# MINUTES

## HEALTH CARE STABILIZATION FUND OVERSIGHT COMMITTEE

November 3, 2009
Room 545-N—Statehouse

### Members Present

Dick Bond, Chairperson
Darrell Conrade
Senator Laura Kelly
Senator Vicki Schmidt
Representative Jim Morrison
Representative Eber Phelps
Penny Schwab
Dr. Arthur D. Snow

### Members Absent

Dr. Paul Kindling
Dr. Terry "Lee" Mills
Dr. James Rider

### Staff Present

Melissa Calderwood, Kansas Legislative Research Department
Dylan Dear, Kansas Legislative Research Department
Bruce Kinzie, Office of the Revisor of Statutes

### Others Present

Berend Koops, Hein Law Firm
Bob Williams, Kansas Association of Osteopathic Medicine
Rob Mealy, Kearney and Associates
Chip Wheelen, Health Care Stabilization Fund
Russ Sutter, Towers Perrin
Rita Noll, Health Care Stabilization Fund
Marci Nielsen, University of Kansas Medical Center
Jerry Slaughter, Kansas Medical Society

Chairperson Dick Bond called the meeting to order at 9:05 a.m. The Chairperson noted that three members of the Committee would be absent and then asked for introductions by the members and staff present. It was noted that Senators Laura Kelly and Vicki Schmidt had been named to the Committee, replacing former Committee members Senator Goodwin and Senator Barnett.

The Chairperson recognized Melissa Calderwood, Kansas Legislative Research Department, for an overview of relevant legislation and materials provided to the Committee for its review. Ms. Calderwood reviewed the *Committee Report to the 2009 Legislature* and its conclusions and recommendations specific to closed claims reporting, individual claims information and the Kansas Open Records Act, financing for an information management system, and recommendations specific to expenditures from the Fund and the graduate education residency programs (Attachment 1). Ms. Calderwood also provided a draft of the *2010 Legislator Briefing Book* article on the Fund and Kansas medical malpractice laws (Attachment 2). Another topic Ms. Calderwood highlighted was the recent Attorney General's opinion 2009-16, which addresses the allotment authority delegated to the Secretary of Administration in KSA 75-3722 and the suspension of the statutory obligation of the State of Kansas to reimburse the Health Care Stabilization Fund pursuant to relevant sections of the Health Care Provider Insurance Availability Act (Attachment 3). Ms. Calderwood noted that Mr. Wheelen would further comment on this matter. Additionally, it was noted that the FY 2009 and FY 2010 Subcommittee reports (Attachment 4) were included. The Committee could review the recommendations of the budget and subcommittee process. Finally, Ms. Calderwood noted monitoring of activities in other states, particularly with Joint Underwriting Association (JUA) funds and health care provider surcharges or funds. One state that was highlighted was the State of New Hampshire, specifically, the use of JUA funds as a solution to the state budget crisis and the pending litigation in the matter (Attachment 5).

Chairperson Bond next called on Chip Wheelen, Executive Director, Health Care Stabilization Fund, to begin an overview of the 2008-2009 activities of the Health Care Stabilization Fund Board of Governors, as well an update of the 2009 Legislative Session (Attachment 6). Mr. Wheelen began his report, noting the history of the Fund and the features of the Act, namely, the requirement for health care providers to purchase professional liability insurance from either commercial companies or the Availability Plan. It was noted by Mr. Wheelen that there are some health care providers (estimated at over 500) who cannot purchase professional liability insurance from a commercial company, and instead participate in the Availability Plan. It was not yet known if the Plan, for this year, will have a favorable experience (surplus income compared to losses and expenses). Mr. Wheelen then highlighted the Board's statutory report (as required by KSA 40-3403(b)) for FY 2009. Among the highlights, surcharge revenue collections amounted to $24,513,975, with the lowest surcharge rate of $50 (chiropractor, first year of Kansas practice, who selected the lowest coverage option) and the highest surcharge rate of $15,469 (neurosurgeon, five or more years of Fund liability exposure, who selected the highest coverage option). There were 27 medical malpractice cases involving 43 Kansas health care providers decided as a result of a jury trial. Seventy-two cases involving 81 claims were settled resulting in HCSF obligations amounting to $23,867,284 (average compensation per claim was $294,658). These amounts are in addition to the compensation agreed to by primary insurers, the report noted. Due to past and future periodic payment of compensation, the amounts previously reported were not necessarily paid during FY 2009; instead, the report indicated, the total claims paid during the fiscal year amounted to $26,411,640. Of this reported amount, a payment of $1,175,000 was paid to claimants on behalf of insurance companies that reimbursed the Fund for these payments. The actual net claims paid during FY 2009, therefore, totaled $25,236,640. Mr. Wheelen concluded the statutory report stating that the preliminary financial report as of June 30, 2009 indicated assets amounting to $219,265,889, and liabilities amounting to $226,173,489.

