dentist certified by the state board of healing arts to administer anesthetics under K.S.A. 65-2899 and amendments thereto, a physical therapist registered by the state board of healing arts, a psychiatric hospital licensed under K.S.A. 75-3307b and amendments thereto, or a mental health center or mental health clinic licensed by the secretary of social and rehabilitation services, except that health care provider does not include (1) any state institution for the mentally retarded, (2) any state psychiatric hospital or (3) any person holding an exempt license issued by the state board of healing arts.

(g) "Inactive health care provider" means a person or other entity who purchased basic coverage or qualified as a self-insurer on or subsequent to the effective date of this act but who, at the time a claim is made for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider, does not have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider.

(h) "Insurer" means any corporation, association, reciprocal exchange, inter-insurer and any other legal entity authorized to write bodily injury or property damage liability insurance in this state, including workers compensation and automobile liability insurance, pursuant to the provisions of the acts contained in article 9, 11, 12 or 16 of chapter 40 of Kansas Statutes Annotated.

(i) "Plan" means the operating and administrative rules and procedures developed by insurers and rating organizations or the commissioner to make professional liability insurance available to health care providers.

(j) "Professional liability insurance" means insurance providing coverage for legal liability arising out of the performance of professional services rendered or which should have been rendered by a health care provider.

(k) "Rating organization" means a corporation, an unincorporated association, a partnership or an individual licensed pursuant to K.S.A. 40-930 or 40-1114, or both, and amendments thereto, to make rates for professional liability insurance.

(l) "Self-insurer" means a health care provider who qualifies as

a self-insurer pursuant to K.S.A. 40-3414 and amendments thereto.

(m) "Medical care facility" means the same when used in the health care provider insurance availability act as the meaning ascribed to that term in K.S.A. 65-425 and amendments thereto, except that as used in the health care provider insurance availability act such term, as it relates to insurance coverage under the health care provider insurance availability act, also includes any director, trustee, officer or administrator of a medical care facility.

(n) "Mental health center" means a mental health center licensed by the secretary of social and rehabilitation services under K.S.A. 75-3307b and amendments thereto, except that as used in the health care provider insurance availability act such term, as it relates to insurance coverage under the health care provider insurance availability act, also includes any director, trustee, officer or administrator of a mental health center.

(o) "Mental health clinic" means a mental health clinic licensed by the secretary of social and rehabilitation services under K.S.A. 75-3307b and amendments thereto, except that as used in the health care provider insurance availability act such term, as it relates to insurance coverage under the health care provider insurance availability act, also includes any director, trustee, officer or administrator of a mental health clinic.

(p) "State institution for the mentally retarded" means Norton state hospital, Winfield state hospital and training center, Parsons state hospital and training center and the Kansas neurological institute.

(q) "State psychiatric hospital" means Larned state hospital, Osawatomie state hospital, Rainbow mental health facility and Topeka state hospital.

(r) "Person engaged in residency training" means:

(1) A person engaged in a postgraduate training program approved by the state board of healing arts who is employed by and is studying at the university of Kansas medical center only when such person is engaged in medical activities which do not include extracurricular, extra-institutional medical service for which such person receives extra compensation and which have not been approved by the dean of the school of medicine and the executive vice-chancellor of the university of Kansas medical center. Persons engaged in residency training shall be considered resident health care providers for purposes of K.S.A. 40-3401 *et seq.*, and amendments thereto; and

(2) a person engaged in a postgraduate training program approved by the state board of healing arts who is employed by a nonprofit

corporation organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated with the university of Kansas school of medicine or who is employed by an affiliate of the university of Kansas school of medicine as defined in K.S.A. 76-367 and amendments thereto only when such person is engaged in medical activities which do not include extra-curricular, extra-institutional medical service for which such person receives extra compensation and which have not been approved by the chief operating officer of the nonprofit corporation or the chief operating officer of the affiliate and the executive vice-chancellor of the university of Kansas medical center.

(s) "Full-time physician faculty employed by the university of Kansas medical center" means a person licensed to practice medicine and surgery who holds a full-time appointment at the university of Kansas medical center when such person is providing health care.

(t) "Sexual act" or "sexual activity" means that sexual conduct which constitutes a criminal or tortious act under the laws of the state of Kansas.

