Approved: February 28, 2008
Date

MINUTES OF THE HOUSE INSURANCE AND FINANCIAL INSTITUTIONS COMMITTEE

The meeting was called to order by Chairman Clark Shultz at 3:35 P.M. on February 25, 2008 in Room 527-S of the Capitol.

All members were present except:
Representative Tom Burroughs- excused
Representative Mike Kiegerl- excused
Representative Brenda Landwehr- excused

Committee staff present:
Melissa Calderwood, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Bruce Kinzie, Revisor of Statutes Office
Ken Wilke, Revisor of Statutes Office
Sue Fowler, Committee Secretary

Conferees appearing before the committee:
Callie Hartle, Kansas Association for Justice
Steve J. Borel, Kansas Association for Justice
Charles Wheelen, Health Care Stabilization Fund
Kurt Scott, KaMMCO
Jerry Slaughter, Kansas Medical Society
Chad Austin, Kansas Hospital AssociationBill Miller, American Subcontractors Association
Janet Stubbs, Kansas Building Industry Workers Compensation Fund
Keith Oliver, Oliver Insurance Agency
Corey Peterson, Associated General Contractors of Kansas, Inc.
SueAnn Schultz, Kansas Association of Insurance Agents and Insurance Management Association

Others attending:
See attached list.

Hearing on:
HB 2782 **Kansas medical liability reporting act**

Melissa Calderwood, Legislative Research Department, provided a brief overview on **HB 2782**.

Proponents:

Callie Hartle, Kansas Association for Justice, (Attachment #1), presented testimony before the committee in support of **HB 2782**.

Steve J. Borel, Kansas Association for Justice, (Attachment #2), gave testimony before the committee in support of **HB 2782**.

Opponents:

Charles Wheelen, Health Care Stabilization Fund, (Attachment #3), appeared before the committee in opposition to **HB 2782**.

Kurt Scott, KaMMCO, (Attachment #4), presented testimony before the committee in opposition to **HB 2782**.

Jerry Slaughter, Kansas Medical Society, (Attachment #5), gave testimony before the committee in opposition to **HB 2782**.

Chad Austin, Kansas Hospital Association, (Attachment #6), presented written testimony in opposition to **HB 2782**.

Hearing closed on **HB 2782**.

MINUTES OF THE House Insurance and Financial Institutions Committee at 3:35 P.M. on February 25, 2008 in Room 527-S of the Capitol.

Hearing on:
HB 2900 **Controlled insurance program act**

Melissa Calderwood, Legislative Research Department, provided a brief overview on **HB 2900**.

Proponents:

Bill Miller, American Subcontractors Association, (Attachment #7), presented testimony before the committee in support of **HB 2900**.

Janet Stubbs, Kansas Building Industry Workers Compensation Fund, (Attachment #8), gave testimony before the committee in support of **HB 2900**.

Keith Oliver, Oliver Insurance Agency, (Attachment #9), appeared before the committee in support of **HB 2900**.

Opponents:

Corey Peterson for Will Larson, Associated General Contractors of Kansas, Inc., (Attachment #10), presented testimony before the committee in opposition to **HB 2900**.

SueAnn Schultz, Kansas Association of Insurance Agends, and Insurance Management Association, (Attachment #11), appeared before the committee in opposition to **HB 2900**.

Hearing closed on **HB 2900**.

Discussion and action on:
HB 2675 **Insurance agents, disciplinary license actions by another state for failure to pay income tax in such state**

Representative Dillmore made a motion to remove **HB 2675** from the table. Seconded by Representative Carlson. Motion carried. Representative Peck made a motion to amend **HB 2675** by adopting a portion of the balloon. Seconded by Representative Anthony Brown. Motion carried. Representative Peck moved **HB 2675** favorable for passage as amended. Seconded by Representative Anthony Brown. Motion carried.

HB 2686 **Requiring market conduct studies for certain insurance companies**

Representative Dillmore moved to adopt the balloon on **HB 2686**. Seconded by Representative Humerickhouse. Motion adopted. Representative Dillmore moved **HB 2686** favorable for passage as amended. Seconded by Representative Grant. Motion carried.

Representative Grant moved without objection to accept the minutes of February 21, 2008.

Next meeting will be Tuesday, February 26, 2008, 3:30 PM, in Room 527-S.

Meeting adjourned.

Insurance and Financial Institutions Committee
Guest Sign In Sheet
Monday, February 25, 2008

Name	Representing
Ken Keller	AS A - Western Extralite Co.
Keith C. Olivier	Olivier Insurance Agency Inc.
Bill Miller	ASA + Midwest Crane
Janet Stubbs	Ks. Bldg Ind. WCF
Carolyn Smith	Velis
Suetann Schultz	KAIA & IMA
Kerri Spielman	KAIA
Steve Borel	KSJA
Callie Denton Hartle	Ks Assn for Justice
Kurt Scott	Ka MMCO
Dave Ross	KaMMCO
Dan Morin	KS Medical Society
Jerry Slaughter	" " "
Mike Hutter	Preferred Health Systems
Ron Seeber	Hein Law Firm

KANSAS ASSOCIATION FOR JUSTICE

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PHONE: 785-232-7756
FAX: 785-232-7730
www.ksaj.org

Your rights. Our mission.

To: Representative Clark Shultz, Chairman
Members of the House Insurance & Financial Institutions Committee

From: Callie Denton Hartle

Date: February 25, 2008

Re: HB 2782 Kansas Medical Liability Reporting Act—**SUPPORT**

The Kansas Association for Justice is a statewide, nonprofit organization of attorneys that serve Kansans seeking justice. I appreciate the opportunity to testify on behalf of KsAJ on HB 2782. KsAJ is pleased to support HB 2782.

The Legislature is often asked to make important policy decisions that are based on a perception that there is excessive, frivolous litigation. Because of this popular notion, many bills advance that significantly immunize wrongdoers, create an unlevel playing field for ordinary citizens, or limit the ability of the civil justice system to protect Kansans. In the health care arena, the prevailing assumption is that litigation drives up the cost of medicine.

But the facts do not bear out this assumption. In Kansas, very few tort or personal injury cases are filed, and even fewer are decided by a jury. According to statistics compiled by the Kansas courts only 2% of cases filed in Kansas courts in FY2005 are personal injury cases, and only 115 cases decided by Kansas juries in 2004 were torts. Of the 115 cases, only 20% were medical malpractice claims.

Nationwide, a study by the Consumer Federation of America showed that medical malpractice costs, as a percentage of health care costs are at an all time low--.55%--*one half of one percent.*

House Insurance
Date: 2-25-08
Attachment # 1

Although these statistics tell an important story, they simply don't tell us enough. The Kansas courts statistics are infrequently updated and leave many questions about the costs of medical malpractice litigation in Kansas unanswered. KsAJ believes the Legislature—and the public—need better information about the cost of medical malpractice litigation, especially when considering how to provide access to affordable health care for Kansans.

We became aware of Tennessee's medical liability reporting act and believe it is a model that Kansas should follow for developing Kansas-specific information about the costs of medical malpractice litigation. Health care costs are skyrocketing. It is important for policymakers and Kansas health care consumers to know to what extent litigation contributes to health care costs to the State, to doctors, and to health care consumers.

KsAJ recommends two amendments to HB 2782:

1. Require counsel for claimants asserting claims to provide information for the report about fee arrangements, including the portion of any settlement or judgment received by claimant's counsel, and permit civil penalties against claimants counsel for failure to report. Last year—2007—was the first year that plaintiff's attorneys were required to submit information in Tennessee. We believe inclusion of this information for purposes of the report is important, and suggest that HB 2782 be amended consistent with the requirements outlined in the Tennessee act. We also believe failure to report should be the basis for a civil penalty as it is with other "reporting entities" and suggest the Committee make appropriate amendments.

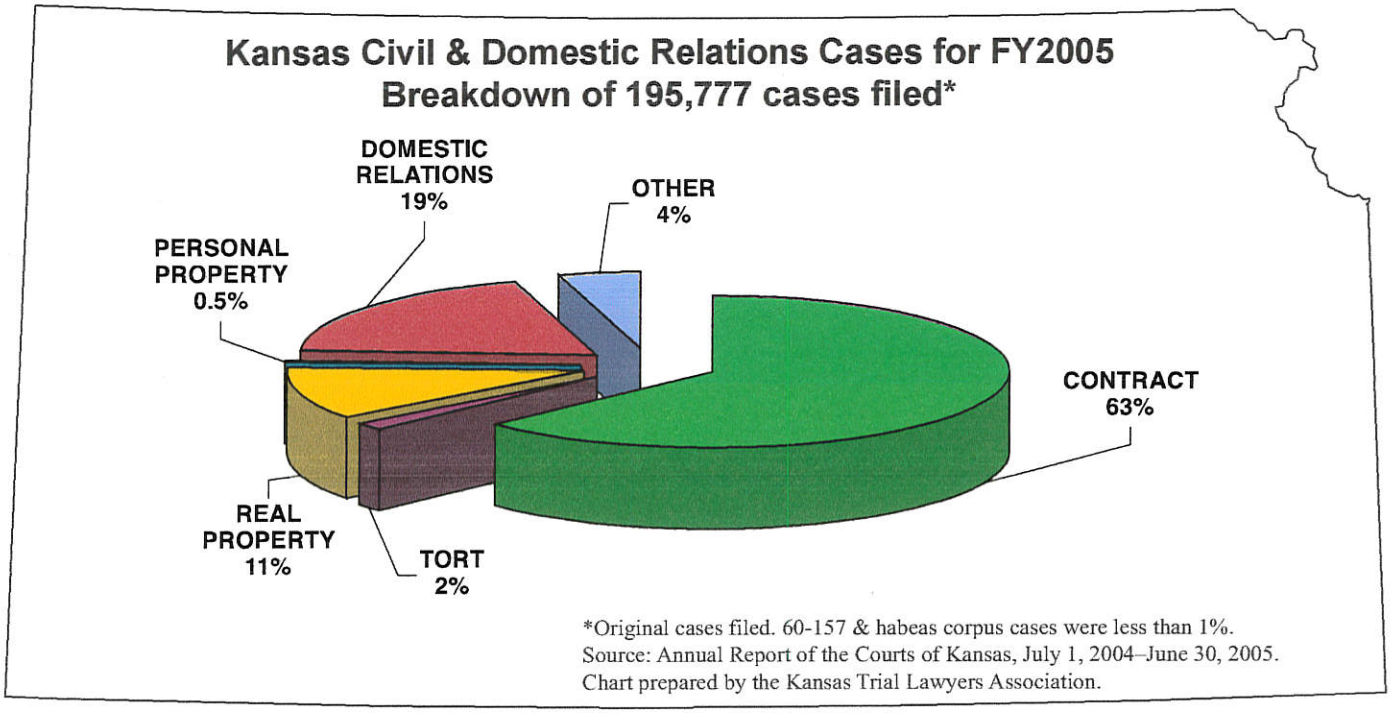
2. Require that the report be posted on the Kansas Insurance Department's website, and other state websites aimed at providing consumers with information. We believe the report will be useful for the public and should be made readily available and easily accessible.

Thank you for the opportunity to present testimony. I respectfully ask that you support HB 2782.

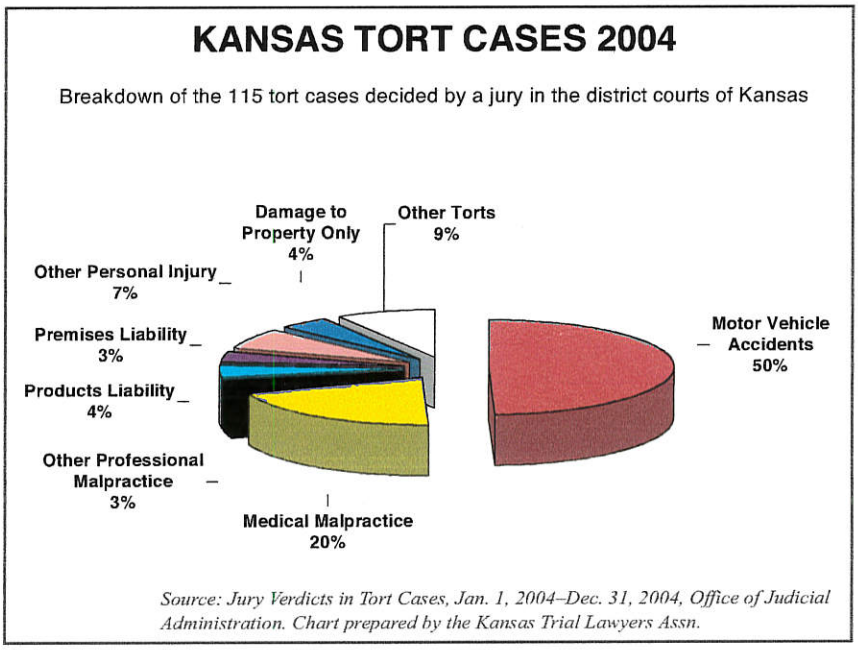
√ REALITY CHECK

There is no "litigation crisis" in Kansas

Only 2% of cases filed in Kansas are torts.



- √ Only 2% of cases filed in FY2005 were torts, or personal injury cases.
- √ 115 tort cases were decided by Kansas juries in 2004, down from 135 cases in 2001.
- √ Half of all tort cases decided by juries in 2004 involved auto accidents.
- √ The median award in 2004 was $18,757, down from $23,416 in 2003.
- √ Punitive damages were awarded in only 5 cases in 2004.



Check Your Facts Before You Change the Law

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Your rights. Our mission.

To: Representative Clark Shultz, Chairman
Members of the House Insurance & Financial Institutions Committee

From: Steven J. Borel, Attorney at Law
On behalf of the Kansas Association for Justice

Date: February 25, 2008

Re: HB 2782 Kansas Medical Liability Reporting Act—**SUPPORT**

The Kansas Association for Justice appreciates the opportunity to provide testimony to the House Insurance and Financial Institutions Committee regarding House Bill 2782, the Kansas Medical Liability Reporting Act.

H.B. 2782 is an act which would require insurance carriers and self-insureds defending medical malpractice claims in Kansas to annually report certain limited information to the Kansas Insurance Department. The information is:

- Identifying information regarding claims.
- The amounts paid, and the dates paid, to or for the benefit of claimants.
- The total amount paid for "direct claim expenses" on each claim. Direct claim expenses are defined as "defense attorneys' fees and expenses, expert witness' fees and expenses, deposition costs and other expenses of handling claims," and
- The total premiums earned per year; total reserves on the last day of each reporting year; total amounts paid on all claims during the reporting period, and the total of all reserves written down or written off during the reporting period.

Under HB 2782, the Kansas Insurance Department would take this information and prepare an annual summary report to the Kansas House of Representatives and the

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Kansas Senate which would analyze the data and would not contain the names of any individuals or healthcare providers.

The report from the insurance department could then be used by the Kansas Legislature in crafting future changes to Kansas law regarding health care cost issues and related subjects.

It is our belief that most of the information required by H.B. 2782 is readily available to most of the "reporting entities" which would be required to report annually to the Kansas Insurance Department, so that the bill would not represent an undue burden on any insurance carrier or self-insured entity.

H.B. 2782 is based on a similar Tennessee law which has been in effect for several years. For the last several years the Tennessee Department of Commerce and Insurance has released a medical malpractice claims report based on this same type of data. Attached is a copy of a press release and the Tennessee report detailing the findings for the year 2007.