Committee members commented on the Missouri modification factor, citing Mr. Wheelen's example of the Kansas resident neurosurgeon (25 percent modification, total premium surcharge of $19,336). A Committee member also questioned when the modification factor would apply and whether the factor was tied to both the license (Kansas or Missouri) and practice status (active or inactive).

Mr. Wheelen then commented on self-insured health care providers, noting that KSA 40-3414 allows certain health care providers to self insure, as well as requiring certain state facilities for veterans and the faculty and residents of the University of Kansas Medical Center and its affiliates to be self insured. Mr. Wheelen noted the successful relationship with the University of Kansas Medical Center (KUMC) over the past 20 years and indicated that, normally, the Board of Governors serves as a third party administrator and is periodically reimbursed by the state for claims paid on behalf of KUMC (both Kansas City and Wichita). Average annual expenditures, Mr. Wheelen reported, have been $2,645,978 ($1,456,465-faculty/$1,189,530-residents). Mr. Wheelen then noted that in February 2009 and again, in July 2009, the Secretary of Administration instituted State General Fund allotments, which discontinued reimbursements to the Health Care Stabilization Fund for the liability claims and related expenses paid on behalf of KUMC residents and faculty. Mr. Wheelen noted the Attorney General's opinion, indicating that the opinion endorses authority for the allotments. Mr. Wheelen then spoke to the ethical obligation and statutory duty for the state to pay those claims. In FY 2009, he continued, $2,919,600 was "lost" (Stabilization Fund-paid claims and expenses not reimbursed by the State General Fund). Mr. Wheelen stated that this loss was significant to the Fund's current budget and it is not known whether the $2.9 million will be carried forward during FY 2010 (as an asset) or written off (as an uncollectible account).

A Committee member then inquired if Mr. Wheelen could translate this loss in terms of the annual surcharge rates for each provider. Mr. Wheelen replied that the effect is huge for a large medical center, while there is not much of an impact on a family provider. He stated the current projection for FY 2011 surcharge is a 12 percent increase.

Rita Noll, Chief Attorney and Deputy Director, was then recognized to address the FY 2009 medical professional liability experience based on all claims resolved in FY 2009, including judgments and settlements. Ms. Noll began her presentation by noting jury verdicts. Of the 27 medical malpractice cases that were tried before juries during FY 2009, 21 cases were tried before juries in Kansas courts and six cases involving Kansas health care providers were tried before juries in Missouri. The largest number of cases, seven, was tried in Sedgwick County, while six were tried in Jackson County, Missouri.

A Committee member asked about what happens in Missouri cases. Ms. Noll stated that Kansas resident health care providers practicing in Missouri are paying the modification factor (25 percent). If a doctor is a Missouri licensed practitioner, private insurance is covering the claim/expense. The Chairperson noted when Missouri law would be applicable for practitioners.

A Committee member also inquired about a scenario where a health care provider lives in Kansas (is not licensed to practice in Kansas) and practices only in Missouri; Ms. Noll responded that the practitioner would be covered under private insurance only.

Russ Sutter, Actuary to the Fund, Towers Perrin, was recognized and spoke to the history of the modification, noting that the Missouri surcharge was 20 percent in 2001 and raised to 25 percent in 2008. This level, he continued, has been fairly adequate to the claims and expenses.