Sec. 2. K.S.A. 1990 Supp. 40-3402 is hereby amended to read as follows: 40-3402. (a) A policy of professional liability insurance approved by the commissioner and issued by an insurer duly authorized to transact business in this state in which the limit of the insurer's liability is not less than $200,000 per occurrence, subject to not less than a $600,000 annual aggregate for all claims made during the policy period, shall be maintained in effect by each resident health care provider as a condition to rendering professional service as a health care provider in this state, unless such health care provider is a self-insurer. Such policy shall provide as a minimum coverage for claims made during the term of the policy which were incurred during the term of such policy or during the prior term of a similar policy. Any insurer offering such policy of professional liability insurance to any health care provider may offer to such health care provider a policy as prescribed in this section with deductible options. Such deductible shall be within such policy limits.

This provision shall not apply to optometrists and pharmacists on or after July 1, 1991.

(1) Each insurer providing basic coverage shall within 30 days after the premium for the basic coverage is received by the insurer or within 30 days from the effective date of this act, whichever is later, notify the commissioner that such coverage is or will be in effect. Such notification shall be on a form approved by the commissioner and shall include information identifying the professional liability policy issued or to be issued, the name and address of all health care providers covered by the policy, the amount of the annual

premium, the inception and expiration dates of the coverage and such other information as the commissioner shall require. A copy of the notice required by this subsection shall be furnished the named insured.

(2) In the event of termination of basic coverage by cancellation, nonrenewal, expiration or otherwise by either the insurer or named insured, notice of such termination shall be furnished by the insurer to the commissioner, the state agency which licenses, registers or certifies the named insured and the named insured. Such notice shall be provided no less than 30 days prior to the effective date of any termination initiated by the insurer or within 10 days after the date coverage is terminated at the request of the named insured and shall include the name and address of the health care provider or providers for whom basic coverage is terminated and the date basic coverage will cease to be in effect. No basic coverage shall be terminated by cancellation or failure to renew by the insurer unless such insurer provides a notice of termination as required by this subsection.

(3) Any professional liability insurance policy issued, delivered or in effect in this state on and after the effective date of this act shall contain or be endorsed to provide basic coverage as required by subsection (a) of this section. Notwithstanding any omitted or inconsistent language, any contract of professional liability insurance shall be construed to obligate the insurer to meet all the mandatory requirements and obligations of this act. The liability of an insurer for claims made prior to July 1, 1984, shall not exceed those limits of insurance provided by such policy prior to July 1, 1984.

(b) Unless a nonresident health care provider is a self-insurer, such provider shall not render professional service as a health care provider in this state unless such provider maintains coverage in effect as prescribed by subsection (a), except such coverage may be provided by a nonadmitted insurer who has filed the form required by subsection (b)(1).

This provision shall not apply to optometrists and pharmacists on or after July 1, 1991.

(1) Every insurance company authorized to transact business in this state, that is authorized to issue professional liability insurance in any jurisdiction, shall file with the commissioner, as a condition of its continued transaction of business within this state, a form 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 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.

(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 legislature as may be appropriate to ensure the viability of the fund.

(3) The board shall be attached to the insurance department and shall be within the insurance department as a part thereof. All budgeting, purchasing and related management functions of the board shall be administered under the direction and supervision of the commissioner of insurance. All vouchers for expenditures of the board shall be approved by the commissioner of insurance or a person designated by the commissioner.

(c) Subject to subsections (d), (e), (f), (i), (k), (m) ~~and~~, (n), *(o) and (p)*, the fund shall be liable to pay: (1) Any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable resident health care providers or resident self-