We believe it would be helpful to the Kansas Legislature in analyzing health care costs to have an impartial, objective annual report based on actual Kansas data, compiled by the Kansas Insurance Department. We look forward to working with the Legislature and all stakeholders to assure that this report is a useful tool for policymakers and the public. We thank the chair and the committee for this opportunity to present testimony, and we welcome your questions.

2007 Medical Malpractice Claims Report

Department of Commerce & Insurance
November 1, 2007

2007 Tennessee Medical Malpractice Report

INTRODUCTION

In 2004, the Tennessee General Assembly enacted 2004 Tenn. Pub. Acts ch. 902 which established medical professional liability claims reporting obligations for various reporting entities. (A copy of 2004 Tenn. Pub. Acts ch. 902 is attached to this report as Appendix A.) This law was codified at Tenn. Code Ann. § 56-54-101. Pursuant to Tenn. Code Ann. § 56-54-101(a), "reporting entities" was defined to include insurance companies and risk retention groups that provide medical malpractice or professional liability insurance, as well as health care professionals and facilities lacking medical malpractice insurance. This law was passed after months of testimony and research by the Joint Tort Reform Subcommittee chaired by State Representative Rob Briley and Senator David Fowler. The Final Report prepared by the Subcommittee recommended passage of legislation that would "provide the committee with a clearer picture of the litigation and claim trends in Tennessee..." The Department of Commerce and Insurance (the "Department") provided testimony to the Subcommittee and actively participated in the development of legislation implementing the Subcommittee's recommendations.

In general, Tenn. Code Ann. § 56-54-101 requires reporting entities, on or before April 1 of each year, to provide information to the Department concerning the number of medical malpractice or professional liability claims asserted, the amount of damages alleged, any damages paid, the types of paid damages, and legal fees paid. The reporting requirements, as originally enacted, focused on the claims that were closed and pending during each calendar year.

Tenn. Code Ann. § 56-54-101 requires the Department to prepare an annual report for the Speakers of the Senate and House of Representatives summarizing this data each year beginning in 2005 and ending in 2008. The statute prescribes that the report may only contain aggregate data.

As a result of the information submitted by the reporting entities for the 2004 calendar year, the Department issued its first report in November of 2005. The report identified several issues relating additional information that should be reported and the General Assembly modified the reporting requirements in the 2006 legislative session. On May 23, 2006 Tenn. Pub. Acts ch. 774 was enacted which amended Tenn. Code Ann. § 56-54-101 to attempt to refine the information to be collected. (A copy of 2006 Tenn. Pub. Acts ch. 774 is attached to this report as Appendix B.) In general, the amendment added a requirement that reporting entities report on the cumulative amount of costs and expenses spent on pending and closed claims from the "inception date of the claim to the end of the preceding calendar year."

Where useful, this report provides not only the aggregate information for 2006, but also shows the information reported for 2004 and 2005 as a convenience to the reader.

I. REPORTING ENTITIES

The information provided by this report is primarily comprised of information obtained from insurance companies writing medical malpractice insurance in this state. It is important to note that the top ten (10) medical malpractice insurance carriers account for over eighty-eight percent (88%) of the total medical malpractice direct premiums written in Tennessee in 2006. To date, the Department has identified nine (9) insurance companies that failed to comply with the statute's reporting obligations. However, all nine (9) were risk retention groups that are federally exempt from having to comply with the reporting requirement. The 2006 malpractice premiums for the risk retention groups that did not file a

report totaled $ 4,139,876 or 1.2% of the total direct written premiums for medical malpractice insurance in this state.

In addition to requiring insurance companies to report required information, Tenn. Code Ann. § 56-54-101 also requires those health care facilities and professionals that are uninsured to report information about its medical malpractice experience. As identified in the previous reports, the Department remains unable to confirm that the information from this group is complete as it has no information concerning which facilities or professionals are, in fact, uninsured. Thus, while the Department has received some information from providers identifying themselves in this category and has included that information in this report, it can not be determined whether the Department has received information from all providers in this category. As such, there may be claims and costs incurred in this state that are not included in this report.[1]

The Department continues to identify opportunities to further refine information collected in this report. It has been represented to the Department that some required information is not collected by reporting entities within the ordinary course of business. The Department did revise the 2006 reporting form to require reporting entities to (1) better identify where a judgment was awarded in favor of the defendant; (2) report the date of the closing of claim to allow the Department to better reconcile the information provided; and (3) identify the amounts paid in settlements and judgments on both a cumulative and calendar year basis.

II. REPORTING PERIOD

This report focuses on the 2006 calendar year. The Department required reporting entities to complete two (2) separate forms to meet their obligations under 2006 Tenn. Pub. Acts ch. 774: (1) one reporting form solicited information regarding all medical malpractice claims closed or otherwise resolved in 2005; and (2) the second form solicited information concerning medical malpractice claims that were still considered pending as of December 31, 2006.[2] Claims identified in the reporting information submitted related to incidents occurring between 1978 and 2006. However, only 681 of the claims reported arose out of an incident that occurred prior to 2000.[3]

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[1] As was the case in the previous reports, the Department received claims information from certain uninsured health care facilities. However, just as before, the Department did not receive any information directly from any uninsured health care professionals. Until the Department is given an ability to identify this population and the uninsured health care facilities, as well as compel risk retention groups to report their information, the Department will remain unable to confirm the completeness of the information contained in these reports. Still, it is estimated that the total number of claims for this category is relatively minor compared to those that were insured during the reporting period.

[2] The Department made the forms available to reporting entities on its web site for easy access. The Department anticipates making further refinements to the forms in order to more accurately and clearly request the information sought under Tenn. Code Ann. § 56-54-101.

[3] Three (3) of the reported claims arise from events occurring in the 1970's, twenty-five (25) of the claims occurred in the 1980's, and six hundred and fifty-three (653) of the claims occurred in the 1990's.

III. CLAIMS CLOSED THROUGH SETTLEMENT, JUDGMENT OR OTHER RESOLUTION AND PENDING CLAIMS

A. Total Claims

The total number of medical malpractice claims reported as closed in 2006 was 2,973. This total represents claims which were resolved through the entry of a final court judgment, settlement with the claimant, or was otherwise resolved by the reporting entity.

The following table details the numbers of claims resolved in each of these three (3) categories:

Table 1 – Claims Closed through Adjudication, Settlement or Other Resolution

	2004 Totals	2004 Percentages	2005 Totals	2005 Percentages	2006 Totals	2006 Percentages
Claims Resolved Through Judgment	6	0.25%	5	0.18%	6	0.20%
Claims Resolved Through Settlement	444	18.77%	461	16.31%	453	15.24%
Claims Otherwise Resolved	1,916	80.89%	2,361	83.52%	2,514	84.56%
Total Number of Claims Closed	2,366	100.00%	2,827	100.00%	2,973	100.00%

B. Pending Claims

Pending claims are claims that were filed in 2006 or in prior years which were still unresolved as of December 31, 2006. It was reported that there were 5,430 claims pending as of December 31, 2006.

IV. DAMAGES AND COSTS

A. Total Damages Asserted by Claimants

The total damages asserted in lawsuits for the claims reported as adjudicated, settled or otherwise resolved in 2006 totaled $ 7,130,623,770. The total damages asserted other than by lawsuit for the claims settled or otherwise resolved in 2006 was $ 33,059,580.

The total damages asserted in lawsuits for pending claims in 2006 totaled $ 20,175,021,837. The total damages asserted other than by lawsuit for pending claims in 2006 was $ 139,414,627.

B. Total Settlements & Judgments

The following table details the amounts reported to have been paid in damages in 2006 for claims adjudicated, settled or otherwise resolved:

Table 2 – Amounts Paid In Damages for Claims Settled, Adjudicated or Otherwise Resolved

	2004 Totals	2004 Percentages	2005 Totals	2005 Percentages	2006 Totals	2006 Percentages
Total Damages Paid by Settlements	$108,333,535	98.2%	$119,091,990	95.15%	$100,223,337	95.29%
Total Damages Paid by Judgments	$1,958,648	1.8%	$6,075,724	4.85%	$4,951,459	4.71%
Total Damages Paid	$110,292,183	100.00%	$125,167,714	100.00%	$ 105,174,796	100.00%

C. Judgments

In all, it was reported that there were three hundred and sixty-two (362) court judgments in 2006. It was reported that three hundred and fifty-six (356) of these judgments resulted in favorable rulings for the defendant where no damages were awarded to the claimant. The following table details each of the six (6) judgments paid in 2006 and the amount and types of damages awarded in each case:

Table 3 – Total Damages Awarded By Final Court Judgment

Judgment Amount	Date of Occurrence	Damages Claimed in Lawsuit	Type of Provider	Compensatory Damages	Non-Economic Damages	Punitive Damages
$8,630	2003	$250,000	Hospital	$6,130	$2,500	$0
$50,000	2002	$1,650,000	Surgeon – OB/Gyn	$50,000	$0	$0
$200,829	1996	$775,000	Surgeon - General	$68,829	$132,000	$0
$500,000	2003	$1,000,000	Surgeon – OB/Gyn	$250,000	$250,000	$0
$1,192,000	2002	$1,500,000	Orthopedic	$454,000	$738,000	$0
$3,000,000	2000	$10,000,000	Internal Medicine	$2,700,000	$300,000	$0

D. Claimant's Counsel

2006 Pub. Acts ch. 774 amended Tenn. Code Ann. § 56-54-101 to require claimants' attorneys to report fees and expenses received in relation to their representation on medical malpractice claims. The following table details the monies paid to claimants' counsel for claims where monies were received by claimants' counsel:

Table 4 – Total Fees Paid to Claimants' Counsel on Claims in 2006[4]

Fees paid to Claimant's Counsel for Closed Claims	Other Legal Expenses Collected by Counsel for Closed Claims	Average Percentage of Settlements Paid to Claimants' Counsel	Average Percentage of Judgments Paid to Claimants' Counsel[5]
$34,925,167	$4,159,453	29.77%	14.23%

Of the reported claims, the great majority of attorneys reported contingency agreements of thirty-three percent (33%) of the total damages. However, the range for fee agreements was from sixteen percent (16%) to forty percent (40%).

E. Total Defense Costs and Expenses Paid on Claims

The total defense costs reported to have been paid during 2006 was $ 67,027,197. For purposes of comparison, the total defense costs reported as being paid during 2004 and 2005 was $ 25,613,584 and $ 61,768,804, respectively. The following table details the expenses paid by reporting entities on claims that were paid in 2006 for both closed and pending claims:

Table 5 – Total Amounts Paid in Defense Costs on Claims in 2006

	Fees Paid to Defense Counsel	Expert Witness Fees	Court Costs	Deposition Costs	Other Legal Fees
Pending Claims	$ 41,611,818	$ 3,746,134	$ 59,034	$ 1,029,507	$ 2,414,074
Closed Claims	$ 14,909,632	$ 1,278,214	$ 102,725	$ 226,207	$ 1,649,852
Total	$ 56,521,450	$ 5,024,348	$ 161,759	$ 1,255,714	$ 4,063,926

The total defense costs that have been paid by reporting entities on all claims that were either closed in 2006 or pending as of December 31, 2006, during the entire pendency of all such claims was $ 153,253,809. The following table details these defense costs:

Table 6 – Total Amounts Paid in Defense Costs on Claims from Inception to Year End

	Fees Paid to Defense Counsel	Expert Witness Fees	Court Costs	Deposition Costs	Other Legal Fees
Pending Claims	$ 85,766,536	$ 7,560,698	$ 116,717	$ 2,073,189	$ 4,453,137
Closed Claims	$ 44,529,034	$ 4,427,601	$ 123,541	$ 984,998	$ 3,218,358
Total	$ 130,295,570	$ 11,988,299	$ 240,258	$ 3,058,187	$ 7,671,495

[4] The numbers used for this chart are completely derived from numbers reported by claimants' counsel. Despite efforts by the Department to encourage the reporting by claimants' counsel, not all such attorneys filed reports with the Department. According to the insurance reporting entities, approximately 700 lawyers represented claimants that received money in 2006. Only 156 attorneys reported receiving fees in 2006. Thus, the information reported is based on the information the Department did receive from the reporting attorneys. It should be stressed, however, that this was the first year that the law required claimants' counsel to file reports.

[5] In all judgments but one, the reporting claimant's counsel reported that the matter was settled and the amount paid to the claimant's counsel was reduced based upon the settlement amount.

V. TOTAL PAYMENTS MADE IN 2006

The following table details the total amounts paid on all claims in 2006, both closed and pending. It is presumed that all legal fees to claimants' counsel, which were not reported, would be included in the amount of damages paid by the reporting entity.

Table 7 – Total Amounts Paid on Pending and Closed Claims

	2005 Totals	2005 Percentages	2006 Totals	2006 Percentages
Total Defense Costs	$ 61,768,804	29.56%	$ 67,027,197	38.92%
Total Damages Paid by Settlement	$ 141,082,277	67.53%	$ 100,223,337	58.20%
Total Damages Paid by Judgment	$ 6,075,724	2.91%	$ 4,951,459	2.88%
Total Payments in 2006	$ 208,926,805	100.00%	$ 172,201,993	100.00%

VI. 2006 DIRECT PREMIUM WRITTEN

A. Premiums

The total direct medical malpractice premiums written in 2006 in Tennessee by insurance companies were $ 344,577,527. This total was determined from the 2006 annual financial statements filed by insurance companies.

B. Reserves

The Department has calculated the reserves or "direct losses unpaid" for the insurance company reporting entities as filed in their 2006 annual financial statement. These reserves totaled $ 794,843,289.[6]

VII. NEXT STEPS

The Department will continue to work with the General Assembly in order to make sure the information provided in this report provides all relevant information needed by the General Assembly. In addition, the Department will also continue to work with the reporting entities to refine the reporting form and to provide specific directions to the reporting entities about how to properly report in order to improve the uniformity of the reporting entities' reporting methodology. The following are specific changes recommended by the Department to be included in the statute or reporting form for future years that would enable the Department to provide additional relevant information:

(1) Health care professionals and institutions should be required to disclose the existence of insurance coverage so that it can better be determined whether all uninsured professionals and facilities have reported; and

[6] The loss adjustment expenses (LAE) of the reporting entities are not available on a statewide basis, and, therefore, are not included. Financial information from reporting entities such as the uninsured health care facilities, which do not charge malpractice premiums or report reserves to the Department as do other insurance companies, are not included in this section. It should also be noted that the Department does not receive information concerning the amount of reserves held specifically for each of the reported claims.

MEDIA RELEASE

STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE

FOR IMMEDIATE RELEASE
NOVEMBER 1, 2007

CONTACT: KELLY M. BROCKMAN
615.741.6007 (OFFICE)

DEPARTMENT OF COMMERCE & INSURANCE RELEASES THIRD INSTALLMENT OF MEDICAL MALPRACTICE CLAIMS REPORT

Nashville, TN.- The Tennessee Department of Commerce and Insurance has completed the 2007 Medical Malpractice Claims Report.

The report is required by state law adopted in 2004 as a result of a study committee conducted by the General Assembly. Tennessee law requires insurance companies and uninsured health care professionals and facilities to report medical malpractice claims data to the Department over a four year period.

The report contains summary information regarding medical malpractice claims pending or resolved in 2006, and the amounts paid in damages, settlements, and expenses for medical malpractice claims.