Ms. Noll's comments also indicated that of the 27 cases tried, 20 resulted in complete defense verdicts; plaintiffs won verdicts in five cases, one case resulted in a "split" verdict, and one

case ended in mistrial. Ms. Noll's testimony included a nine-year history of total cases, defense verdicts, plaintiff verdicts, split verdicts, and mistrials.

Ms. Noll then highlighted the claims settled by the Fund, indicating that during FY 2009, 81 claims in 72 cases were solved involving HCSF monies. Settlement amounts for the fiscal year totaled $24,867,284. The FY 2008 total was $17,352,500 to settle 65 claims in 57 cases. Ms. Noll then commented that the number of claims is up, but within the range of what was experienced earlier this decade. One concern, she noted, was the number of claims (individual settlements) for amounts greater than $500,000, 20 in FY 2009 and 13 in FY 2008. The Fund is anticipating a rise in the number of claims over the next few years, given the current economic situation. The figures presented do not include settlement contributions by primary or excess insurance carriers. Ms. Noll then noted that HCSF individual claim settlement contributions during FY 2009 ranged from a low of $3,000 to a high of $800,000. Of the 81 claims involving Fund moneys, the Fund provided primary coverage for inactive health care providers in 20 claims. The Fund received tenders of primary insurance carriers' policy limits in 58 claims (in addition to the $23.87 million incurred by the Fund – primary insurance carriers contributed $11.47 million to the settlement of those claims). Ms. Noll's report also included FY 1995 to FY 2009 settlement contributions by primary carriers, the HCSF, and excess carriers; claims settled by primary carriers (FY 2000-FY 2009); a report of HCSF total settlements and verdict amounts, as well as the new cases opened, for FY 1977 to FY 2009; and new cases by fiscal year (FY 1977-FY 2009). The Fund was notified of 310 new cases during FY 2009.

The Chief Attorney next addressed the self-insurance programs and reimbursements for the University of Kansas Foundations and Faculty and residents. Ms. Noll first highlighted the FY 2009 KU Foundations and Faculty and University of Kansas Medical Center (KUMC) and Wichita Center for Graduate Medical Education (WCGME) program costs that were not reimbursed from the State General Fund – $2,190,724.52 (KU Foundations and Faculty) and $728,875.79 (KUMC and WCGME residents) – a total of $2,919,600.31 was not reimbursed to the Fund in FY 2009. Ms. Noll noted that there had been, prior to January 2009, a reimbursement from the SGF for $83,616.87 for the KUMC and WCGME residents program costs. Ms. Noll noted the expenditures by fiscal year for the Foundations and Faculty and KU and WCGME residents (FY 1990-FY 2009 reported). She addressed the FY 2008 program costs and Fund expenditures, noting that there was an experience of lower claims in FY 2008 and it was anticipated that there would be an increase in FY 2009 (number of residents and faculty named in lawsuits and large number of claims to resolution). Ms. Noll indicated there was one settlement for KUMC residents, and no settlements for WCGME residents (FY 2009). Monies for excess coverage (paid by the Fund for excess coverage claims) totaled $4,062,500 – nine settlements [$800,000 for KUMC residents; $3,262,500 for Faculty, Foundations].

The Chairperson then inquired about the cost to cover only residents for medical malpractice per year ($1 million) and whether the Fund representatives had approached the Governor on this portion of the larger issue of reimbursement. The Fund representatives indicated they had not. The Committee then discussed the allotment and appealing for all or certain portions of the reimbursement moneys (residents, faculty, or both).

A Committee member inquired about faculty members making contributions for medical malpractice coverage. It was noted that there is a Private Practice Reserve Fund ($500,000 placed in the Fund to cover the "pool").

Dr. Marcia Nielsen, Vice-Chancellor of Public Affairs, KUMC, was recognized by the Chairperson. Dr. Nielsen provided the Committee with a statistical report on contributions (KUMC): primary coverage ($500,000) and separately, $856,895 (faculty/ physician foundations) and

$362,000 (university residents), for a total of $1.2 million. [These are the amounts paid for the $800,000 excess coverage via the Health Care Stabilization Fund.]