insurers for any personal injury or death arising out of the rendering of or the failure to render professional services within or without this state; (2) subject to the provisions of subsection (m), any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable nonresident health care providers or nonresident self-insurers for any such injury or death arising out of the rendering or the failure to render professional services within this state but in no event shall the fund be obligated for claims against nonresident health care providers or nonresident self-insurers who have not complied with this act or for claims against nonresident health care providers or nonresident self-insurers that arose outside of this state; (3) subject to the provisions of subsection (m), any amount due from a judgment or settlement against a resident inactive health care provider for any such injury or death arising out of the rendering of or failure to render professional services; (4) subject to the provisions of subsection (m), any amount due from a judgment or settlement against a nonresident inactive health care provider for any injury or death arising out of the rendering or failure to render professional services within this state, but in no event shall the fund be obligated for claims against: (A) Nonresident inactive health care providers who have not complied with this act; or (B) nonresident inactive health care providers for claims that arose outside of this state, unless such health care provider was a resident health care provider or resident self-insurer at the time such act occurred; (5) reasonable and necessary expenses for attorney fees incurred in defending the fund against claims; (6) any amounts expended for reinsurance obtained to protect the best interests of the fund purchased by the commissioner, which purchase shall be subject to the provisions of K.S.A. 75-3738 through 75-3744, and amendments thereto, but shall not be subject to the provisions of K.S.A. 75-4101 and amendments thereto; (7) reasonable and necessary actuarial expenses incurred in administering the act, including expenses for any actuarial ~~study~~ *studies* contracted for by the legislative coordinating council, which expenditures shall not be subject to the provisions of K.S.A. 75-3738 through 75-3744, and amendments thereto; (8) annually to the plan or plans, any amount due pursuant to subsection (a)(3) of K.S.A. 40-3413 and amendments thereto; (9) reasonable and necessary expenses incurred by the insurance department and the board of governors in the administration of the fund; (10) return of any unearned surcharge; (11) reasonable and necessary expenses for attorney fees and other costs incurred in defending a person engaged or who was engaged in residency training or the private practice corporations or foundations and their full-time physician faculty em-

ployed by the university of Kansas medical center from claims for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider; (12) notwithstanding the provisions of subsection (m), any amount due from a judgment or settlement for an injury or death arising out of the rendering of or failure to render professional services by a person engaged or who was engaged in residency training or the private practice corporations or foundations and their full-time physician faculty employed by the university of Kansas medical center; (13) reasonable and necessary expenses for the development and promotion of risk management education programs; (14) notwithstanding the provisions of subsection (m), any amount, but not less than the required basic coverage limits, owed pursuant to a judgment or settlement for any injury or death arising out of the rendering of or failure to render professional services by a person, other than a person described in clause (12) of this subsection, who was engaged in a postgraduate program of residency training approved by the state board of healing arts but who, at the time the claim was made, was no longer engaged in such residency program; and (15) reasonable and necessary expenses for attorney fees and other costs incurred in defending a person described in clause (14) of this subsection.

(d) All amounts for which the fund is liable pursuant to subsection (c) shall be paid promptly and in full except that, if the amount for which the fund is liable is $300,000 or more, it shall be paid, by installment payments of $300,000 or 10% of the amount of the judgment including interest thereon, whichever is greater, per fiscal year, the first installment to be paid within 60 days after the fund becomes liable and each subsequent installment to be paid annually on the same date of the year the first installment was paid, until the claim has been paid in full. Any attorney fees payable from such installment shall be similarly prorated.

(e) In no event shall the fund be liable to pay in excess of $3,000,000 pursuant to any one judgment or settlement against any one health care provider relating to any injury or death arising out of the rendering of or the failure to render professional services on and after July 1, 1984, and before July 1, 1989, subject to an aggregate limitation for all judgments or settlements arising from all claims made in any one fiscal year in the amount of $6,000,000 for each provider.

(f) The fund shall not be liable to pay in excess of the amounts specified in the option selected by the health care provider pursuant to subsection (l) for judgments or settlements relating to injury or death arising out of the rendering of or failure to render professional

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services by such health care provider on or after July 1, 1989.

(g) A health care provider shall be deemed to have qualified for coverage under the fund: (1) On and after the effective date of this act if basic coverage is then in effect; (2) subsequent to the effective date of this act, at such time as basic coverage becomes effective; or (3) upon qualifying as a self-insurer pursuant to K.S.A. 40-3414 and amendments thereto.

(h) A health care provider who is qualified for coverage under the fund shall have no vicarious liability or responsibility for any injury or death arising out of the rendering of or the failure to render professional services inside or outside this state by any other health care provider who is also qualified for coverage under the fund. The provisions of this subsection shall apply to all claims filed on or after the effective date of this act.

(i) Notwithstanding the provisions of K.S.A. 40-3402 and amendments thereto, if the board of governors determines due to the number of claims filed against a health care provider or the outcome of those claims that an individual health care provider presents a material risk of significant future liability to the fund, the board of governors is authorized by a vote of a majority of the members thereof, after notice and an opportunity for hearing in accordance with the provisions of the Kansas administrative procedure act, to terminate the liability of the fund for all claims against the health care provider for damages for death or personal injury arising out of the rendering of or the failure to render professional services after the date of termination. The date of termination shall be 30 days after the date of the determination by the board of governors. The board of governors, upon termination of the liability of the fund under this subsection, shall notify the licensing or other disciplinary board having jurisdiction over the health care provider involved of the name of the health care provider and the reasons for the termination.