"This is the third of four annual reports quantifying the frequency and cost of medical malpractice claims in Tennessee," said Leslie A. Newman, Commissioner for the Department of Commerce and Insurance. "We appreciate the efforts of insurance companies and medical professionals statewide to assist us in obtaining the information submitted for the report. We also appreciate the trial lawyers efforts this year as this was the first year they were required to submit information for this report."

Based upon financial data reported to the Department, insurance companies wrote over $345 million in medical malpractice premiums in Tennessee in 2006. According to the submitted medical malpractice claims information, Tennessee trial courts issued six medical malpractice judgments totaling $4,951,459. In 2006, over 2,973 medical malpractice claims were resolved by insurance companies and uninsured health care facilities. Eighty-five percent (85%) of these claims resolved in 2006 resulted in no payment of damages. Settlement of claims occurred for 15.24% of medical malpractice claims in 2006 and resulted in payment of damages totaling $100,233,337. Expenses paid in 2006 for defense of medical malpractice claims totaled $67,027,197. Insurance companies reported that financial reserves established in 2006 for Tennessee medical malpractice claims totaled $794,843,289. Approximately 5,430 open medical malpractice claims were identified as of December 31, 2006.

A copy of the report is available at the Department's website at www.tennessee.gov/commerce.

###

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615.741.2241

Health Care Stabilization Fund

Charles L. Wheelen, Executive Director
300 S.W. 8th Avenue, Second Floor
Topeka, Kansas 66603-3912

Web Site: http://www.hcsf.org/
Telephone: 785-291-3777
Fax: 785 291 3550

Testimony on House Bill 2782
House Insurance and Financial Institutions Committee
February 25, 2008
By Charles L. (Chip) Wheelen

Thank you for the opportunity to express our opposition to HB2782. The Health Care Stabilization Fund Board of Governors believes this bill would create redundant reporting requirements for our agency, and would incur unnecessary additional costs.

It is important to recognize that the Health Care Stabilization Fund is not a commercial insurance company. Our agency is the product of a successful public-private partnership established in the Health Care Providers Insurance Availability Act (K.S.A. 40-3401 *et. seq.*) We are not subject to regulation by the Commissioner of Insurance. Instead, we are directly accountable to the Legislature. Our reporting requirements are outlined in our enabling legislation, and each year we provide an extensive report to the Legislature's Health Care Stabilization Fund Oversight Committee. A copy of our most recent report to the Oversight Committee is attached for your information.

We recently testified in the House Social Services Budget Committee regarding the extensive recordkeeping requirements necessary for proper administration of the HCPIAA. We acknowledged that our three databases are inadequate, and requested supplemental spending authority in the current fiscal year in order to hire a consultant. Our objective is to design a new management information system for our agency that will be compatible with the new accounting system contemplated by the Department of Administration.

In the meantime, we cannot readily provide all the information described in section three of the bill. Our records simply do not include some of the elements spelled out in HB2782. Furthermore, because we are a state agency, our records have always been based on fiscal years; whereas, HB2782 requires calendar year reports. It would be extremely difficult, if not impossible, for us to meet the reporting requirements for April 1, 2009.

We are particularly concerned about the language in subsection (d) of section five at line 13 on page three. This subsection would repeal the confidentiality provisions contained in subsection (b) of section five. As you may already know, most of our claim payments are the product of a settlement agreement; not a jury trial. And for whatever reasons, most of these settlement agreements include provisions for confidentiality.

House Insurance
Date: 2-25-08
Attachment # 3

Subsection (d) of section five would exacerbate an existing problem. We are already confronted with a genuine dilemma regarding confidential information. Because we are considered a public agency, our records are subject to the Kansas Open Records Act, and we must comply with requests for information.

Upon receiving a court-approved settlement agreement, we always assure that the plaintiff is compensated promptly. Certain members of our Legal Section staff and our Fiscal Section staff are exposed to these documents because we need to process the claim payment. Of course I always review the settlement agreement before I sign a voucher for payment of the claim. Our staff knows that we have an ethical obligation to honor the confidentiality of these agreements.

The quandary is this; if we are asked to respond to a request for information about a particular case, we are obligated to divulge information that the private parties have requested be kept confidential. For this reason, we have drafted a substitute for HB2782 that would address this problem. It is attached to this testimony.

We urge you to favorably consider our draft substitute in lieu of the original version of HB2782. Thank you for your attention to our concerns.

Section 1. K.S.A. 45-221 is hereby amended to read as follows: 45-221. (a) Except to the extent disclosure is otherwise required by law, a public agency shall not be required to disclose:

(1) Records the disclosure of which is specifically prohibited or restricted by federal law, state statute or rule of the Kansas supreme court or the disclosure of which is prohibited or restricted pursuant to specific authorization of federal law, state statute or rule of the Kansas supreme court to restrict or prohibit disclosure.

(2) Records which are privileged under the rules of evidence, unless the holder of the privilege consents to the disclosure.

(3) Medical, psychiatric, psychological or alcoholism or drug dependency treatment records which pertain to identifiable patients.

(4) Personnel records, performance ratings or individually identifiable records pertaining to employees or applicants for employment, except that this exemption shall not apply to the names, positions, salaries or actual compensation employment contracts or employment-related contracts or agreements and lengths of service of officers and employees of public agencies once they are employed as such.

(5) Information which would reveal the identity of any undercover agent or any informant reporting a specific violation of law.

(6) Letters of reference or recommendation pertaining to the character or qualifications of an identifiable individual, except documents relating to the appointment of persons to fill a vacancy in an elected office.

(7) Library, archive and museum materials contributed by private persons, to the extent of any limitations imposed as conditions of the contribution.

(8) Information which would reveal the identity of an individual who lawfully makes a donation to a public agency, if anonymity of the donor is a condition of the donation, except if the donation is intended for or restricted to providing remuneration or personal tangible benefit to a named public officer or employee.

(9) Testing and examination materials, before the test or examination is given or if it is to be given again, or records of individual test or examination scores, other than records which show only passage or failure and not specific scores.

(10) Criminal investigation records, except as provided herein. The district court, in an action brought pursuant to K.S.A. 45-222, and amendments thereto, may order disclosure of such records, subject to such conditions as the court may impose, if the court finds that disclosure:

(A) Is in the public interest;

(B) would not interfere with any prospective law enforcement action, criminal investigation or prosecution;

(C) would not reveal the identity of any confidential source or undercover agent;

(D) would not reveal confidential investigative techniques or procedures not known to the general public;

(E) would not endanger the life or physical safety of any person; and

(F) would not reveal the name, address, phone number or any other information which specifically and individually identifies the victim of any sexual offense in article 35 of chapter 21 of the Kansas Statutes Annotated, and amendments thereto.

If a public record is discretionarily closed by a public agency pursuant to this subsection, the record custodian, upon request, shall provide a written citation to the specific provisions of paragraphs (A) through (F) that necessitate closure of that public record.

(11) Records of agencies involved in administrative adjudication or civil litigation, compiled in the process of detecting or investigating violations of civil law or administrative rules and regulations, if disclosure would interfere with a prospective administrative adjudication or civil litigation or reveal the identity of a confidential source or undercover agent.

(12) Records of emergency or security information or procedures of a public agency, or plans, drawings, specifications or related information for any building or facility which is used for purposes requiring security measures in or around the building or facility or which is used for the generation or transmission of power, water, fuels or communications, if disclosure would jeopardize security of the public agency, building or facility.

(13) The contents of appraisals or engineering or feasibility estimates or evaluations made by or for a public agency relative to the acquisition of property, prior to the award of formal contracts therefor.

(14) Correspondence between a public agency and a private individual, other than correspondence which is intended to give notice of an action, policy or determination relating to any regulatory, supervisory or enforcement responsibility of the public agency or which is widely distributed to the public by a public agency and is not specifically in response to communications from such a private individual.

(15) Records pertaining to employer-employee negotiations, if disclosure would reveal information discussed in a lawful executive session under K.S.A. 75-4319, and amendments thereto.

(16) Software programs for electronic data processing and documentation thereof, but each public agency shall maintain a register, open to the public, that describes:

(A) The information which the agency maintains on computer facilities; and

(B) the form in which the information can be made available using existing computer programs.

(17) Applications, financial statements and other information submitted in connection with applications for student financial assistance where financial need is a consideration for the award.

(18) Plans, designs, drawings or specifications which are prepared by a person other than an employee of a public agency or records which are the property of a private person.

(19) Well samples, logs or surveys which the state corporation commission requires to be filed by persons who have drilled or caused to be drilled, or are drilling or causing to be drilled, holes for the purpose of discovery or production of oil or gas, to the extent that disclosure is limited by rules and regulations of the state corporation commission.

(20) Notes, preliminary drafts, research data in the process of analysis, unfunded grant proposals, memoranda, recommendations or other records in which opinions are expressed or policies or actions are proposed, except that this exemption shall not apply when such records are publicly cited or identified in an open meeting or in an agenda of an open meeting.

(21) Records of a public agency having legislative powers, which records pertain to proposed legislation or amendments to proposed legislation, except that this exemption shall not apply when such records are:

(A) Publicly cited or identified in an open meeting or in an agenda of an open meeting; or

(B) distributed to a majority of a quorum of any body which has authority to take action or make recommendations to the public agency with regard to the matters to which such records pertain.

(22) Records of a public agency having legislative powers, which records pertain to research prepared for one or more members of such agency, except that this exemption shall not apply when such records are:

(A) Publicly cited or identified in an open meeting or in an agenda of an open meeting; or

(B) distributed to a majority of a quorum of any body which has authority to take action or make recommendations to the public agency with regard to the matters to which such records pertain.

(23) Library patron and circulation records which pertain to identifiable individuals.

(24) Records which are compiled for census or research purposes and which pertain to identifiable individuals.

(25) Records which represent and constitute the work product of an attorney.

(26) Records of a utility or other public service pertaining to individually identifiable residential customers of the utility or service, except that information concerning billings for specific individual customers named by the requester shall be subject to disclosure as provided by this act.

(27) Specifications for competitive bidding, until the specifications are officially approved by the public agency.

(28) Sealed bids and related documents, until a bid is accepted or all bids rejected.

(29) Correctional records pertaining to an identifiable inmate or release, except that:

(A) The name; photograph and other identifying information; sentence data; parole eligibility date; custody or supervision level; disciplinary record; supervision violations; conditions of supervision, excluding requirements pertaining to mental health or substance abuse counseling; location of facility where incarcerated or location of parole office maintaining supervision and address of a releasee whose crime was committed after the effective date of this act shall be subject to disclosure to any person other than another inmate or releasee, except that the disclosure of the location of an inmate transferred to another state pursuant to the interstate corrections compact shall be at the discretion of the secretary of corrections;

(B) the ombudsman of corrections, the attorney general, law enforcement agencies, counsel for the inmate to whom the record pertains and any county or district attorney shall have access to correctional records to the extent otherwise permitted by law;

(C) the information provided to the law enforcement agency pursuant to the sex offender registration act, K.S.A. 22-4901, *et seq.*, and amendments thereto, shall be subject to disclosure to any person, except that the name, address, telephone number or any other information which specifically and individually identifies the victim of any offender required to register as provided by the Kansas offender registration act, K.S.A. 22-4901 *et seq.* and amendments thereto, shall not be disclosed; and

(D) records of the department of corrections regarding the financial assets of an offender in the custody of the secretary of corrections shall be subject to disclosure to the victim, or such victim's family, of the crime for which the inmate is in custody as set forth in an order of restitution by the sentencing court.

(30) Public records containing information of a personal nature where the public disclosure thereof would constitute a clearly unwarranted invasion of personal privacy.

(31) Public records pertaining to prospective location of a business or industry where no previous public disclosure has been made of the business' or industry's interest in locating in, relocating within or expanding within the state. This exception shall not include those records pertaining to application of agencies for permits or licenses necessary to do business or to expand business operations within this state, except as otherwise provided by law.

(32) Engineering and architectural estimates made by or for any public agency relative to public improvements.

(33) Financial information submitted by contractors in qualification statements to any public agency.

(34) Records involved in the obtaining and processing of intellectual property rights that are expected to be, wholly or partially vested in or owned by a state educational institution, as defined in K.S.A. 76-711, and amendments thereto, or an assignee of the institution organized and existing for the benefit of the institution.

(35) Any report or record which is made pursuant to K.S.A. 65-4922, 65-4923 or 65-4924, and amendments thereto, and which is privileged pursuant to K.S.A. 65-4915 or 65-4925, and amendments thereto.

(36) Information which would reveal the precise location of an archeological site.

(37) Any financial data or traffic information from a railroad company, to a public agency, concerning the sale, lease or rehabilitation of the railroad's property in Kansas.

(38) Risk-based capital reports, risk-based capital plans and corrective orders including the working papers and the results of any analysis filed with the commissioner of insurance in accordance with K.S.A. 40-2c20 and 40-2d20 and amendments thereto.

(39) Memoranda and related materials required to be used to support the annual actuarial opinions submitted pursuant to subsection (b) of K.S.A. 40-409, and amendments thereto.

(40) Disclosure reports filed with the commissioner of insurance under subsection (a) of K.S.A. 40-2,156, and amendments thereto.

(41) All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the commissioner by the national association of insurance commissioners' insurance regulatory information system.

(42) Any records the disclosure of which is restricted or prohibited by a tribal-state gaming compact.

(43) Market research, market plans, business plans and the terms and conditions of managed care or other third party contracts, developed or entered into by the university of Kansas medical center in the operation and management of the university hospital which the chancellor of the university of Kansas or the chancellor's designee determines would give an unfair advantage to competitors of the university of Kansas medical center.

(44) The amount of franchise tax paid to the secretary of revenue or the secretary of state by domestic corporations, foreign corporations, domestic limited liability companies, foreign limited liability companies, domestic limited partnership, foreign limited partnership, domestic limited liability partnerships and foreign limited liability partnerships.

(45) Records, other than criminal investigation records, the disclosure of which would pose a substantial likelihood of revealing security measures that protect: (A) Systems, facilities or equipment used in the production, transmission or distribution of energy, water or communications services; (B) transportation and sewer or wastewater treatment systems, facilities or equipment; or (C) private property or persons, if the records are submitted to the agency. For purposes of this paragraph, security means measures that protect against criminal acts intended to intimidate or coerce the civilian population, influence government policy by intimidation or coercion or to affect the operation of government by disruption of public services, mass destruction, assassination or kidnapping. Security measures include, but are not limited to, intelligence information, tactical plans, resource deployment and vulnerability assessments.

(46) Any information or material received by the register of deeds of a county from military discharge papers (DD Form 214). Such papers shall be disclosed: To the military dischargee; to such dischargee's immediate family members and lineal descendants; to such dischargee's heirs, agents or assigns; to the licensed funeral director who has custody of the body of the deceased dischargee; when required by a department or agency of the federal or state government or a political subdivision thereof; when the form is required to perfect the claim of military service or honorable discharge or a claim of a dependent of the dischargee; and upon the written approval of the commissioner of veterans affairs, to a person conducting research.

(47) Information that would reveal the location of a shelter or a safehouse or similar place where persons are provided protection from abuse.

(48) Any information or record pertaining to payments from the health care stabilization fund pursuant to subsection (c) of K.S.A. 40-3403.

(b) Except to the extent disclosure is otherwise required by law or as appropriate during the course of an administrative proceeding or on appeal from agency action, a public agency or officer shall not disclose financial information of a taxpayer which may be required or requested by a county appraiser or the director of property valuation to assist in the determination of the value of the taxpayer's property for ad valorem taxation purposes; or any financial information of a personal nature required or requested by a public agency or officer, including a name, job description or title revealing the salary or other compensation of officers, employees or applicants for employment with a firm, corporation or agency, except a

public agency. Nothing contained herein shall be construed to prohibit the publication of statistics, so classified as to prevent identification of particular reports or returns and the items thereof.