Jerry Slaughter, Executive Director, Kansas Medical Society (KMS), was recognized by the Chairperson. He noted that the faculty members pay the surcharge that is applicable to their specialty.

The Chairperson next invited Mr. Sutter to provide an actuarial report. Mr. Sutter began his presentation noting that as the Fund considered the FY 2010 surcharge, it was necessary to consider two scenarios (A and B). It was necessary, he continued, to include external factors affecting the Fund, namely, the economy and the February 2009 Governor's allotment. Scenario A for the fiscal years ending June 30, 2009 and June 30, 2010 assumes full reimbursement for KU/WCGME; whereas Scenario B assumes only limited reimbursement. Mr. Sutter also noted that, for those discounted estimates, a lower yield was being assumed – the previous year had used 3.5 percent; now the estimates rely on a 2.0 percent interest rate (present value).

- **Scenario A** (full reimbursement forecast) indicated that as of June 30, 2009, the Fund held assets of $220.1 million and liabilities (discounted) of $187.0 million, with $33.1 million in unassigned reserves. Projections for June 2010 include $221.9 million in assets and liabilities (discounted) of $191.6 million, with $30.3 million in reserve.

- **Scenario B** (partial reimbursement forecast, assuming 80 percent reduction) indicated that as of June 30, 2009, the Fund held assets of $219.1 million and liabilities (discounted) of $195.1 million, with $24.0 million in unassigned reserves. The projection for June 2010 would be $218.7 million in assets and $200.0 million (discounted) in liabilities, with $18.7 million in reserve.

Mr. Sutter noted that the Board of Governors was encouraged to consider an increase in FY 2010 surcharge rates (5 to 10 percent), given the likelihood of a drop in the return on investments, the potential for a drop in reimbursements (State General Fund), and Towers Perrin's understanding of the Board's goals. The Board of Governors elected to raise rates for FY 2010 as follows: Classes 1, 6, 12, 13, 14: no change; Classes 2, 5: +3.0 percent; Classes 3, 4, 7, 8, 9: +5.0 percent; Classes 10, 11: +7.0 percent; and Classes 15-21: +3 points. The overall impact of these changes was an estimated +5.3 percent. Mr. Sutter then commented on how a projected overall 12 percent surcharge [for FY 2011] increase would affect the classes – increased annual payment of $120 (Class 1) to $1,800 (neurosurgeon).

Mr. Sutter then reviewed the Fund's liabilities, as of June 30, 2009, beginning with tail (coverage) liabilities for inactive providers. Mr. Sutter noted undiscounted ($80.2 million) and discounted (assuming 2.0 percent, present value – $60.4 million) liabilities projected. A tail coverage claim, he noted, may not be paid out until 2040. "Free tail coverage," the actuary continued, is a very real benefit of the Fund.

A Committee member then inquired about how a provider with less than five years (Fund participation) pays. Mr. Sutter answered that the provider pays by a percentage in his or her annual surcharge. There was a brief discussion on payments for tail coverage for providers who move from one state to another (covering their previous practice/claims experience).

Mr. Slaughter indicated that the assessment of "free" as it applies to tail coverage required clarification – physicians and hospitals pay for this coverage on an accrual basis, regardless of when the liabilities arise.

Mr. Sutter responded, indicating that "prepaid" could define the coverage more accurately.

Mr. Sutter then offered observations about changes to the forecast for the Fund. He noted three influential factors: loss reserves and number of open claims increased during FY 2008; reported losses on active provider claims for FY 1997-FY 2006 dropped during the year (used to predict future claims); and the average lag between incident date and report date has decreased [cited as a favorable development, leads to reduction in tail liabilities]. Mr. Sutter also noted another observation, Class 15 (Availability Plan) has decreased (FY 2006-FY 2008) as companies, including Kansas Medical Mutual Insurance Company (KaMMCO), are more willing to write policies, and also, interest income has been holding up better than anticipated ($9.7 million in FY 2008 and $5.0 million in the first half of FY 2009). Finally, Mr. Sutter highlighted the findings by provider class and potential impacts on the Fund, including court cases that could affect the cap on non-economic damages in Kansas (a "significant increase").