(j) (1) Upon the payment of moneys from the health care stabilization fund pursuant to subsection (c)(11), the commissioner shall certify to the director of accounts and reports the amount of such payment, and the director of accounts and reports shall transfer an amount equal to the amount certified, reduced by any amount transferred pursuant to paragraph (3) of this subsection, from the state general fund to the health care stabilization fund.

(2) Upon the payment of moneys from the health care stabilization fund pursuant to subsection (c)(12), the commissioner shall certify to the director of accounts and reports the amount of such payment which is equal to the basic coverage liability of self-insurers,

and the director of accounts and reports shall transfer an amount equal to the amount certified, reduced by any amount transferred pursuant to paragraph (3) of this subsection, from the state general fund to the health care stabilization fund.

(3) The university of Kansas medical center private practice foundation reserve fund is hereby established in the state treasury. On July 1, 1989, or as soon thereafter as is practicable, the private practice corporations or foundations referred to in subsection (c) of K.S.A. 40-3402, and amendments thereto, shall remit $500,000 to the state treasurer, and the state treasurer shall credit the same to the university of Kansas medical center private practice foundation reserve fund. If the balance in such reserve fund is less than $500,000 on July 1 of any succeeding year, the private practice corporations or foundations shall remit the amount necessary to increase such balance to $500,000 to the state treasurer for credit to such fund as soon after such July 1 date as is practicable. When compliance with the foregoing provisions of this paragraph have been achieved on or after July 1 of any year in which the same are applicable, it shall be the duty of the state treasurer to certify to the commissioner that the reserve fund has been funded for the year in the manner required by law. Moneys in such reserve fund may be invested or reinvested in accordance with the provisions of K.S.A. 40-3406, and amendments thereto, and any income or interest earned by such investments shall be credited to the reserve fund. Upon payment of moneys from the health care stabilization fund pursuant to subsection (c)(11) or (c)(12) with respect to any private practice corporation or foundation or any of its full-time physician faculty employed by the university of Kansas, the director of accounts and reports shall transfer an amount equal to the amount paid from the university of Kansas medical center private practice foundation reserve fund to the health care stabilization fund or, if the balance in such reserve fund is less than the amount so paid, an amount equal to the balance of the fund.

(4) Upon payment of moneys from the health care stabilization fund pursuant to subsection (c)(14) or (15), the commissioner shall certify to the director of accounts and reports the amount of such payment, and the director of accounts and reports shall transfer an amount equal to the amount certified from the state general fund to the health care stabilization fund.

(k) Notwithstanding any other provision of the health care provider insurance availability act, no psychiatric hospital licensed under K.S.A. 75-3307b and amendments thereto shall be assessed a premium surcharge or be entitled to coverage under the fund if such

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hospital has not paid any premium surcharge pursuant to K.S.A. 40-3404 and amendments thereto prior to January 1, 1988.

(l) On or after July 1, 1989, every health care provider shall make an election to be covered by one of the following options provided in this subsection which shall limit the liability of the fund with respect to judgments or settlements relating to injury or death arising out of the rendering of or failure to render professional services on or after July 1, 1989. Such election shall be made at the time the health care provider renews the basic coverage in effect on the effective date of this act or, if basic coverage is not in effect, such election shall be made at the time such coverage is acquired pursuant to K.S.A. 40-3402, and amendments thereto. Notice of the election shall be provided by the insurer providing the basic coverage in the manner and form prescribed by the commissioner and shall continue to be effective from year to year unless modified by a subsequent election made prior to the anniversary date of the policy. The health care provider may at any subsequent election reduce the dollar amount of the coverage for the next and subsequent fiscal years, but may not increase the same, unless specifically authorized by the board of governors. Such election shall be made for persons engaged in residency training and persons engaged in other post-graduate training programs approved by the state board of healing arts at medical care facilities or mental health centers in this state by the agency or institution paying the surcharge levied under K.S.A. 40-3404, and amendments thereto, for such persons. Such options shall be as follows:

(1) *OPTION 1.* The fund shall not be liable to pay in excess of $100,000 pursuant to any one judgment or settlement for any party against such health care provider, subject to an aggregate limitation for all judgments or settlements arising from all claims made in the fiscal year in an amount of $300,000 for such provider.