(c) As used in this section, the term "cited or identified" shall not include a request to an employee of a public agency that a document be prepared.

(d) If a public record contains material which is not subject to disclosure pursuant to this act, the public agency shall separate or delete such material and make available to the requester that material in the public record which is subject to disclosure pursuant to this act. If a public record is not subject to disclosure because it pertains to an identifiable individual, the public agency shall delete the identifying portions of the record and make available to the requester any remaining portions which are subject to disclosure pursuant to this act, unless the request is for a record pertaining to a specific individual or to such a limited group of individuals that the individuals' identities are reasonably ascertainable, the public agency shall not be required to disclose those portions of the record which pertain to such individual or individuals.

(e) The provisions of this section shall not be construed to exempt from public disclosure statistical information not descriptive of any identifiable person.

(f) Notwithstanding the provisions of subsection (a), any public record which has been in existence more than 70 years shall be open for inspection by any person unless disclosure of the record is specifically prohibited or restricted by federal law, state statute or rule of the Kansas supreme court or by a policy adopted pursuant to K.S.A. 72-6214, and amendments thereto.

(g) Any confidential records or information relating to security measures provided or received under the provisions of subsection (a)(45) shall not be subject to subpoena, discovery or other demand in any administrative, criminal or civil action.

Sec. 2. K.S.A. 45-221 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

Health Care Stabilization Fund

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Report

to the

Health Care Stabilization Fund Oversight Committee

On Behalf of the
Health Care Stabilization Fund Board of Governors

Arthur D. Snow, Jr., M.D., Chairman
Timothy Bolz, D.C.
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Elaine L. Ferguson, D.O.
Larry Shaffer

December 14, 2007

By Charles L. Wheelen
Executive Director

Thank you for your public service as a member of the Oversight Committee, and for this opportunity to present important information on behalf of our Board of Governors.

For several years the Executive Director of the HCSF was Robert D. Hayes. After a distinguished career of public service, Mr. Hayes decided to retire in September this year. Some of those years were difficult, and even controversial, but Mr. Hayes provided steady leadership and guidance needed to assure the survival of the Health Care Stabilization Fund. As a result of his diligence, the HCSF is actuarially sound and it continues to serve its intended purpose.

Historical Review

During the first half of the seventies decade, many Kansas physicians were confronted with rapidly escalating medical malpractice insurance premiums. Some physicians could not purchase professional liability insurance at all. By 1975, several insurers had discontinued offering medical malpractice coverage in Kansas, and the remaining companies had reached their capacity. Some doctors continued to practice without liability insurance, but others limited their services in order to reduce their exposure to liability. It became increasingly difficult for patients to find physicians willing to deliver infants or perform surgery.

The 1976 Legislature responded by enacting the original version of the Health Care Providers Insurance Availability Act, which, among other things, created the Health Care Stabilization Fund. To accommodate those doctors who could not buy commercial insurance coverage, a joint underwriting association was created; the Health Care Providers Insurance Availability Plan.

An important feature of the early version of the Availability Act was a requirement that insurers sell "claims made" rather than occurrence coverage. This was accompanied by a somewhat unique provision for prior acts coverage under the HCSF. In other words, the health care provider was insured for any claims made during the term of the insurance policy, regardless of when the incident occurred. Equally important, if the doctor retired or left Kansas to practice elsewhere, he or she had prior acts (tail) coverage via the HCSF for any claims that might arise after his or her claims made insurance policy was discontinued.

Unlike commercial insurance policies, the HCSF provided unlimited coverage. In other words, a doctor or hospital could be sued for any amount of money, and there was no limit on the amount a jury could award to a plaintiff, or the amount that could be agreed to in a settlement. Yet there was a statutory limit on the reserves that could be maintained in the Fund.

1980 was a significant year in the Fund's history because 87 new cases were filed and the trend continued with 98 new cases in 1981. By the end of fiscal year 1982, the Fund had paid out over $5-million in losses and there was cause for alarm. It appeared obvious that accrued future liabilities were rapidly exceeding cash reserves in the Fund.

The 1984 Legislature attempted to correct problems inherent in the original Act. The law was changed to limit the Fund's liability to $3-million per claim and $6-million annual aggregate liability. Another major amendment removed the statutory limit on the Fund's balance and prescribed that the premium surcharges should be based on estimated future liabilities. In other words, the Legislature decided the HCSF should be administered like an insurance plan, and should be actuarially sound.

During the second half of the eighties decade there was significant pressure on the Legislature to reform the rules of civil litigation. The medical profession and its allies engaged in an aggressive campaign for tort reform, whereas some members of the legal profession and certain consumer organizations were adamantly opposed. Eventually the Legislature passed a number of tort reform measures, and the cornerstone was a $250,000 limit on non-economic damages.

The controversy surrounding tort reform focused a great deal of attention on the HCSF, and there were those who blamed the Fund for causing the crisis. Some legislators insisted that the State should divest from the HCSF and legislation was passed that provided for a gradual phase-out. It was argued that in the absence of the Stabilization Fund, the commercial insurance industry would respond by offering adequate coverage to physicians and other health care professionals. But legislators were unwilling to use general tax revenue to pay for HCSF liabilities that were not funded by existing reserves.

In the meantime, the Legislature reduced the Fund coverage to $1-million per claim with annual aggregate limits of $3-million. Another important policy decision pertained to tail coverage. It was decided that a health care provider should participate in the Fund at least five years before the provider could become inactive and receive the benefit of prior acts coverage. In other words, the tail coverage had to be purchased by payment of premium surcharges for at least five years.

The filing of new cases began to level off during the early nineties, and the Fund balance began to gradually increase. By 1992 the Fund was considered actuarially sound, and premium surcharges were reduced accordingly. By this time there had been some changes in the Legislature and interest in phasing out the HCSF waned. Instead, the 1994 Legislature decided to remove the Fund from the Insurance Department and delegate responsibility for administration to the Board of Governors.

Principal Features of the Act

Defined health care providers are required to purchase professional liability insurance with coverage limits of $200,000 per claim with an annual aggregate total limit of $600,000 coverage. The health care providers are also required to select one of three options for additional coverage via the HCSF. Those options are:

$100,000 per claim with $300,000 annual aggregate
$300,000 per claim with $900,000 annual aggregate
$800,000 per claim with $2,400,000 annual aggregate

Most health care providers choose the highest coverage option which provides $1-million per claim with an annual aggregate limit of $3-million when combined with the primary level of insurance. Some health care providers purchase excess insurance in addition to the HCSF coverage.

There are sixteen categories of defined health care providers currently participating in the HCSF: (1) all three licensees under the Healing Arts Act - DCs, DOs, MDs, (2) three types of medical care facilities - hospitals, ambulatory surgery centers, recuperation centers, (3) podiatrists, (4) nurse anesthetists, (5) professional corporations, (6) limited liability companies, (7) partnerships, (8) not-for-profit corporations, (9) graduate medical education programs affiliated with KU, (10) dentists certified by the Board of Healing Arts to administer anesthesia, (11) psychiatric hospitals, and (12) community mental health centers. State psychiatric hospitals and state hospitals for the mentally disabled are specifically excluded from the definition.

21st Century

Several states throughout the country have experienced another crisis situation. In some areas, medical malpractice insurance is unavailable, and in other areas, the cost of premiums has caused physicians to retire early or limit the services available to patients. Some physicians are confronted with a dilemma when they cannot afford to relocate or retire because the cost of prior acts (tail) coverage is unaffordable. The old phrase "malpractice crisis" has been replaced, and is more accurately described as a professional liability insurance (PLI) crisis.

In Kansas, however, the Health Care Stabilization Fund has accomplished precisely what was intended. It provides stability by assuring that physicians and other health care professionals have access to liability insurance. It operates somewhat like a mutual, not-for-profit insurance company because it is held in trust by the State of Kansas instead of being owned by investors. There is no demand for profits and dividends. Instead, we assure that health care providers are actively defended when there is litigation involving the Fund, and that when there is a settlement or judgment in favor of a plaintiff, the injured party is promptly compensated. In other words, the Fund is efficiently administered in accordance with the Health Care Providers Insurance Availability Act.

Commercial Insurance

Currently there are over twenty insurance companies or risk retention groups offering the primary level of insurance in Kansas. Some of those companies and RRGs offer coverage only to a specific profession or specialty group. Most Kansas health care providers can purchase professional liability insurance from one of these companies, but there are some who cannot. As a result, there are almost 600 health care providers participating in the Availability Plan.

This year the HCSF will be required to transfer over $2-million to subsidize underwriting losses attributable to the Availability Plan. This will increase the total accrued net subsidies to over $15-million in revenue that has been collected from Kansas health care providers. On the other hand, during the recent five-year period, the Plan has produced modest surplus revenues. We are hopeful that the Availability Plan will continue to serve its purpose without requiring substantial transfers from the HCSF.

Financial Status and Trends

Subsection (b) of K.S.A. 40-3403 imposes specific reporting requirements on our Board of Governors. This section of our report will address those reporting requirements and will elaborate.

We concluded fiscal year 2007 with a fund balance of $206,861,948. Our actuary, Mr. Sutter will provide detailed information regarding estimated future liabilities and will explain why this Fund balance is adequate but not excessive.

The surcharge rates for fiscal year 2007 were adjusted based on loss experience for the category of health care provider. The increases ranged from 3% for chiropractors and physicians who do not perform invasive procedures, to 15% for surgical specialists and nurse anesthetists. The lowest annual surcharge was only $50 for a chiropractor selecting the lowest coverage option.

The highest surcharge for an individual health care professional was $13,898 for a neurosurgeon selecting the highest coverage option. During fiscal year 2007 we collected premium surcharges amounting to $23,056,279. Premium surcharge rates did not change for the current fiscal year.

It is particularly noteworthy that in July this year our Board of Governors made an important decision. In the past, it has been our practice to assign reserves for prior acts of inactive health care providers only after the health care provider became inactive, and therefore eligible for tail coverage. Beginning in fiscal year 2008 we will alter our practice and estimate our future liabilities for tail coverage when health care providers are still actively practicing their profession. This will necessarily reduce our unassigned reserves to a modest percentage of our fund balance, but will improve the accuracy of our estimated total future liabilities.

For fiscal year 2007, those health care providers who also provided services in Missouri were charged an additional 20% because of the added liability exposure. For fiscal year 2008, the Missouri practice modification factor was increased to 25% based on our Actuary's recommendation. Institutional health care providers continue to pay surcharges based on a percentage of their primary insurance premium. Those percentage rates did not change in either fiscal year.

During fiscal year 2007 we also received investment income amounting to $7,900,081. You may recall that the Pooled Money Investment Board manages investment of our unencumbered balances. A graph that compares our recent investment performance with other benchmarks accompanies this report.

We began fiscal year 2007 with 707 open cases. During the year, we closed 374 cases and opened 239 new ones, ending the fiscal year with 572 open cases. Because there was a significant increase in new cases during fiscal year 2006, there was cause for concern. The average number of new cases during the past three fiscal years is, however, consistent with, or less than prior years.

Because many cases involve two or more claims, our legal staff was extremely busy during fiscal year 2007. Claims payments during fiscal year 2007 amounted to $22,467,114 and several cases remained open at the conclusion of the year. In addition, we expended $4,840,828 for claims related costs such as attorney fees. A detailed report on litigation and claims activity has been compiled by our Chief Attorney and is an addendum to this report.

Self-Insured Health Care Providers

You may recall that K.S.A. 40-3414 allows certain health care providers to self-insure. That section of the Statutes also declares certain state facilities for veterans, as well as faculty and residents at the University of Kansas Medical Center and its affiliates, to be self-insured. Our Deputy Director who also serves as our Chief Attorney will provide a separate report on the status and cash-flow characteristics of those programs.

In addition to the state-owned medical care facilities and affiliates of the KU Medical Center, there are currently twelve self-insured hospitals and surgery centers that have been approved by our Board of Governors and have been issued a certificate of self insurance.

Contemporary Issues

One of the challenges of managing information, particularly when the data transcends fiscal years, is selection of an appropriate database or financial management software system. In our case, we need to maintain accurate records of all health care providers who participate in the Fund and because of our tail coverage obligations; those records must be maintained for long periods of time.

In addition, we must retain volumes of information pertaining to hundreds of cases and the separate claims within each case. And finally, we need the capacity to correlate income data with providers who pay the premium surcharges, and the capacity to correlate expense data with claims and cases.

Because of this need to assure accurate information management, our Board of Governors decided to contract for auditing services to recommend ways we can improve our systems. We have estimated a cost of about $75,000 for such services and have submitted a request for supplemental spending authority that must be approved by the Legislature. **It is respectfully requested that the Oversight Committee endorse our request and include the recommendation in your report.**

Another issue we are confronted with pertains to the definition of medical care facility. The original legislative intent appears obvious and clear, but many hospitals and other facilities have changed over the years. For a variety of reasons, some medical care institutions are adding ancillary facilities or programs that may or may not be directly related to the original mission of the institution. Each time this occurs, the HCSF is exposed to additional liability for the services offered by those ancillary facilities or programs.

Our Board of Governors recently decided to begin drafting administrative regulations that will clarify the definition of "medical care facility" solely for purposes of the Health Care Providers Insurance Availability Act. We believe we can establish some criteria and standards that will be acceptable to the hospital industry, and will establish reasonable guidelines for interpretation of legislative intent.

Conclusion

Because of the perseverance of our Legislature, as well as the medical profession and the hospital industry, the Health Care Stabilization Fund has overcome difficult obstacles and challenges. At one time in its history the Fund was scheduled to expire, and its demise was imminent. Instead, it was rehabilitated and recovered. Because of the leadership provided by certain dedicated individuals, we have achieved the original public policy goal established by the 1976 Legislature.

We are particularly grateful for the leadership provided by a former Chairman of the Senate Financial Institutions and Insurance Committee who, during the early nineties, orchestrated a comprehensive overhaul of the Health Care Providers Insurance Availability Act. Those amendments are the principal reasons for our success today.

Thank you for your attention. Of course we will provide any additional information you request.

Health Care Stabilization Fund

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Medical Professional Liability Experience
Fiscal Year 2007

By Rita Noll
Deputy Director and Chief Attorney

This report for the Board of Governors of the Health Care Stabilization Fund summarizes medical professional liability experience in Kansas during fiscal year 2007. The report is based on statistical data gathered by the Fund in administering the Health Care Provider Insurance Availability Act.

This report on medical malpractice litigation is based on all claims resolved in fiscal year 2007 including judgments and settlements. By far, the majority of medical malpractice cases are resolved by settlement rather than by jury trial.

Medical professional liability refers to a claim made against a health care provider for the rendering of or failure to render professional services (K.S.A. 40-3403). Health care provider is defined in K.S.A. 40-3401 to include physicians, chiropractors, podiatrists, registered nurse anesthetists, and certain medical care facilities. Fiscal year 2007 covers the period of time from July 1, 2006 through June 30, 2007.

It should be noted that dollar amounts will not necessarily correspond with the agency's accounting and budgeting documents because claims are not necessarily paid in the same fiscal year that the settlement was approved by the court, or the judgment was rendered by a jury.