Chairperson Bond again recognized Mr. Wheelen for further remarks, including an update on issues from the 2009 Session and any requests or recommendations. Mr. Wheelen introduced two members of his staff and then provided an update on the Fund's technology improvement plans. He noted his testimony before the Committee at its last meeting regarding the technology plans and indicated that $251,834, as predicted, was "taken" to the SGF, with a total funding loss of $285,000. Mr. Wheelen also noted the difficulty in obtaining cost estimate from vendors selling information systems and software designed for professional liability systems. The Fund then sought estimates from two companies that offer management information systems specifically designed for patient compensation insurance (workers' comp and medical professional liability). One of those companies has already installed its enterprise management information system at two commercial insurance companies that sell coverage to about half of the practicing health care providers in Kansas, it was noted. That company estimated an installation cost of $600,000 to $750,000 for the Board of Governors' system; the installation would accommodate the electronic transfer of information between the HCSF and the two major insurers. Another company is in the process of installing a management information system for medical malpractice insurers and has provided an estimate that the first year costs for the Fund to install a similar system would be $751,548. This company's solution would likely involve the installation of a web portal for electronic communication of information, Mr. Wheelen indicated. He then stated that given these estimates and continuing need for technology improvements, the Board of Governors included $800,000 in its FY 2011 budget request. Of that amount, approximately $50,000 is for the routine replacement of computers and other hardware, as well as the cost of seminars, workshops, and other training opportunities for staff. Mr. Wheelen stated that the entire requested amount may not be spent and an RFP would be submitted.

Mr. Wheelen then addressed the relationship of the State of Kansas and the self-insurance arrangement between the Fund and the State. He noted that during the 2009 Session, the Legislature, on two separate occasions, transferred moneys from the Health Care Stabilization Fund to the State General Fund, despite the recommendations of the Oversight Committee and regardless of objections of the Board of Governors. As a result, Mr. Wheelen's testimony continued, the Stabilization Fund is no longer used exclusively for those purposes expressed in the Health Care Provider Insurance Availability Act. This change in the fiduciary relationship has generated a great deal of discussion among members of the Board with concern for the actuarial soundness of the Fund and future budget discussions, Mr. Wheelen indicated, further noting the statutory requirement for the Board of Governors to "make such recommendations to the legislature as may be appropriate

to ensure the viability of the fund." In response to the Board concerns about the fiduciary relationship, Mr. Wheelen asked the Committee to consider the following request:

> The Legislature should immediately enact legislation that would prevent any future allotment orders that could discontinue or otherwise interfere with reimbursements to the HCSF for claims and expenses paid on behalf of residents and faculty at KU Medical Center. In addition, when the State of Kansas recovers from the current budget crisis, the Legislature should reimburse the Stabilization Fund for FY 2009 and FY 2010 claims and expenses paid on behalf of residents and faculty at KU Medical Center, and should also reimburse $285,074 to the Stabilization Fund for the two transfers taken from the Fund in FY 2009.

Mr. Wheelen also noted the use of the term "suspend" in the Attorney General's opinion and asked the Committee to consider whether the term, as it applied to the allotment authority, would mean delayed, stopped, or restored. The Executive Director then noted six specific requests for the Oversight Committee to consider (fiduciary relationship; funds transfers only in purposes expressed in the Health Care Provider Insurance Availability Act; legislation that would exempt reimbursements from the Fund from allotment authority delegated to the Secretary of Administration; reimbursement to the Fund for self-insurance program claims, FY 2009 and FY 2010; reimbursement in the amount fo $285,074 for the two transfers to the SGF in FY 2009; and the request for expenditure authority in FY 2011 for technology improvements and professional development).

The Committee members briefly discussed the allotment process and other funding sources subject to the allotment authority.

A Committee member inquired about the possible reduction in staff (data entry) that could be afforded by the technology systems upgrade.