(2) *OPTION 2.* The fund shall not be liable to pay in excess of $300,000 pursuant to any one judgment or settlement for any party against such health care provider, subject to an aggregate limitation for all judgments or settlements arising from all claims made in the fiscal year in an amount of $900,000 for such provider.

(3) *OPTION 3.* The fund shall not be liable to pay in excess of $800,000 pursuant to any one judgment or settlement for any party against such health care provider, subject to an aggregate limitation for all judgments or settlements arising from all claims made in the fiscal year in an amount of $2,400,000 for such provider.

(m) The fund shall not be liable for any amounts due from a judgment or settlement against resident or nonresident inactive

health care providers who first qualify as an inactive health care provider on or after July 1, 1989, unless such health care provider has been in compliance with K.S.A. 40-3402, and amendments thereto, for a period of not less than five years. If a health care provider has not been in compliance for five years, such health care provider may make application and payment for the coverage for the period while they are nonresident health care providers, nonresident self-insurers or resident or nonresident inactive health care providers to the fund. Such payment shall be made within 30 days after the health care provider ceases being an active health care provider and shall be made in an amount determined by the commissioner to be sufficient to fund anticipated claims based upon reasonably prudent actuarial principles. The provisions of this subsection shall not be applicable to any health care provider which becomes inactive through death or retirement, or through disability or circumstances beyond such health care provider's control, if such health care provider notifies the board of governors and receives approval for an exemption from the provisions of this subsection. Any period spent in a postgraduate program of residency training approved by the state board of healing arts shall not be included in computation of time spent in compliance with the provisions of K.S.A. 40-3402, and amendments thereto.

(n) 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 made after July 1, 1991, against a licensed optometrist or pharmacist relating to any injury or death arising out of the rendering of or failure to render professional services by such optometrist or pharmacist 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).*~~

(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*~~

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qualified as an inactive provider prior to July 1, 1991 and obtained coverage pursuant to subsection (m).

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 therefor in the same manner as provided for in subsection (m).

~~*such inactive health care provider procured coverage therefor in the same manner as provided for in subsection (m).*~~

~~(n)~~ *(p)* 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 by the speaker of the state house of representatives, one of whom shall be appointed by the minority leader of the state house of representatives and six of whom shall be persons appointed by the legislative coordinating council. The four members appointed by the president and minority leader of the state senate and the speaker and minority leader of the state house of representatives shall be members of the state legislature. Of the six members appointed by the legislative coordinating council, four shall either be health care providers or be employed by health care providers, one shall be a representative of the insurance industry and one shall be appointed from the public at large who is not affiliated with any health care provider or the insurance industry, but none of such six members shall be members of the state legislature. *Members serving on the committee on the effective date of this act shall continue to serve at the pleasure of the appointing authority.*

(b) The legislative coordinating council shall designate a chairperson of the committee from among the members thereof. The committee shall meet upon the call of the chairperson. It shall be the responsibility of the committee to make ~~a~~ *an annual* report to the legislative coordinating council on or before September ~~1, 1990,~~ *of each year* and to perform such additional duties ~~after September 1, 1990,~~ as the legislative coordinating council shall direct. The report required to be made to the legislative coordinating council shall include recommendations to the legislature for commencing the

phase-out of the fund on July 1, ~~1991~~ *1994*, an analysis of the market for insurance for health care providers, ~~an analysis of the impact and recommendation 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 the fund has liability~~ and recommendations for legislation necessary to implement or alter the phase-out of the fund.

(c) The commissioner or the commissioner's designee shall provide any consulting actuarial firm contracting with the legislative coordinating council with such information or materials pertaining to the health care stabilization fund deemed necessary by the actuarial firm for performing the requirements of ~~an~~ *any* actuarial ~~review~~ *reviews* for the health care stabilization fund oversight committee notwithstanding any confidentiality prohibition, restriction or limitation imposed on such information or materials by any other law. The consulting actuarial firm and all employees and former employees thereof shall be subject to the same duty of confidentiality imposed by law on other persons or state agencies with regard to information and materials so provided and shall be subject to any civil or criminal penalties imposed by law for violations of such duty of confidentiality. Any ~~report~~ *reports* of the consulting actuarial firm shall be made in a manner which will not reveal directly or indirectly the name of any persons or entities or individual reserve information involved in claims or actions for damages for personal injury or loss due to error, omission or negligence in the performance of professional services by health care providers. Information provided to the actuary shall not be subject to discovery, subpoena or other means of legal compulsion in any civil proceedings and shall be returned by the actuary to the health care stabilization fund.