MEDICAL PROFESSIONAL LIABILITY EXPERIENCE

A. Jury Verdicts

From HCSF data, 36 medical malpractice cases involving 46 Kansas health care providers were tried to juries during fiscal year 2007. Of these, 32 cases were tried to juries in Kansas courts and four cases involving Kansas health care providers were tried to juries in Missouri. These jury trials were held in the following jurisdictions:

Sedgwick County	13
Johnson County	8
Jackson Co., MO	4
Douglas County	2
Shawnee County	2
U.S. District Court, KS	1
Labette County	1
Wyandotte County	1
Reno County	1
Crawford County	1
Geary County	1
Thomas County	1
Total	36

Of the 36 cases tried, 31 resulted in defense verdicts. Plaintiffs won verdicts in five cases. Juries returned verdicts for plaintiffs and awarded damages in the following cases:

Case	Court	Verdict Amount*	HCSF Amount*
Plaintiff v. Doctor	Douglas Co.	$759,679.74	$579,679.74
Plaintiff v. Doctor	Sedgwick Co.	$735,182.00	$535,182.00
Plaintiff v. Doctor	Shawnee Co.	$ 52,555.42	
Plaintiff v. Doctor	Johnson Co.	$ 62,296.65	
Plaintiff v. Doctor	Jackson Co., MO	$745,543.33	$545,543.33

*Note: Cases may be on appeal.

This year's experience compares to previous fiscal years as follows:

	FY 07	FY 06	FY 05	FY04	FY03	FY02	FY01	FY00	FY99
Total	36	29	34	28	27	19	21	28	26
Defense Verdict	31	23	22	23	23	10	13	18	16
Plaintiff Verdict	5	6	7	3	3	6	6	7	5
Hung Jury			1		1		1	2	3
Split Verdict			3	2		2		1	1
Mistrial			1			1	1		1

B. Settlements

Claims settled by the Fund. During FY 2007, 61 claims in 53 cases were settled involving HCSF monies. Settlement amounts incurred by the HCSF for the fiscal year totaled $20,929,250. This compares to last year's total of $24,917,984 to settle 89 claims in 81 cases. These figures do not include settlement contributions by primary or excess carriers. The settlement amounts are payments made, or to be made, by the HCSF in excess of primary coverage or on behalf of inactive health care providers. The average Fund settlement amount per claim for FY 2007 claims is $343,102.45. This compares to last year's average of $279,977.

Fiscal Year	Number of Claims/Cases	Fund Amount	Settlement Average
FY 2007	61/53	$20,929,250.00	$343,102
FY 2006	89/81	$24,917,984.00	$279,977
FY 2005	90/74	$23,544,658.00	$261,607
FY 2004	79/64	$18,905,505.00	$239,310
FY 2003	87/76	$17,483,778.00	$200,963
FY 2002	67/58	$16,173,742.00	$241,399
FY 2001	54/44	$15,592,748.80	$288,755
FY 2000	69/59	$20,071,607.50	$290,893
FY 1999	70/57	$18,344,368.15	$262,062
FY 1998	60/53	$11,461,345.13	$191,022
FY 1997	39/33	$12,448,978.83	$319,204
FY 1996	67/51	$21,808,406.14	$325,498
FY 1995	42/36	$15,344,749.98	$365,351
FY 1994	59/45	$19,526,821.53	$330,963
FY 1993	45/37	$18,239,093.06	$405,313
FY 1992	33/27	$ 7,890,119.83	$239,095
FY 1991	44/NA	$16,631,491.94	$377,988

Health Care Stabilization Fund individual claim settlement contributions during fiscal year 2007 ranged from a low of $10,000 to a high of $800,000. HCSF settlements fall within the following ranges and are compared to individual claim settlements in previous years:

	FY 07	FY06	FY05	FY04	FY03	FY02	FY01	FY00	FY99	FY98
$000-$9,999	0	0	0	0	3	2	1	0	1	0
$10,000-$49,999	6	9	5	13	11	7	6	6	11	8
$50,000-$99,999	7	12	13	18	18	7	10	6	7	13
$100,000-$499,999	27	51	58	37	44	40	24	41	37	33
$500,000-$999,999	21	17	14	11	11	11	13	16	13	6
$1,000,000-or more	0	0	0	0	0	0	0	0	1	0
Total Claims	61	89	90	79	87	67	54	69	70	60

Of the 61 claims involving Fund monies, the Fund provided primary coverage for inactive health care providers in 9 claims. The Fund received tenders of primary insurance carriers' policy limits in 48 claims. Therefore, in addition to the $20,929,250 incurred by the Fund, primary insurance carriers contributed $9,488,750 to the settlement of these claims. (The tender amount in one case was less than $200,000 as the aggregate primary policy limits were reached.) Also, the Fund "dropped down" to provide first dollar coverage in four cases in which aggregate primary policy limits were reached. Further, six claims involved contribution from an insurer whose coverage was excess of Fund coverage. The total amount of these contributions was $3,125,000.

Total settlement contributions for claims involving Fund contribution for the last thirteen fiscal years are as follows:

Fiscal Year	Primary Carriers	HCSF	Excess Carriers
FY 07	$ 9,488,750.00	$20,929,250.00	$ 3,125,000.00
FY 06	$14,580,000.00	$24,917,984.00	$ 5,089,425.00
FY05	$15,800,000.00	$23,544,658.00	$10,450,000.00
FY04	$12,600,000.00	$18,905,505.00	$ 8,550,000.00
FY03	$14,200,000.00	$17,483,778.00	$ 2,787,500.00
FY02	$11,400,000.00	$16,173,742.00	$ 2,680,000.00
FY01	$ 8,800,000.00	$15,592,748.80	$ 6,710,000.00
FY00	$12,515,000.00	$20,071,607.50	$ 2,465,000.00
FY99	$11,800,000.00	$18,344,368.15	$ 8,202,500.00
FY98	$ 8,825,000.00	$11,461,345.13	$ 3,040,000.00
FY97	$ 6,046,667.33	$12,448,978.83	$ 1,117,500.00
FY96	$11,000,000.00	$21,808,406.14	$ 1,065,000.00
FY95	$ 7,000,000.00	$15,344,749.98	(Not available)

Claims settled by primary carriers. In addition to the settlements discussed above, the HCSF was notified that primary carriers settled an additional 167 claims in 146 cases. The total amount of these reported settlements is $10,870,339. These figures compare to the last several fiscal years as follows:

FY	Number of Claims/Cases	Amount Paid by Primary Carrier
2007	167/146	$10,870,339.00
2006	110/98	$ 8,545,218.00
2005	103/88	$ 8,058,894.00
2004	99/85	$ 6,978,801.00
2003	122/99	$ 9,087,872.00
2002	141/124	$10,789,299.00
2001	109/88	$ 8,124,459.00
2000	116/102	$ 8,390,869.00

C. HCSF Total Settlements and Verdict Amounts

During fiscal year 2007 the HCSF incurred $20,929,250.00 in 61 claim settlements and became liable for $1,660,405.27 as a result of three jury verdicts for a total 64 claims. The following figures compare total Fund settlements and awards since the inception of the Health Care Stabilization Fund.

Fiscal Year	Total Claims	Settlements & Awards	Average Per Claim
FY 2007	64	$22,589,655.27	$352,963.36
FY 2006	90	25,017,984.00	277,977.60
FY 2005	97	26,119,569.91	269,273.30
FY 2004	81	19,055,505.00	235,253.15
FY 2003	90	18,295,320.32	203,281.34
FY 2002	71	17,467,033.19	246,014.55
FY 2001	58	17,114,748.80	295,081.86
FY 2000	73	20,868,192.91	285,865.66
FY 1999	71	21,344,368.15	300,624.90
FY 1998	66	12,834,705.13	194,465.23
FY 1997	41	13,653,618.34	333,015.08
FY 1996	70	23,258,406.14	332,262.94
FY 1995	45	17,023,882.17	378,308.49
FY 1994	65	21,194,765.96	326,073.32
FY 1993	48	24,614,093.06	492,281.86
FY 1992	35	8,824,834.14	252,138.11
FY 1991	49	19,666,797.32	401,363.21
FY 1990	48	13,627,222.20	283,700.46
FY 1989	58	18,713,543.00	315,750.00
FY 1988	51	13,402,756.00	262,799.00
FY 1987	47	13,296,808.00	282,910.00
FY 1986	42	11,492,857.00	273,639.00
FY 1985	41	15,152,042.00	369,562.00
FY 1984	34	9,538,741.00	280,551.00
FY 1983	25	6,522,369.00	260,894.00
FY 1982	24	3,060,126.00	127,505.00
FY 1981	8	1,760,645.00	220,080.00
FY 1980	0	0.00	-
FY 1979	3	203,601.00	67,867.00
FY 1978	0	0.00	-
FY 1977	1	137,500.00	137,500.00

D. New Cases by Fiscal Year

The Health Care Stabilization Fund was notified of 304 cases during fiscal year 2007. The following chart lists the number of new cases opened according to fiscal year.

FY	Number of Cases
2007	304
2006	457
2005	336
2004	368
2003	392
2002	361
2001	341
2000	294
1999	319
1998	293
1997	318
1996	296
1995	326
1994	247
1993	263
1992	245
1991	230
1990	205
1989	251
1988	285
1987	320
1986	276
1985	245
1984	175
1983	153
1982	124
1981	98
1980	87
1979	50
1978	19
1977	2

TOWERS PERRIN
TILLINGHAST

Health Care Stabilization Fund

Fiscal Year 2008 Surcharge Issues

Presentation to the Health Care Stabilization Fund Oversight Committee

December 14, 2007

Presented by:
Russel L. Sutter
Tillinghast

This document was designed for discussion purposes only.
It is incomplete, and not intended to be used, without the accompanying oral presentation and discussion.

Table of Contents

This presentation will address the following topics:

- Our projections of unassigned reserves at June 2007 and June 2008.
- Our findings regarding Fund performance in the following areas:
  - Loss experience
  - Assets and liabilities
- The experience by provider class
- Fund history in the following areas:
  - Revenue and projected losses
  - Rate changes
- Tail liabilities for current active providers

Questions are welcome throughout the presentation.

This presentation may be considered an addendum to our report dated March 20, 2007. As such, the **Distribution and Use** and **Reliances and Limitations** sections of that report apply to this presentation.

Summary

- When we reported to the Fund Board of Governors in March 2007, our findings included the following
  - The Fund is financially sound
  - Loss experience in 2006 was better than in 2004 and 2005
  - Fund assets were higher than expected
  - Experience by class varied significantly.
- Considering all this, the Board elected to raise surcharge rates on two classes by 5% and increase the Missouri surcharge from 20% to 25%.
- Since the March report, the Fund's assets have increased more than expected. However, reserves on known claims have also increased more than expected.

Projected Unassigned Reserves – June 2007

The Fund's unassigned reserves were estimated to be $54.1 million at June 30, 2007 on a discounted basis. On an undiscounted basis, the estimated unassigned reserves were $39.3 million.

	Discounted	Undiscounted
Assets	$203.7	$203.7
Liabilities	149.6**	164.5
Unassigned Reserves	$ 54.1	$ 39.3

* Based on December 2006 data; presented to the Board of Governors in March, 2007.
**Present value assuming 4.7% yield.

Projected Unassigned Reserves – June 2008

Current indications suggest that the unassigned reserves will decrease to approximately $52.4 million (discounted) and $37.3 million (undiscounted) by June 30, 2008.

	Projected at 6/30/2008 ($ millions)			
	Original*		Updated**	
	Discounted	Undiscounted	Discounted	Undiscounted
Assets	$205.2	$205.2	$208.4	$208.4
Liabilities	151.8	166.9	156.0	171.1
Unassigned Reserves	$ 53.4	$ 38.3	$ 52.4	$ 37.3

Both Fund assets and liabilities are expected to be higher at June 2008 than previously anticipated. In addition, the transfer to the Plan in FY2008 of $2.2 million is higher than expected.

* Based on December 2006 data.
** Updated to reflect activity through October 31, 2007. Excludes impact of change in accounting for tail liabilities.

Findings – CY06 Performance

- Fund loss performance during Calendar Year 2006 was much better than in CY04 and CY05. The Row 1 amount was 31% lower than the prior 10-year average.

1. Settlements on Active Providers	$16.2m	$28.4m	$22.4m	$12.8m
2. Settlements on Inactive Providers	$1.6m	$3.2m	$2.1m	$0.6m
3. Claim Reserves on Active Providers at Year-End				
a. # Open Claims*	166	243	218	168
b. $ of Reserves	$28.7m	$36.4m	$32.2m	$35.0m
4. Claim Reserves on Inactive Providers at Year-End				
a. # Open Claims*	54	52	51	42
a. $ of Reserves	$3.8m	$4.1m	$4.7m	$4.5m

*Counted if Fund reserve is greater than $0.

Findings – Fund Assets and Reserves

- Fund assets have increased significantly since December 2005. However, the recent jump in claim reserves has brought "Assets Available for Unknown" back to the low $140 millions from nearly $150 millions at year-end 2006.

	($ millions)				
Date	Assets (1)	Future Payments (2)	Claim Reserves* (3)	Owed to Plan (4)	Assets Available for Unknown (5)=(1)-(2)-(3)-(4)
12/31/2001	$193.9	$10.5	$30.0	$0.3	$153.1
12/31/2002	197.1	5.4	39.7	1.5	150.5
12/31/2003	198.1	7.2	37.3	1.6	152.0
12/31/2004	193.1	10.5	44.1	0.0	138.5
12/31/2005	191.6	10.6	41.3	-0.7	140.4
12/31/2006	199.1	7.7	43.6	-1.5	149.3
10/31/2007	209.0	10.8	55.0	2.2	141.0

*Loss and expense, includes inactive providers. Reserves established on a case-by-case basis.

Findings – Indications by Provider Class

- Our analysis of experience by Fund class continues to show significant differences in relative loss experience among classes. However, differences have narrowed since our initial study in 2005, largely as a result of the rate changes in FY06 and FY07.

Relative Rate Change Indicated		
Decrease > 11%	Increase < 11% Decrease < 11%	Increase > 11%
Class 1 (-28%)	Class 4 (-11%)	Class 7 (+15%)
Class 16	Class 6	Class 8
Class 18	Class 17	Class 13
Class 20	Class 9	Class 11 (+44%)
Class 14 (-16%)	Class 12	
	Class 19	
	Class 15 (0%)	
	Class 5	
	Class 10	
	Class 2	
	Class 3 (+11%)	

- Pages 13 and 14 have further details on class experience and definitions.

Findings – Missouri Surcharge

- We analyzed the relative adequacy of the 20% Missouri surcharge. The table below summarizes the Fund's experience for those receiving the surcharge versus all other providers.