The Chairperson called for a brief recess.

After, the recess, Chairperson Bond recognized Kurt Scott, Chief Operations Officer for KaMMCO, and Jerry Slaughter to comment on the status of the medical malpractice market in Kansas. Mr. Scott testified that there are more carriers in the market and overall, primary rates are down. He also noted that the number of claims for KaMMCO insureds is dramatically down. The number of claims filed, Mr. Scott continued, is a major cost driver.

The Chairperson then inquired of the market share for KaMMCO. Mr. Scott stated that KaMMCO insures approximately 2,550 physicians – just over 50 percent of actively practicing providers and 75 hospitals, which he characterized as mostly smaller, rural hospitals.

Jerry Slaughter began his comments, noting the two statutory questions before the Committee. Mr. Slaughter expressed support for the continuation of the Oversight Committee, as a vital link to the Legislature's understanding of the role the Fund plays, and for the actuarial report provided by Mr. Sutter. He then talked about the legal environment in Kansas and the potential impact on medical malpractice coverage in Kansas. Mr. Slaughter noted the case, *Miller v. Johnson*, had been argued before the Kansas Supreme Court on October 29. The decision has tremendous implications on the medical malpractice climate in Kansas [a constitutional challenge to the current $250,000 cap on non-economic damages for personal injury cases]. Mr. Slaughter indicated if the cap is not upheld, a legislative remedy would be needed [Constitutional amendment]. Mr. Slaughter also noted the Zayat case before the Court of Appeals [*McGinnes v. Zayat*] that also tests the law governing the cap on non-economic damages. Mr. Slaughter then commented on the

issue of the allotments, stating the belief that the Fund was to be held in Trust for specified purposes that were written into law and enumerated in the Fund statutes. Mr. Slaughter noted that the Fund moneys subject to the allotment were not appropriations, but instead, transfers. Mr. Slaughter stated a concern for any future allotments, given the current legal environment. He indicated that the Medical Society, along with the Kansas Hospital Association, intended to ask the Legislature to review KSA 75-3722 and the allotment structure.

A Committee member then inquired about the allotments and moneys transferred from special revenue funds. Mr. Slaughter indicated that some agencies are "swept" and while the net impact is the same (loss of revenue), an allotment order prevents the payment of funds to an agency.

The Chairperson then asked if KMS was supportive of the six requests from the Board of Governors and specifically, the suggested amendment to the allotment statute. Mr. Slaughter stated the Society is generally supportive of the six requests, but indicated that the resolution of the allotment issue is the responsibility of the provider community.

A Committee member commented that the conversation was helpful and protection of the Fund was imperative. Mr. Slaughter indicated that KMS agrees, noting the allotments send a bad message to the provider community that is making responsible payments. Mr. Slaughter concluded his remarks indicating support for the Fund request regarding the training and research for the KU programs.

The Chairperson then welcomed Bob Williams, Executive Director, Kansas Association of Osteopathic Medicine (KAOM) (Attachment 7). Mr. Williams testified that KAOM is supportive of the Board of Governors' position to restore the fiduciary relationship between the State of Kansas and the Health Care Stabilization Fund and to restore the actuarial integrity of the Fund by enacting legislation to prevent any future allotment orders which could interfere with reimbursements to the Fund. Mr. Williams also commented that the issue of allotments and the stability of the Fund also impact patients (costs) and the accessibility to providers.

Following the formal presentations, the Presiding Officer asked if anyone had any suggested changes to the Health Care Provider Insurance Availability Act.

The Committee briefly discussed the allotment statute (KSA 75-3722) and whether the HCPIAA should be amended. No amendments were offered.

The Chairperson then invited Committee discussion on recommendations for the Committee report. The discussion began with the two statutory questions posed to the Oversight Committee. The Committee first considered the necessity of contracting for an independent actuarial review. *It was moved by Rep. Morrison and seconded by Mr. Conrade that the Committee not request an independent actuarial review. The motion carried.*

The Committee then considered its role in the legislative oversight of the Health Care Stabilization Fund. *It was moved by Representative Morrison and seconded by Representative Phelps that the Committee oversight be continued.*

The Committee then discussed the necessity for communicating to each caucus the importance of the Fund and its protection from certain expenditures, including the allotments.