(d) The staff of the legislative research department, the office of the revisor of statutes and the division of legislative administrative services shall provide such assistance as may be requested by the committee and to the extent authorized by the legislative coordinating council.

(e) Members of the committee attending meetings of the committee, or attending a subcommittee meeting thereof authorized by the committee, shall be paid compensation, travel expenses and subsistence expenses as provided in K.S.A. 75-3212, and amendments thereto.

(f) This section shall be a part of and supplemental to the health care provider insurance availability act. The provisions of this section shall expire on July 1, ~~1991~~ *1994*.

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Sec. 5. K.S.A. 1990 Supp. 40-3404 is hereby amended to read as follows: 40-3404. (a) Except for any health care provider whose participation in the fund has been terminated pursuant to subsection (i) of K.S.A. 40-3403 and amendments thereto, the commissioner shall levy an annual premium surcharge on each health care provider who has obtained basic coverage and upon each self-insurer for each fiscal year. Such premium surcharge shall be an amount equal to a percentage of the annual premium paid by the health care provider for the basic coverage required to be maintained as a condition to coverage by the fund by subsection (a) of K.S.A. 40-3402 and amendments thereto. The annual premium surcharge upon each self-insurer, except for persons engaged in residency training, shall be an amount equal to a percentage of the amount such self-insurer would pay for basic coverage as calculated in accordance with rating procedures approved by the commissioner pursuant to K.S.A. 40-3413 and amendments thereto. The annual premium surcharge upon 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, shall be an amount equal to a percentage of an assumed aggregate premium of $600,000. The annual premium surcharge upon the employers of persons engaged in residency training, as described in subsection (r)(2) of K.S.A. 40-3401, and amendments thereto, shall be an amount equal to a percentage of an assumed aggregate premium of $400,000. The surcharge on such $400,000 amount shall be apportioned among the employers of persons engaged in residency training, as described in subsection (r)(2) of K.S.A. 40-3401, and amendments thereto, based on the number of residents employed as of July 1 of each year.

(b) In the case of a resident health care provider who is not a self-insurer, the premium surcharge shall be collected in addition to the annual premium for the basic coverage by the insurer and shall not be subject to the provisions of K.S.A. 40-252, 40-1113 and 40-2801 *et seq.*, and amendments thereto. The amount of the premium surcharge shall be shown separately on the policy or an endorsement thereto and shall be specifically identified as such. Such premium surcharge shall be due and payable by the insurer to the commissioner within 30 days after the annual premium for the basic coverage is received by the insurer, but in the event basic coverage is in effect at the time this act becomes effective, such surcharge shall be based upon the unearned premium until policy expiration and annually thereafter. Within 15 days immediately following the effective date of this act, the commissioner shall send to each insurer information necessary for their compliance with this subsection. The

This provision shall not apply to optometrists and pharmacists on or after July 1, 1991.

certificate of authority of any insurer who fails to comply with the provisions of this subsection shall be suspended pursuant to K.S.A. 40-222 and amendments thereto until such insurer shall pay the annual premium surcharge due and payable to the commissioner. In the case of a nonresident health care provider or a self-insurer, the premium surcharge shall be collected in the manner prescribed in K.S.A. 40-3402 and amendments thereto.

(c) The premium surcharge *made for any annual period beginning on or after the effective date of this act* shall be *in* an amount deemed sufficient by the commissioner, *together with the premium surcharges for any subsequent annual periods made prior to July 1, 1994,* to fund *the total of any existing deficiencies in the fund on the effective date of this act and all* anticipated claims *to be made before July 1, 1994, for which the fund will be liable* based upon reasonably prudent actuarial principles. In setting the amount of such surcharge, the commissioner: (1) May require any health care provider who has paid a surcharge for less than 24 months to pay a higher surcharge than other health care providers; *and* (2) shall require that any health care provider who is insured by a policy of professional liability insurance with deductibles pay a surcharge based on an amount equal to a percentage on the annual amount of premium that would have been paid by the health care provider for basic coverage required to be maintained by the fund as provided by K.S.A. 40-3402 and amendments thereto without any deductibles; ~~and (3) shall amortize any anticipated deficiencies in the fund over a reasonable period of time~~.