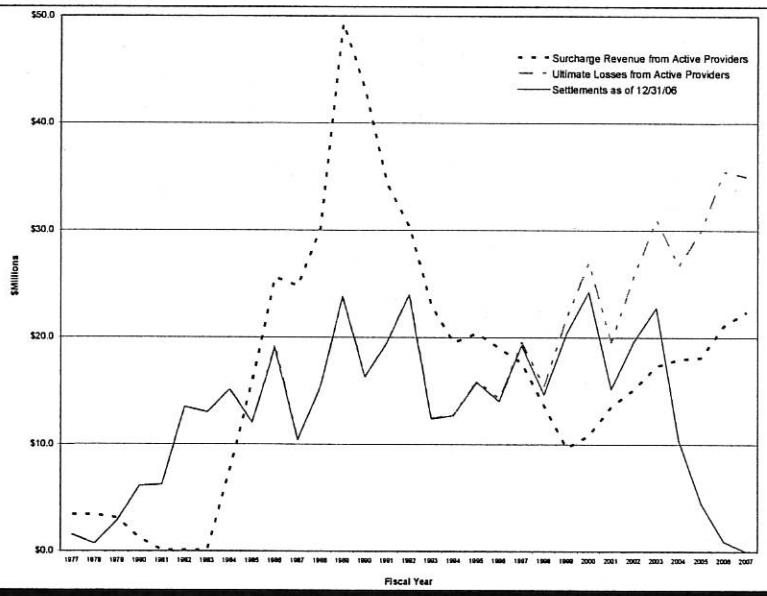
(1)	(2)	(3)	(4)	(5)
	% of Fund Revenue FY04-FY06		Distribution of Losses from FY01-FY07 Policies	
MO Surcharge Applicable	With 20% Surcharge	If No Surcharge	Paid Losses & Expenses	Current Loss Reserves
All Provider Classes				
Yes	20.2%	17.4%	22.4%	21.8%
No	79.8%	82.6%	77.6%	78.2%
Classes 1-16 Only				
Yes	25.0%	21.7%	27.3%	26.8%
No	75.0%	78.3%	72.7%	73.2%

- The data suggests that the 20% surcharge should actually be higher (approximately 30%).

Findings – History of Losses and Surcharges

- The attached chart compares the Fund's surcharge revenue history with the corresponding losses from active providers, as currently projected. Also shown are actual settlements at 12/2006.

Health Care Stabilization Fund
Surcharge Revenue vs. Losses from Active Providers



Fund History – Recent Rate Changes

- The table below shows the changes in Fund surcharge rates for FY2004 through FY2008 by class. All amounts reflect the $800,000/$2.4 million coverage level.

	Surcharge Rate Change				
HCSF Class	FY2004	FY2005	FY2006	FY2007	FY2008
1	0%	0%	5%	3%	0%
2	0%	0%	25%	15%	0%
3	0%	0%	15%	10%	0%
4	0%	0%	22%	5%	0%
5	0%	0%	18%	5%	0%
6	0%	0%	22%	5%	0%
7	0%	0%	22%	10%	0%
8	0%	0%	25%	15%	0%
9	0%	0%	10%	3%	0%
10	0%	0%	22%	10%	0%
11	0%	0%	25%	15%	5%
12	0%	0%	5%	3%	0%
13	0%	0%	25%	15%	5%
14	0%	0%	5%	3%	0%
15-21	-9%	-9%	9%	0%	0%
Average	-2%	-2%	15%	6%	1%*

*Includes impact of Missouri surcharge increase.

Findings – FY2008 Surcharge

- Surcharge rates were increased for FY2008 as follows.

Fund Classes	Change in Surcharge Rates
11, 13	+5.0%
All Other	No Changes
Missouri Surcharge	From 1.20 to 1.25

- The net impact of the changes is an overall expected rate increase of 1.1%.
- We viewed the decision as reasonable
  - Overall amount is modest, consistent with recent Fund experience
  - Rate change directed to classes with most losses
  - Missouri experience supported a higher surcharge than 20%

Experience and Rate Changes by Class

Class	FY2007 Surcharge Distribution	5-Year Loss Ratio Relativity	Selected FY2008 Rate Change
1	1.9%	0.06	+0.0%
2	12.5%	1.15	+0.0%
3	10.0%	1.18	+0.0%
4	2.2%	0.66	+0.0%
5	2.6%	1.14	+0.0%
6	5.4%	0.79	+0.0%
7	3.3%	1.40	+0.0%
8	6.9%	1.47	+0.0%
9	7.2%	0.88	+0.0%
10	8.0%	1.08	+0.0%
11	1.9%	2.63	+5.0%
12	1.2%	0.78	+0.0%
13	1.6%	2.16	+5.0%
14	0.8%	0.08	+0.0%
15	10.9%	0.99	+0.0%
16	4.4%	0.40	+0.0%
17	16.5%	0.90	+0.0%
Other	2.5%	0.22	+0.0%
Total	100.0%	1.00	+0.2%

Class Definitions, Distributions and Rates

		FY06 # Providers	FY07 Rate*
Class 1	– Physicians, No Surgery. Includes dermatology, pathology, psychiatry	535	$1,045
Class 2	– Physicians, No Surgery	2,169	1,724
Class 3	– Physicians, Minor Surgery	1,182	2,255
Class 4	– Family Practitioners, including minor surgery and OB	236	2,475
Class 5	– Surgery Specialty – Includes urology, colon/rectal, GP with major	221	2,904
Class 6	– Surgery Specialty – Includes ER (no major), ENT	386	3,736
Class 7	– Anesthesiology	299	2,916
Class 8	– Surgery Specialty – Includes general, plastic, ER with major	274	6,702
Class 9	– Surgery Specialty – Includes cardiovascular, orthopedic, traumatic	280	6,854
Class 10	– Surgery Specialty – Includes OB/GYN	204	9,672
Class 11	– Surgery Specialty – Neurosurgery	41	13,898
Class 12	– Chiropractors	813	562
Class 13	– Registered Nurse Anesthetists	473	990
Class 14	– Podiatrists	95	2,546
Class 15	– Plan insureds	674	35%
Class 16	– Professional corporations, partnerships	984	35%
Class 17	– Medical care facilities	179	35%
Class 18	– Mental health centers	20	35%
Class 19	– Psychiatric hospitals	1	35%
Class 20	– Residency training program	666	35%
Class 21	– Other	0	35%
		9,732	

*$800,000/$2,400,000 Fund coverage, 5+ years of Fund compliance.

Tail Liabilities for Active Providers

- An active provider with 5+ years of Fund compliance is eligible for tail coverage from the Fund.
  - The Fund has recognized this liability when providers become inactive, not when providers achieve 5 years of compliance. Our reserve estimates have been consistent with this procedure.
- In July, the Board of Governors decided to change its accounting in order to recognize the tail liabilities of active providers with 5+ years of Fund compliance
  - This will reduce the unassigned reserves with the June 2008 estimates. Future changes in unassigned reserves should not be affected.
  - Rough estimates of these additional liabilities are approximately $25 million to $35 million. As a result, the $52.4 million of unassigned reserves on Page 4 probably becomes $20 million to $30 million when these liabilities are included

KaMMCO

KANSAS MEDICAL MUTUAL INSURANCE COMPANY

To: House Insurance and Financial Institutions Committee

From: Kurt Scott
Chief Operating Officer

Date: February 25, 2008

Subject: HB 2782; Concerning the Kansas Medical Liability Reporting Act

Thank you for the opportunity to present testimony in opposition to House Bill No. 2782 of the Session of the Kansas Legislature. I am Kurt Scott, Chief Operating Officer of Kansas Medical Mutual Insurance Company (KaMMCO), a Kansas domestic mutual insurance company formed by the Kansas Medical Society in 1989 to insure its members for medical professional liability. As a mutual insurance company, KaMMCO is owned and directed by its member insureds. KaMMCO is the largest writer of medical professional liability insurance in Kansas, insuring more than half of the State's physicians and hospitals.

House Bill No. 2782 would require insurance companies, self-insured hospitals, the Kansas Health Care Stabilization Fund, reinsurance companies, among others to report certain premium and claim data for health care providers as defined by K.S.A. 40-3401 to the Kansas Insurance Commissioner. The data required to be reported includes:

1. Claim number
2. Claimant name
3. Claimant Social Security Number
4. Name, address, and phone number of the claimant's attorney
5. Whether a lawsuit has been filed
6. The jurisdiction of the lawsuit (if applicable)
7. Specialty of the health care provider(s)
8. Claim payments paid to the claimant
9. Claim expenses paid
10. Premiums earned
11. Total reserves (including reserve changes)

As an advocate for its member physicians and hospitals and the patients they care for, KaMMCO is a proponent of transparency in the medical professional liability insurance business. This line of insurance has significant implications for the health of our State

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and its citizens, and regulators and policy makers need adequate and accurate information from which to develop balanced legislation and regulation. However, there are many flaws contained in House Bill No. 2782, and KaMMCO opposes its passage in the present form, and at this time, for the following reasons:

A. With the exception of the claimant's social security number and the name of the plaintiff attorney, all of the information requested is already contained in numerous reports filed with various State agencies and national statistical agencies. For example, K.S.A. 40-225 requires insurance companies to file an Annual Statement on a form prescribed by the National Association of Insurance Commissioners (NAIC), which includes detailed premium, reserve, claim payment and claim expense payment information. This report is required by State law to be audited for accuracy each year by an independent CPA firm and is subject to periodic examination by the Kansas Insurance Commissioner. In addition, K.S.A. 40-961 requires insurance companies, on a calendar quarterly basis, to report detailed data in electronic form to a national statistical agency, the Insurance Services Office (ISO). All of the data required by HB 2782, save the claimant's SSN and attorney contact information, is included in this report on a claim-by-claim basis. Further, there are various claim reports insurers are required to file with the Health Care Stabilization Fund, Board of Healing Arts, and National Practitioner Data Bank, which include several components of the data required by HB 2782. KaMMCO fails to see the necessity of filing the same data multiple times in multiple formats when the information is already publicly available.

B. The NAIC is currently working on model legislation, the Medical Malpractice Closed Claim Reporting Model Law, which appears to encompass most, if not all, of the information sought by HB 2782. KaMMCO believes it would be prudent to wait until this model law is finalized to determine if it meets the needs of the State, before passing even more duplicative reporting requirements for insurers.

C. Great care must be used when reporting individually identified professional liability claims information. HB 2782 would require insurers to report injured patients' names, social security numbers, as well as details about confidential settlements to state regulators. HB 2782 does not appear to amend the Kansas Open Records Act to exclude these reports from becoming open to public inspection, either intentionally or accidentally. In this era of privacy, HIPAA and identity theft, it seems unwise to report such individually identifiable information.

In conclusion, KaMMCO supports efforts to ensure transparency in medical professional liability insurance so policy makers may make well-informed, balanced public policy decisions which affect the health of our State and its citizens. But continuing to enact costly, duplicative reporting requirements, when that information already exists in the public domain, seems unnecessarily redundant to KaMMCO and the physicians and hospitals it represents, especially when it risks the disclosure of personal and private information and could undermine the claim settlement process. Therefore, KaMMCO respectfully opposes passage of House Bill No. 2782.

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To: House Insurance and Financial Institutions Committee

From: Jerry Slaughter
Executive Director

Date: February 25, 2008

Subject: HB 2782; Concerning the Kansas Medical Liability Reporting Act

The Kansas Medical Society appreciates the opportunity to appear today in opposition to HB 2782, a bill introduced by the trial lawyers association, which creates a new reporting requirement for professional liability insurance companies and self insured hospitals. While we oppose this particular measure, for the reason we will explain below, we support the concept of transparency, and reporting of all relevant claims and financial information related to medical malpractice insurance.

Our primary concern with this legislation is that it is unnecessary and premature at this particular time, given the fact that the National Association of Insurance Commissioners (NAIC) is currently working on a model law, the "Medical Malpractice Closed Claim Reporting Model Law," which will accomplish virtually everything contemplated in HB 2782. It would seem to us that we should wait until the NAIC model law, with a uniform national data set, is completed, and then consider adopting it, with any enhancements deemed appropriate for our state. To do otherwise will just add cost and complexity to the reporting of this information, which ultimately is passed on to physicians and hospitals in the form of higher premiums. As evidence of the costs associated with detailed reporting such as this, please refer to the fiscal note prepared by the Division of Budget, which estimates a cost on $444,500 to the Insurance Department and the Health Care Stabilization Fund. Those costs do not include additional costs to individual insurers which will also be passed on to health care providers.

We would urge you to defer action on this legislation until the NAIC model law is ready. However, if you choose to act on this bill, we would strongly recommend that you consider an amendment to include one of the major, and missing, elements of the cost of adjudicating medical malpractice claims. We are not aware of any source of even the most basic information regarding the cost of claim prosecution borne by plaintiffs in

medical malpractice claims. There is virtually no information reported by claimants, nor by their attorneys, on the expenses, including contingent fee amounts paid to plaintiff's counsel, associated with judgments and settlements. If we want to obtain the full picture of the costs of adjudicating medical malpractice claims, this information must also be collected.

We would like to suggest the following two amendments (in bold type), either as a part of this bill, if the committee elects to work the measure, or as part of the NAIC model bill, when it is before this committee in the near future:

In Section 2; (f) ''reporting entity'' means any of the following:
(1) Every insurance company, self-insured entity, risk retention group and excess or reinsurer, including, but not limited to, the Kansas health care stabilization fund, which provides medical malpractice or professional health care liability insurance, reinsurance, excess insurance, coverage or risk retention services to or for the benefit of any health care provider; and
(2) every health care provider which does not maintain or is not covered by malpractice or professional liability insurance coverage during any part of a reporting year; **and**
(3) every claimant's attorney in a medical malpractice action.

In Section 3; **(f) the reports required to be filed by claimant's attorneys pursuant to this section shall include the names and social security numbers, if known, of all claimants represented by the claimant's attorney, the claimant's attorneys' fees and expenses, the names and addresses of expert witnesses and any fees and expenses paid to them, deposition costs and other expenses of handling claims, any fees paid to other attorneys or others for referral of claims, and all amounts paid, or to be paid, to or for the benefit of the claimant or the claimant's heirs pursuant to any settlement or judgment.**

In summary, KMS supports the concept of transparency in medical malpractice claims reporting. However, we would encourage the legislature to not add duplicative, costly reporting requirements that just collect the same information that is already reported. Instead, we would urge careful consideration of the forthcoming model NAIC bill, and urge the addition of the amendments mentioned above. Thank you for the opportunity to offer these comments on HB 2782.

KANSAS HOSPITAL ASSOCIATION

Thomas L. Bell
President

February 25, 2008

TO: House Insurance and Financial Institutions Committee

FROM: Chad Austin
Vice President, Government Relations

RE: House Bill 2782

The Kansas Hospital Association appreciates the opportunity to provide comments opposing House Bill 2782. This legislation would create the Kansas Medical Liability Reporting Act.

After careful review of this proposed legislation it is KHA's opinion that HB 2782 is not needed for the following reasons.

- The National Association of Insurance Commissioners is currently working on a model law that would replicate many of the provisions outlined in this proposed legislation. Kansas should not proceed in creating a new law that could possibly conflict with and/or duplicate the provisions outlined by the NAIC model.

- This proposed legislation states that information and data submitted to the Kansas Insurance Department shall be confidential and not subject to public inspection, subpoena or legal compulsion and shall not be admissible in any criminal, civil or administrative proceeding. Section (d) then undoes this protection and states that these provisions will expire on July 1, 2013.

- Confidentiality is one of the key components of most settlement agreements with health care providers. Section 5 of HB 2782 states that nothing in this act should be construed to prevent parties from entering into confidential settlement agreements but then states that no settlement agreements may alter the reporting requirements. This contradictory language unravels the process by which most of the medical malpractice liability claims are handled by insisting on the reporting of these agreements.

- According to the Kansas Division of the Budget, the estimated State fiscal impact would be $444,500 in FY 2009. KHA believes this type of expenditure may be premature in light of certain information already available and the potential of a model law being created by the National Association of Insurance Commissioners.

KHA requests that this Committee will refrain from taking action on HB 2782. Thank you for your consideration of our comments.