The Committee discussed the timing of its report and publication to the Legislature. The Committee and staff reviewed publication timing of the report and appropriate legislative committees

that could receive and review the report. *It was moved by Senator Vicki Schmidt and seconded by Ms. Schwab to direct the Committee report to the Insurance, Budget, and Health standing Committees and to the House Speaker, Senate President, Senate Minority Leader, and House Minority Leader. The motion carried.* Oversight Committee members indicated additional explanations before the Committee and information about the Fund history are appreciated and helpful.

The Committee reviewed the six recommendations submitted by Mr. Wheelen. Mr. Wheelen clarified that the allotment was not "on the Fund," but rather, on the "reimbursements" (to the Fund from the State General Fund). After discussion about the requests and clarification that the Oversight Committee would not introduce legislation (would be done by the health care provider community) and the language regarding "Funds held in trust" be continued in the report, *the motion was made by Representative Morrison and seconded by Mr. Conrade to continue the language about the Funds held in trust and make the recommendations as stated in items 1-6 in the Board of Governors' staff testimony. The motion carried.*

The six recommendations are as follows with headings added for clarification purposes:

- *Fiduciary Relationship.* The Legislature should protect the taxpayers of Kansas from Health Care Stabilization Fund [HCSF] liabilities by restoring the fiduciary relationship between the state and the HCSF.

- *Transfer of Funds, Expressed Purposes.* The Legislature should never transfer funds from the HCSF for any purpose other than those expressed in the Health Care Provider Insurance Availability Act. [see also, language re: Funds held in trust]

- *Allotment Authority, Reimbursements to the Fund.* The Legislature should immediately enact legislation that exempts reimbursements from the State of Kansas to the Health Care Stabilization Fund from the allotment authority delegated to the Secretary of Administration. *The Committee notes that the health care providers, rather than this Committee or the Fund Board of Governors, is to request such legislation.*

- *Reimbursement for FY 2009, FY 2010 Expenditures.* The Legislature should make arrangements for the eventual reimbursement to the HCSF those funds that should have been reimbursed by the state for claims paid by the HCSF on behalf of residents and faculty at [the] KU Medical Center during fiscal years 2009 and 2010.

- *Fund Transfers to the State General Fund, Reimbursement of.* The Legislature should make arrangements for eventual reimbursement to the HCSF [in] the amount of $285,074 for the two transfers to the State General Fund in FY 2009.

- *Technology Improvements, Professional Development.* The Legislature should grant the HCSF Board of Governors' FY 2011 request for expenditure authority in the amount of $800,000 for technology improvements and professional development.

The language to be continued from the prior year Committee report:

*Fund To Be Held In Trust.* The Committee recommends the continuing of the following language to the Legislative Coordinating Council, the Legislature, and the Governor regarding the Health Care Stabilization Fund:

- The Health Care Stabilization Fund Oversight Committee continues to be concerned about and is opposed to any transfer of money from the HCSF to the State General Fund. The HCSF provides Kansas doctors, hospitals, and the defined health care providers with individual professional liability coverage. The HCSF is funded by payments made by or on the behalf of each individual health care provider. Those payments made to the HCSF by health providers are not a fee. The state shares no responsibility for the liabilities of the HCSF. Furthermore, as set forth in the Health Care Provider Insurance Availability Act, the HCSF is required to be ". . . held in trust in the state treasury and accounted for separately from other state funds."

- Further, this Committee believes the following to be true: All surcharge payments, reimbursements, and other receipts made payable to the Health Care Stabilization Fund shall be credited to the Health Care Stabilization Fund. At the end of any fiscal year, all unexpended and unencumbered moneys in such Health Care Stabilization Fund shall remain therein and not be credited to or transferred to the State General Fund or to any other fund.

There being no further business to come before the Committee, the meeting was adjourned at 11:35 a.m.