Sec. 6. K.S.A. 1990 Supp. 40-3401, 40-3402, 40-3403, 40-3403b and 40-3404 are hereby repealed.

Sec. 7. This act shall take effect and be in force from and after its publication in the statute book.

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).

II + I
2/7/91
Attachment 5

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.

5-7

(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.

5-9

(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.

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).

5-11

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.

5-12

together with undiscounted HCPIAP transfers and miscellaneous expenses of $2.545 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.

HEALTH CARE STABILIZATION FUND

Cash Balance Plus Investments

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
TRIAL LAWYERS ASSOCIATION
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TESTIMONY
OF THE
KANSAS TRIAL LAWYERS ASSOCIATION
BEFORE THE
SENATE FINANCIAL INSTITUTIONS
AND INSURANCE COMMITTEE

FEBRUARY 7, 1991

SB 38 - Abolishing the HCSF

The Kansas Trial Lawyers Association cannot support SB 38 in its present form. During the past three years that a phase out of the Health Care Stabilization Fund has been debated, our position has been consistent. We believe the Fund has lived out its usefulness and should therefore be abolished as soon as possible. However, we do not feel it is in the best interest of Kansas health care consumers that mandatory liability insurance for providers be repealed.

To consider this issue from the point of view of victims of medical malpractice, it is important to remember the legislative environment in which mandatory insurance came into being. In 1975/76 some health care providers simply could not find a carrier to sell them liability insurance. The Fund was created to fill that void. At the same time, however, a number of so-called tort reforms were adopted as part of the overall package of medical malpractice legislation enacted in the 1976 session.

These "tort reforms" were in part justified by their proponents as a quid pro quo. The health care providers were given their "reforms" and victims were in turn assured any recovery would be paid because of the mandatory (and unlimited) insurance coverage. Some of the limits on the civil justice system victims had to take as part of the bargain included a shortened statute of limitations, evidence of collateral source benefits, post-verdict hearings on plaintiff attorney fees, the imposition of periodic payment of judgments, mandatory screening panels, and expanded immunity from liability in peer review situations.

KTLA would like to suggest the Legislature consider the constitutional implications of eliminating mandatory insurance. We are now in the process of doing our own research and will make it available to this Committee. The question is, "What is the status of the constitutionality of legislation enacted with a quid pro quo, when the quid pro quo is repealed?"

FI+I
2/7/91
Attachment 6

Some question has been raised about the state's role in mandating insurance coverage for any group. The practice of medicine is a privilege, not a right, and it is, therefore, the duty of the State to determine qualifications and requirements for licensure. A parallel can be drawn with auto insurance. Driving, too, is a privilege, not a right. If it is good public policy to require drivers to be insured, it surely makes sense to require insurance of surgeons and other health care providers. It is clearly in the best interest of Kansas health care consumers that providers be insured.

The State of Kansas also has a stake in this issue. To the extent some would go uninsured if SB 38 becomes law, the State will increasingly be asked through the Department of SRS to pay medical bills and provide other services. This is further compounded by the fact that a significant percentage of our population has no health insurance.

Finally, we believe it's important to urge you to focus on why some doctors or other health care providers would go bare. If it's true the vast majority would buy insurance, who are those who would not and what is their motivation for doing so? Most professionals, (doctors, architects, engineers and lawyers) consider it good business practice to carry malpractice insurance. Those that do not, frankly, may not have their client or patient's best interests in mind.

We hope you'll move cautiously on this proposal. While supporting the elimination of the HCSF, we ask you to leave the mandatory insurance provision in the law. Thank you.

KANSAS ASSOCIATION OF NURSE ANESTHETISTS

February 6, 1991

Honorable Richard Bond
Statehouse
Topeka, KS 66612

Dear Senator Bond:

Tuesday evening, I learned your committee was hearing testimony on SB 38 which deals with the Health Care Stabilization Fund. Because of employment commitments, I am unable to personally present testimony on behalf of the Kansas Association of Nurse Anesthetists.

I have enclosed a copy of my testimony from September 6, 1990 which was given before the Health Care Stabilization Fund Oversight Committee. I feel these comments still represent many of the concerns of the nurse anesthetist. I am FAXing this document today so it can be submitted to your Committee for consideration tomorrow morning.