House Insurance
Date: 2-25-08
Attachment # 6

Kansas Hospital Association
215 SE 8th Ave. • P.O. Box 2308 • Topeka, KS • 66601 • 785/233-7436 • Fax: 785/233-6955 • www.kha-net.org

MIDWEST CRANE AND RIGGING, INC.

15585 S. KEELER • P.O. BOX 970 • OLATHE, KANSAS 66051-0970
(913) 747-5100 • FAX (913) 764-0102

Feb.25th, 2008

To: The House Insurance Committee

Re: HB-2900

Chairman Clark Shultz, Vice Chairman Anthony Brown, and Committee

My name is Bill Miller. I am here to testify in support of HB-2900. I represent the American Subcontractors Association and my business, Midwest Crane and Rigging, Inc. ASA represents subcontractors and suppliers in Kansas and Western Missouri. Midwest Crane is headquartered in Olathe, Kansas with offices in Topeka and St. Joseph, Missouri.

Owner or contractor controlled insurance programs, commonly referred to as wrap-up policies, have become the number one problem for subcontractors according to a survey completed last summer. Wrap-ups are a relatively new insurance program that forces all subcontractors on a project to give up their own insurance program for that project and, in exchange for the premium that they would have paid; they are covered under one policy furnished by the owner or the general contractor.

This on the surface seems innocent enough. This is not at all the truth. These programs have serious deficiencies for the participants and in many cases, for the owner as well.

HB-2900 addresses 13 of the most serious problems.

1. The program sponsor can cancel the wrap-up policy at any stage of the project. When the wrap-up policy is terminated, each subcontractor is required to purchase like coverage at the same rate that was in effect. This cannot be done. Most general liability policies have a wrap-up exclusion that excludes any coverage if their insured is a participant in a wrap-up. The sub's underwriters will not provide coverage for a part of a project. They would have all of the exposure and a very small premium. This bill prohibits cancellation of the policy unless the subcontractor also has the option of terminating the contract.

2. Completed operations coverage is coverage for resultant damage caused by latent defective work discovered after completion of the project. State law requires 10 years of protection for the owner for this possibility. Many wrap-ups cancel within 2 or 3 years. Since most general liability policies have wrap-up exclusion, and if the subcontractor is no longer is business, the owner is

House Insurance
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Attachment # 7

unprotected. This bill requires completed operations coverage to extend for the full term of the statute of repose.

3. Wrap-up policies do not provide coverage for owned or leased equipment on the site. Many wrap-ups do not provide coverage for the liability that a lessee is required to assume in a rental contract. They unknowingly are self insuring the leasing company. This bill requires severability of interests that treats each participant as if they were individually insured and picks up all liability that is required by a contract.

4. Most wrap-up program managers require that the participants insure them for any potential liability for off site activities related to the project. Most general liability policies have wrap-up exclusion and therefore there is no coverage to provide. This is a contractual requirement that cannot be met. This bill prohibits this contractual requirement that is beyond the coverage that is included in the wrap-up policy itself.

5. Some wrap-up policies have denied coverage for damage to a subcontractors work caused by another subcontractor who is also covered under the same policy. The severability of interest provision in this bill requires coverage for this type of claim.

6. Some wrap-up policies that include builders risk coverage could make a claim against a subcontractor for liability for damage to the building or materials for it. The subcontractor has no coverage of their own to cover this. This bill grants a blanket waiver of subrogation to each participant to prevent this type of claim for which there is no coverage.

7. Workers compensation claims are chargeable to each participants experience as an employer which is used to establish the rate of premium based upon experience. This bill requires that the general liability portion reimburse the work comp side for the cost of claims that result from one subcontractor injuring another subcontractor's employee. This then is not charged to the experience rating of the injured workers employer.

8. When a subcontractor is forced to enroll in a wrap-up program, they lose their agent representation. With out their agent, they have no one to represent them to ensure that they have the coverage necessary to protect them and others for whom they are liable. This is like being in a legal proceeding with out an attorney. This bill maintains the agency relationship with the program sponsor paying the fee that the agent would have received if the project was not covered by a wrap-up.

9. Most wrap-ups have an unusually high deductible that is passed on to the subcontractor. This results in cheaper premiums for the sponsor at the expense

of the subcontractor. This bill does not allow this deductible to be passed on to the subcontractor.

10. Some wrap-up sponsors have disciplinary monetary fines that are assessed against the subcontractors that range up into the thousands of dollars. These fines are at the sole discretion of the contractor or construction manager and can be for perceived unsafe actions that would not be a violation under ordinary government safety standards. This bill would not allow monetary fines to be assessed unless by a government agency.

11. Wrap-up policies require that if a worker is injured, the subcontractor provide alternate duty and keep the injured worker on the payroll even if there is no alternate duty for the injured worker. The subcontractor is assessed a fine of approximately $1500.00 per week it this is not done. This is to prevent the program sponsor from paying the temporary disability payments to the injured worker. This bill stops this practice.

12. All wrap-up program managers institute extreme safety programs that are far more stringent that Department of Labor standards. Some are so extreme as to make it nearly impossible to accomplish the work. This can be devastating to a subcontractor who is required to maintain a schedule that has severe daily liquated damages for project delay. This bill requires that the bid documents have detailed safety requirements that will be imposed for work on that site. This will allow the subcontractor to price the job accordingly and to determine if the schedule can realistically be met.

13. Most participants in wrap-up programs can not get claims details and loss history. Subcontractors are responsible for claims monitoring and most want to be involved in case management. This bill requires timely reporting of claims details and loss history to all participants.

Wrap-up programs are necessary in many cases where the required limits are such that it would be cost prohibitive for every contractor and subcontractor to purchase. Unfortunately, these programs have become very lucrative for the very large owners and contractors at the expense of the subcontractors and in some cases at the expense of public owners. It is unusually apparent that on competitive bid projects, wrap-ups are not in use.

I urge your support for HB-2900. We are not trying to eliminate wrap-up insurance programs. We want them to be regulated to comply with and provide the coverage that the policies we buy for ourselves provide.

Bill Miller
President
Midwest Crane & Rigging, Inc

Session of 2008

HOUSE BILL No. 2900

By Committee on Judiciary

2-14

AN ACT concerning insurance; enacting the controlled insurance programs act.

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

Section 1. The provisions of section 1 through 6, and amendments thereto, shall be known and may be cited as the controlled insurance programs act.

Sec. 2. As used in the controlled insurance programs act:

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

(b) "Completed operations liability" has the meaning ascribed thereto in K.S.A. 40-4101, and amendments thereto.

(c) The terms "construction," "contract," "contractor," "owner," "person" and "subcontractor" have the meanings ascribed thereto in K.S.A. 16-1802, and amendments thereto.

(d) "Controlled insurance program" means a program of liability insurance coverage that is established by an owner or contractor who contractually requires participation by contractors or subcontractors who are engaged in work required by a construction contract. Controlled insurance programs shall include, but not be limited to, coverage programs that are for a fixed term of coverage on a single construction site, and a consolidated or wrap-up insurance program as the term is used in subsection (b)(3) of K.S.A. 16-1803, and amendments thereto.

(e) "Participant" means any contractor or subcontractor whose participation in a controlled insurance program is required by a construction contract. Participant shall not include an owner or contractor who establishes a controlled insurance program.

(f) "Substantial completion of a construction project" means the time when the work on a construction project is sufficiently complete as to permit the project to be used for its intended purpose.

Sec. 3. Controlled insurance programs shall:

(a) Establish a method for timely reporting of claims details and loss histories to all participants;

(b) provide that cancellation of any or all of the coverage provided to a participant shall permit the participant to terminate the construction contract requiring its participation, to receive payment for all work com-

pleted through the date of cancellation and for all proven costs of termination, including, but not limited to, cancellation of supply orders and costs of demobilization;

(c) not charge participants a deductible for coverage;

(d) keep self-insured retentions fully funded by the owner or contractor establishing the controlled insurance program;

(e) disclose specific requirements for safety or equipment prior to accepting bids from contractors and subcontractors on a construction project;

(f) allow fines for alleged safety violations to be assessed only by government agencies; and

(g) permit participants to be represented by such participants own insurance agents with a minimum fee of 10% to be paid by the program sponsor.

Sec. 4. If a controlled insurance program includes general liability coverage for the participants, then:

(a) Coverage for completed operations liability shall not, after substantial completion of a construction project, be cancelled, lapse or expire before the limitation on actions has expired as established by subsection (b) of K.S.A. 60-513, and amendments thereto;

(b) general liability coverage shall not be required of project participants except for liabilities not arising on the site of the construction project. Any coverage maintained by the participants shall cover liabilities not arising on the site of the construction project;

(c) the general liability coverage provided to participants shall provide for severability of interest, so that participants shall be treated as if separately covered under the policy and are not charged with the knowledge of other participants; and

(d) participants shall not be required to provide indemnity against claims for bodily injury and property damage arising out of such participant's work except to the extent and to the limits of contractual liability coverage provided by the controlled insurance program.

Sec. 5. If a controlled insurance program includes coverage for the workers' compensation liabilities of the participants, then:

(a) ~~The coverage shall include all workers' compensation liabilities arising on the site of the construction project; and any coverage maintained by the participants shall cover all workers' compensation liabilities not arising on the site of the construction project;~~

(b) participants shall not be required to waive rights of recovery for claims covered by the controlled insurance program, even if those rights of recovery accrue against another participant in the controlled insurance program covered by general liability insurance provided by the controlled insurance program; and

New(a) Workers Compensation coverage shall include all workers compensation liabilities for which payroll attributable to the contractual agreement has been reported and premiums collected, covering all services performed incidental to or arising on the site of the construction project.

(c) participants shall not be required to provide employment to a worker who has been injured on the job unless:

(1) The worker's treating health care provider certifies that the worker is fit to carry out the pre-injury job or modified work similar to the pre-injury job without significant risk of re-injury; and

(2) the employer has the pre-injury job or modified work available.

Sec. 6. The commissioner is hereby authorized to adopt such rules and regulations relating to controlled insurance programs as may be necessary to carry out the provisions of the controlled insurance programs act.

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

8.0 Return to Work

8.1 Scope and Application

In order to return injured workers back to work on the Arrowhead Stadium Project as quickly as possible, each Contractor and subcontractor at every tier will comply with the requirements of this "Return to Work" program. This program has been established to provide "light duty" or "restricted duty" work for workers injured on this project and cannot perform their normal daily work duties. Outlined below are the "Return to Work" procedures for this project:

8.2 Procedures

- The "Return to Work" policy for this project is to return all contractor and subcontractor workers to work as quickly as possible after a job-related injury or illness has occurred.
- The "Return to Work" policy for this project will also consider "Restricted Duty" or "Light Duty" work for workers injured off the project, but associated with this project.
- All contractors and subcontractors shall ensure that work is provided for all workers who have been released to "Restricted Duty" or "Light Duty" by the attending physician. If work is unavailable, then the workers will be designated as a Safety Coordinator and assist in promoting safety on the jobsite.
- No worker released by the attending physician under "Restricted Duty" or "Light Duty" will be placed in a lost time status without the approval of the Project Safety Manager.
- All injuries and illnesses will be evaluated on a case-by-case basis by the Project Safety Manager.
- All workers must receive a full medical release from the attending physician before resuming normal work activities
- "Modified or restricted duty" is provided to the worker only for the duration which the attending physician places work activity restrictions on the worker.
- No worker on "Restricted Duty" or "Light Duty" will be allowed to work more than forty (40) hours per week.
- Subcontractors are prohibited from engaging workers in work activities on the project site that are currently under medical restrictions due to an occupational injury / illness that occurred on an unrelated project.
- Workers of subcontractors injured on this project, currently under the medical care of a physician who has placed the injured worker under the guide lines of a light duty or restricted work program, shall be prohibited from being terminated and/or laid off as a result of work completion, work slow down, etc. until such time the worker is released for full duty by the attending physician.
- Failure to implement this policy will result in monetary fines outlined in the Project Safety Program and Insurance Manual.

9.0 Incident Review Board

9.1 Scope and Application

The Incident Review Board meeting serves two basic purposes: first acting as an organized and documented process for the contractor and subcontractors to discover the facts surrounding an incident, second as a process for the corrective actions developed by the contractor and subcontractors to prevent a similar type of incident.

Contractors and subcontractors are responsible for promptly investigating all incidents, identifying causal factors, and developing corrective action.

9.2 Procedures

The following procedures will be followed:

- Contractors and subcontractors will immediately report all incidents within **1 hour**.
- Contractors and subcontractors will complete and submit all appropriate incident forms and paperwork within **24 hours**.
- Arrowhead Stadium Project Safety Manager will schedule an Incident Review Board meeting within **3 days** of the incident.
- Attendees may include: BU Director of Safety, Project Safety Manager, Project Executive/Manager/Superintendent/Foreman, Contractors and/or Subcontractors Management Representative, Insurance Safety Coordinator, Contractor and/or Subcontractor Safety Coordinator, Affected Workers, Witnesses, and other designated individuals as deemed warranted.
- The Project Safety Manager will chair the meeting by discussing all the facts surrounding the incident and corrective measures to be taken by all parties to prevent similar incidences from re-occurring.
- Disciplinary action based on the facts surrounding the incident may be imposed against the contractor, subcontractor, and/or worker(s) involved.

10.0 Non-Compliance to Safety Policies

10.1 Scope and Application

In an effort to ensure compliance to the insurance and safety program requirements of this project, Federal OSHA standards, state regulations, local laws, and contractor and subcontractor individual safety programs, the Arrowhead Stadium Project Safety Program hereby implements this program of "non-compliance" for all contractors and subcontractors working on this project.

This program of "non-compliance" has been established to promote safety on the project with all contractors and subcontractors. It is designed to eliminate offenders, repeat offenders, and Contractors and/or subcontractors who violate the requirements of this safety and insurance program.

This "non-compliance" program may be used or superceded with more severe disciplinary action based on the degree of the infraction(s). In any case, the Project Safety Manager reserves the right and sole authority in determining what type of discipline is initiated, up to and including removal of the worker(s), contractor(s), or subcontractor(s) from the project, in conjunction with monetary fines.

For safety infractions, the following is a suggested (not mandatory) guideline:

1st offence: Verbal warning is given to the offender. Monetary fines may be issued.

2nd offence: Written warning is issued and the offender's supervisor and project manager are brought into the office for a "discussion" with the Project Safety Manager. A copy of the written warning is sent to the offending workers contractor and/or subcontractor office stating that a third offense will result in the worker being removed from the project. Monetary fines may be issued.

3rd offence: The offender is removed from the project. Monetary fines may be issued.

NOTE: SERIOUS SAFETY INFRACTIONS WILL RESULT IN IMMEADIATE MONETARY FINES AND/OR REMOVAL OF THE WORKER (ZERO TOLERANCE) AND/OR REMOVAL OF THE WORKERS SUPERVISOR.

IF REPEAT SAFETY INFRACTIONS WITH OTHER CREW MEMBERS OCCUR, THE SUPERVISOR OF SAID OFFENDERS SHALL BE SUBJECT TO REMOVAL FROM THE PROJECT AND/OR MONETARY FINES WILL BE ISSUED.

10.2 Safety Enforcement Fine System

To assist in our efforts to provide a safe workplace for all workers and visitors, the following monetary fines are available for application at the discretion of the Project Safety Manager.

Depending on the frequency and severity of the violation(s), fines can be assessed per exposure, per worker, and/or per day. Category of fines is at the discretion of the Project Safety Manager. Contractors will be responsible for any fines levied against any subcontractors under their direct contract. Fines will be charged through an invoice or a deduct change order to the contractor.

Violations		Contractor & Subcontractor Fines
Personal Protective Equipment		$250 - $2,500
Excavation/Trenching		$250 - $5,000
Electrical		$250 - $5,000
Scaffolding		$250 - $5,000
Cranes/Rigging		$250 - $5,000
Specialty Programs (i.e.: Confine space, LO/TO, Hazard Communication, etc.)		$250 - $5,000
Return to Work		$1,500 a week
Fall Protection		$250 - $5,000
Safety Orientation/Drug Testing		$250 - $2,500
Safety Management		$250 - $5,000
General Safety		$250 - $5,000
General Insurance		$250 - $5,000

10.3 OSHA Violations and Fines

Contractors and subcontractors responsible for OSHA jobsite inspections and/or Arrowhead Stadium Project multi-employer citations and fines will be responsible for paying all fines and cost (ie: legal, personnel cost, etc.) associated with the inspection and citations. All cost associated with the inspection and citations will be charged through an invoice or a deduct change order to the contractor or subcontractor. For subcontractors, the prime contractor their under contract with will be charged for all fines and associated cost.

CHERYL GEORGE

From: "Lichtenauer, Kim" <klichtenauer@lockton.com>
To: <c.george@builderec.com>
Sent: Friday, July 20, 2007 9:51 AM
Subject: JE Dunn ROCIP

July 20, 2007

Re: JE Dunn
Rolling Owner Controlled Insurance Program (ROCIP)
KC Live Block 139

Dear Cheryl :

The Block 139 Project Controlled Insurance Program will discontinue on 7/20/07. Any work performed on the Block 139 site after 7/20/07, will be insured by your traditional insurance. However, completed operations coverage is extended for a period of ten years.

A new Certificate of Insurance must be issued providing evidence of coverage under your traditional insurance program. Please provide the Certificate of Insurance to the Program Insurance Administrator (Lockton Companies) by 8/1/07.

Your final payroll report must also be sent to Lockton by 8/10/07. A payroll reporting form is attached for your use. If you have any other outstanding payroll reports, send them in at this time. Past due payroll reports could delay any payments you may have coming.

Please fax your certificates and payroll reports to Tammi Henderson at Lockton Companies, at 816-783-9403. Should you have any questions, please call me at 816-960-9403.

Sincerely,

LOCKTON COMPANIES, LLC

Tammi Henderson
Senior CIP Coordinator

CHERYL GEORGE

From: "Lichtenauer, Kim" <klichtenauer@lockton.com>
To: <c.george@builderec.com>
Sent: Friday, July 20, 2007 11:36 AM
Subject: Block 140

July 20, 2007

Re: JE Dunn
Rolling Owner Controlled Insurance Program (ROCIP)
KC Live Block 140

Dear Cheryl:

The Block 140 Project Controlled Insurance Program will discontinue on 7/20/07. Any work performed on the Block 140 site after 7/20/07, will be insured by your traditional insurance. However, completed operations coverage is extended for a period of ten years.

A new Certificate of Insurance must be issued providing evidence of coverage under your traditional insurance program. Please provide the Certificate of Insurance to the Program Insurance Administrator (Lockton Companies) by 8/1/07.

Your final payroll report must also be sent to Lockton by 8/10/07. A payroll reporting form is attached for your use. If you have any other outstanding payroll reports, send them in at this time. Past due payroll reports could delay any payments you may have coming.

Please fax your certificates and payroll reports to Tammi Henderson at Lockton Companies, at 816-783-9403. Should you have any questions, please call me at 816-960-9403.

Sincerely,

LOCKTON COMPANIES, LLC

Tammi Henderson
Senior CIP Coordinator

HOUSE COMMITTEE ON INSURANCE AND FINANCIAL INSTITUTIONS
FEBRUARY 25, 2008

HB 2900

MR. CHAIRMAN & MEMBERS OF THE COMMITTEE:

My name is Janet Stubbs, Administrator of the Kansas Building Industry Workers Compensation Insurance Fund. KBIWCF is a group funded pool formed under the Kansas statutes for the members of the residential and light commercial construction industry operating since 2/1/1993. We currently have approximately $14 million in premium and 875 individual companies.

I am appearing today in support of HB 2900 as it relates to workers compensation under "wrap-up" contracts. Our concern stems from the practice of the subcontractors being required to pay the premium to the general contractor for the payroll generated as a result of a specific contract. In most such agreements, any premium for a worker's payroll pays only for injuries which occur within the fence at the site. In other words, if a worker is injured driving to and from the jobsite or on errands for the job in a company vehicle, that injury is not covered under that policy.

The subcontractor's policy for other jobs on which he may have employees would be expected to pay for an injury for which they are not receiving premium for the risk described above to which they are exposed. We currently have companies which we insure that have employees driving company vehicles from Wichita to Junction City, from Salina to Lawrence, and from Topeka to Salina, etc. Now you may have someone tell you that workers are not covered going to and from work and I would tell you that we have been required by Kansas ALJ's to pay such a claim.

The intent of the language on page 2, beginning on line 35 is to require the coverage provider receiving premium for the payroll on the job for which a contract has been signed to have the liability for that body until his payroll is attributable to another jobsite as long as his/her activity is legally related to his job.

We understand the reasoning by the promoters of WRAPS. First, the current method of operation makes it extremely lucrative for the contractors/owners and the insurance administrators. Some large general contractors have been requiring 30 hour OSHA training for which they charge subs rather high prices to take through their own "university". We provide this training free of charge to our members. In addition, many carriers do not notify certificate holders if or when they cancel a company on which a certificate has been issued. Last, but not least, the owner or contractor on a WRAP receives the dividends that a safety program generates and the subcontractor may lose a volume premium discount as well as the dividend.

Mr. Chairman, I respectfully request your passage of HB 2900 and would be glad to respond to any questions your committee might have.

Oliver INSURANCE AGENCY, INC

Testimony on House Bill 2900
Before the Committee on Judiciary
By Keith C. Oliver Insurance
February 25, 2008

Thank you Mr. Chairman and members of the Committee for the opportunity to submit written testimony in support of House Bill 2900. My name is Keith C. Oliver; I am the owner of the Oliver Insurance Agency, Inc. as well as an associate member of the American Subcontractors Association of Greater Kansas City. My agency represents approximately 650 business customers, approximately 30% to 35% of them are involved with construction, and many of them are subcontractors.

We have noticed a growing trend among larger contractors to require subcontractors to participate in a controlled insurance program. At one time, these controlled programs were confined to large projects like the construction of the Sprint Campus, but the recent trend has changed to "Rolling CCIP". This is an insurance program sponsored by large contractors that requires all subcontractors to be included in a Contractor Controlled Insurance Program (CCIP) that rolls from one project to the next, even if that particular project is not a "jumbo" project. The contractors that sponsor these programs often form captive insurance companies to profit from the exposures they take. While there is nothing wrong with profiting from taking risk, requiring others to risk their business requires some rules designed to bring transparency and prevent abuses. House Bill 2900 spells out a reasonable set of rules that would prevent a number of abuses yet make these plans a useful way to manage risk.

Many of the House Bill 2900's requirements are self-evident; some need explanation. For example section 3 (c), does not allow the sponsor to charge the participant for deductibles. The sponsor will have a significant liability deductible and get a premium credit for the deductible. The participant may not have elected to purchase an insurance policy with a large deductible. The participants insurance cost deduction is taken from its bid, without the benefit of a deductible credit. The participant may not be in the same financial position as the sponsor to bear a large deductible.

Section 3 (f). Fines for safety violations may seem like a good idea, but fines should be left to enforcement agencies. Safety fines can be used as a club to get additional work done beyond the scope of the agreed work, or punish those that have fallen from favor. Certainly, nothing in this bill would prevent the safety supervisor or project managers from warning workers, banning individuals from the jobsite, or even disqualifying the subcontractor because of unsafe acts.

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Overland Park Kansas 66211
Phone (913)-341-1900 – Fax (913)-649-4624

Section 3 (g). The requirement that the participant's agent be compensated is important. The decision to participate in Controlled Insurance Plan requires a great deal of effort on the part of the agent, in reviewing the insurance requirements and plan documents as well as determining the cost of any "insurance savings". Often these programs are sold as premium savings programs, so it is important to have the cost of advising the participant transparent. Certainly, the agent's commission is necessary to compensate the participant's insurance advisor for the work needed to review the Controlled Insurance Plan.

Sections 4 (a) and (b). Several requirements for general liability arise from the fact that a participant's liability policy will eliminate coverage for any work done in a controlled insurance program, so it is vital that the controlled insurance program maintain coverage for completed operations until the statue of repose runs, otherwise the participant has a large uncovered exposure. It is also important that any indemnity requirement for bodily injury or property damage be limited to the extent of coverage provided by the sponsor, since the participant's policy would exclude any liability arising from the controlled insurance program.

Section 4 (c) requires that the standard severability of interest clause be present. Without this provision, the participant's coverage would be seriously compromised. For example, if the employer's liability exclusion is interpreted as applying to all insureds, then the exclusion eliminates coverage for a participant who injured another participant's employee. The exclusion would apply to all employees on the project, not separately to each participant's employees.

Section 5 (b). Workers' Compensation rating plans apply experience rating to all employers that reach a modest premium size. This rating plan includes the experience in a Controlled Insurance Plan. If the right to recover those losses is waived then losses that are caused by another negligent party can have a significant impact on a contractor's Workers' Compensation premium for three years. Without a right to recover losses caused by others negligence, the participant is stuck with the impact of those losses.

Section 5 (c). A Return to Work program" is a proven method to reduce Workers' Compensation losses, so Controlled Insurance Plans often require participants to provide modified duty jobs for injured workers. Many contractors do not have light duty jobs. The savings are taken by the plan sponsor, but the costs of the return to work program are born by the participant.

Thank you for your consideration of House Bill 2900, I believe it would bring balance to this growing area of concern for contractors.

6201 College Boulevard Suite 230
Overland Park Kansas 66211
Phone (913)-341-1900 – Fax (913)-649-4624

AGC of KANSAS

Building a Better Kansas Since 1934

200 SW 33rd St. Topeka, KS 66611 785-266-4015

TESTIMONY OF
ASSOCIATED GENERAL CONTRACTORS OF KANSAS
BEFORE HOUSE INSURANCE AND FINANCIAL INSTITUTIONS COMMITTEE
HB 2900

February 25, 2008

By Will Larson, Associated General Contractors of Kansas, Inc.

Mister Chairman and members of the committee, my name is Will Larson with Larson & Blumreich, Chartered. I serve as legal counsel for the Associated General Contractors of Kansas, Inc. The AGC of Kansas is a trade association representing the commercial building construction industry, including general contractors, subcontractors and suppliers throughout Kansas (with the exception of Johnson and Wyandotte counties).

The AGC of Kansas opposes House Bill 2900 and respectfully asks that the committee reject this bill at this time.

Some companies and owners in the construction industry offer certain insurance programs where all companies on the project are covered under a single policy. It is unclear what proponents of this bill are trying to accomplish with HB 2900.

Our major concern about HB 2900 is that we have only had a very short time to review the bill which deals with complex and sophisticated insurance arrangements. There are several parts of the Bill that are vague and unclear. There are other parts of the Bill that may have unintended consequences for the construction industry. The Bill may require certain provisions in insurance policies that are may not be available in the insurance market. We believe that certain aspects of the bill require careful consideration by and consultation between representatives of the building construction industry and insurance professionals.

The AGC would like to take the next few months to closely review the language included in HB 2900 before taking any further action.

The AGC of Kansas **respectfully requests that you reject HB 2900 at this time**. Thank you for your consideration.

House Insurance
Date: 2-25-08
Attachment # 10

Kansas Association of Insurance Agents

Testimony on House Bill 2900
Before the House Insurance & Financial Institutions Committee
By SueAnn V. Schultz
February 25th, 2008

Thank you Mr. Chairman and members of the Committee for the opportunity to submit written testimony in opposition to House Bill 2900. My name is SueAnn Schultz and I'm representing the Kansas Association of Insurance Agents as the Governmental Affairs Chair. We have approximately 520 member agencies and branches throughout the state and our members employ approximately 2,500 Kansans. In addition, I am appearing on behalf of my employer, The IMA Financial Group, Inc., and IMA of Kansas, Inc., the largest Kansas domiciled independent insurance agency with three offices in Kansas and over 250 employees.

KAIA first had an opportunity to view the proposed legislation at a Governmental Affairs committee meeting January 29th, 2008. At that time, KAIA elected not to support the bill, recommending instead that it be studied and, if appropriate public policy, then reconsidered during the legislative session next year. On behalf of KAIA and IMA, I would recommend this committee not take action approving this bill; rather, that it be sent to an interim committee study.

OCIP ("Owner Controlled Insurance Program") and CCIP ("Contractor Controlled Insurance Program") programs are very complex insurance transactions. This proposed bill identifies some of the issues associated with OCIP and CCIP programs – but whether or not legislation is appropriate or even necessary is a question that needs to be answered before considering adoption of public policy related thereto. It has been IMA's experience that the parties collectively negotiate the structure and implementation of an OCIP or CCIP – including the owner, general contractor and major subcontractors. IMA has, during various projects, represented each of the different interested parties. A knowledgeable broker can provide valuable assistance and guidance to its Insured (owner, general contractor or subcontractor) – the key is involvement at the outset to assure your Insured is adequately represented.

To give you some perspective, IMA's general philosophy is that these programs are usually not cost effective for projects under $150,000,000 - $175,000,000. Thus the number of projects in Kansas that even qualify for consideration of inclusion in an OCIP or CCIP is extremely limited. The general concept is that by providing one insurance program for all participants (owner, general contractor and all subcontractors), not only are there significant insurance cost savings, more importantly, there are no gaps in insurance coverage and the project will inherently be safer and more administratively efficient. Whether or not those general objectives are obtained depends on how the project is originally structured, implemented and administered.

KAIA and IMA believe that many of the issues raised by the proponents of this bill are issues that can and should be resolved by the parties to the transaction based on the economics of the specific project. As an example: most of the OCIP's and CCIP's that IMA has been involved in require that notice be provided before cancellation can occur and that the sponsor have an option to either procure alternate coverage or require that the coverage be provided by the subs. The sponsor will reimburse the subs their actual premium but not to exceed premiums using the rates that were reported by the subs in their insurance deduct calculations. This is a fair provision in that it limits the reimbursement to what the subs originally reported as their insurance costs. Another example: before enrolling in an OCIP or CCIP, the contract/project manual will describe what is required for completed operations. If the completed ops coverage doesn't cover the statute of repose, the participating parties can request extension of the coverage which is readily available in the marketplace.

Finally, there are too many ambiguous provisions in this draft legislation. Who is required to establish the method for reporting of claim details and loss histories to the participants (owner, contractor, carrier?) What is timely (when the claim is known, reserved or closed?) If coverage is terminated, does the mandatory nature of "payment for all work completed through the date of cancellation…" override offset, indemnification or hold harmless provisions of the project contract? What does "fully funded" mean – cash, LOC, 1 claim or per claim SIR?
Payment of a minimum fee of 10% - 10% of what (premium, profit, commission?)

There are numerous further examples I could provide – all of which simply demonstrates that this extremely complicated and complex insurance vehicle is an appropriate subject for an interim committee study.

We urge the Committee not to act favorably on HB 2900, but instead recommend it for an interim committee study. We would be happy to provide additional information or answer questions.