Thank-you for your consideration in this matter.

Sincerely,

Katharine Clark

Katharine Clark, CRNA, MS
411 N. Armour
Wichita, KS 67206

7 I & I
2/7/91
Attachment 7

KANSAS ASSOCIATION OF NURSE ANESTHETISTS

TESTIMONY AND REMARKS MADE BEFORE THE HEALTH CARE STABILIZATION FUND OVERSIGHT COMMITTEE
SEPTEMBER 6, 1990

by Katharine Clark, CRNA, MS
representing the Kansas Association of Nurse Anesthetists

Thank you for the opportunity to address this Committee. My name is Katharine Clark. I am a certified registered nurse anesthetist (CRNA) and I represent the Kansas Association of Nurse Anesthetists (KANA). Under Kansas statutes, the nurse anesthetist is referred to as a Registered Nurse Anesthetist (RNA), so, throughout out this document, I will use this title.

The Registered Nurse Anesthetist is the only category of nurse that is included in the Health Care Stablization Fund. Because we do participate in the HCSF, we have a vested interest in decisions that affect it.

Currently, there are approximately 310 active practicing Registered Nurse Anesthetists in the state of Kansas. We administer anesthesia in a variety of settings: hospitals, out-patient departments, ambulatory clinics and office settings. The Registered Nurse Anesthetist is responsible for the majority of anesthesia in the rural community. A 1990 Kansas membership survey revealed that of the 132 hospitals offering surgical services, 110 had the nurse anesthetist as the sole provider of anesthesia services.

The Kansas Health Care Provider Insurance Availability Act (The Act) became effective July 1, 1976, to assure the availability of professional liability insurance for specific categories of health care providers. This Act contains provisions which fall into three major areas:

1. It requires health care providers actively engaged in rendering professional services in Kansas to maintain mandatory basic professional liability coverage.

2. It establishes the Health Care Stabilization Fund as an excess loss fund for qualifying health care providers and provided for Health Care Stabilization Fund assessments, investment of Fund monies, claim payment responsibilities, and other matters relating to the financial operation of the Fund.

3. It establishes the availability mechanism which provides the required basic professional liability coverage for any health care provider who is unable to obtain the required coverage from the voluntary insurance markets. (Joint Underwriting Association or JUA)

In 1976, the Registered Nurse Anesthetist agreed to participate in the HCSF because 30% of our members were having difficulty obtaining insurance.

Today, in Kansas, as well as throughout the United States, the primary provider of insurance for the nurse anesthetist is St. Paul Fire and Marine Co. Although there are other companies who offer professional liability insurance to physicians, they will not extend coverage to the Registered Nurse Anesthetist unless they are physician-employed. Thus, coverage from these companies would not be available to approximately 100 of our members. Under the present system, if the RNA was unable to obtain basic coverage, the JUA could provide the coverage.

In recent years, two groups of nurses have had difficulty with insurance availability; the nurse practitioner and the nurse midwife. In 1987, the nurse practitioner was notified that the American Nurses Association's policy would no longer include the nurse practitioner.

The nurse practitioner story was reminiscent of the dilemma faced by the nurse midwives in 1986 when their professional liability insurance was not renewed. Eventually, coverage was obtained for both the nurse practitioner and the nurse midwife, but it resulted in a disruption of service and an alteration in some employment settings.

The Registered Nurse Anesthetist is required by state statute to carry professional liability insurance. If the coverage is not available, the RNA would not be able to practice and many hospitals would be unable to continue surgical services.

If the HCSF is to be phased-out, the KANA requests:

1. Some mechanism be implemented to address a future problem of insurance unavailability.

2. The decision to phase-out the HCSF should take into account the impact on all health care providers currently covered in the HCSF.

3. The process should be in a orderly fashion and not create a disruption in coverage.

4. The process would not be a financial burden to the health care provider.

5. Tail coverage would be provided.

In closing, I would like to remind you that although there are only 310 Registered Nurse Anesthetis practicing in Kansas, we are the sole provider of anesthesia services in 110 hospitals in the state.

On October 16, 1990, the Kansas Association of Nurse Anesthetists will celebrate it's 50th anniversary. For more than 50 years, the Registered Nurse Anesthetist has been providing quality care to the citizens of Kansas. We would like to be able to continue to provide that care for at least the next 50 years.

Thank you for the opportunity to address this Committee.