Prepared by Melissa Calderwood
Edited by Dylan Dear

Approved by Committee on:

February 1, 2010
(Date)

# Sign-In Sheet

Health Care Stabilization Fund Oversight Committee
November 3, 2009

| NAME | REPRESENTING |
|---|---|
| Berend Koops | Hein Law Firm |
| Bobby Williams | KS Assoc. Osteopathic Medicine |
| Rob Mealy | Kennedy & Assoc. |
| Russ Sutter | Towers Perrin |
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# Report of the Health Care Stabilization Fund Oversight Committee to the 2009 Kansas Legislature

**CHAIRPERSON:** Mr. Dick Bond

**LEGISLATIVE MEMBERS:** Senators Greta Goodwin and James Barnett; and Representatives Eber Phelps, and Jim Morrison

**NON-LEGISLATIVE MEMBERS:** Mr. Darrell Conrade, Dr. Paul Kindling, Dr. Terry "Lee" Mills, Jr., Dr. James Rider, Ms. Penny Schwab, and Dr. Arthur D. Snow, Jr.

## STUDY TOPIC

- The Committee must review the operation of the Health Care Stabilization Fund and report and make recommendations to the Legislative Coordinating Council regarding the financial status of the Fund, including any recommendations for legislation necessary to implement recommendations of the Committee.

# Health Care Stabilization Fund Oversight

## Annual Report

### Conclusions and Recommendations

The Committee discussed its own role in providing legislative oversight of the Fund, as outlined by statute. The Health Care Stabilization Fund (HCSF) Oversight Committee continues in its belief that the Committee serves a vital role as a link between the Fund Board of Governors, the providers, and the Legislature, and should be continued.

The Committee also reviewed the necessity for the need to contract for an independent actuarial review in 2009. While the Committee continues in its belief that the ability to contract an independent annual review is important for the safety and soundness of the Fund, the Committee does not see a need for an independent review in 2009. The issue will be revisited at the Committee's meeting in 2009.

Further, after the receipt of the annual report by the Health Care Stabilization Fund Board of Governors, its actuary, and conferees at its December meeting, the Committee also makes the following recommendations:

- **Claims Reporting.** The Committee is satisfied with the adequacy of information currently reported on an annual basis by the Health Care Stabilization Fund Board of Governors. The Committee recognizes the review of claims reporting legislation by the 2008 Interim Special Committee on Insurance and supportive of its recommendation to defer any further action on this issue until the National Association of Insurance Commissioners (NAIC) has completed its work on model legislation.

- **Kansas Open Records Act, Individual Claims.** The Committee shares the concern of the Board of Governors regarding privacy and confidentiality. The Committee recognizes that while the Board of Governors is a public agency, personally-identifiable medical information is subject to the federal Health Insurance Portability and Accountability Act (HIPAA) and most of the settlement agreements (claims) approved by the courts include provisions for confidentiality. The Committee endorses the recommendation of the Board of Governors and believes that individual claims information should be exempt from the Kansas Open Records Act, while the Board's aggregate claims information should be made public information.

- **Information Management System, Expenditure Authority and Exemption from Purchasing Laws.** The Committee continues in its support of the modernization of information management and technology at the Health Care Stabilization Fund Board of Governors. The Committee notes the previous work done by a consultant for the Board of Governors which indicates that the HCSF's systems and processes are "heavily manual and paper based, provide

limited real time and historical information tracking, have led to process inefficiencies, do not provide the functionality needed by users, and are not flexible or expandable enough to grow and adapt to the changing and evolving needs of HCSF." The Committee also notes that the Fund will not be permitted (in the near future) to use Kansas Incentive Savings Program (KSIP) expenditure authority for technology development and is therefore supportive of an increased expenditure authority for state operations in an amount not likely to exceed $40,000 for an information technology consultant. Further, the Committee recognizes that the system will require specifications unique to a professional liability insurance system, and to expedite the quality and outcome of the project, an exemption from KSA 75-3739 and 75-3740 is necessary in this system design.

- **Fund To Be Held In Trust.** Finally, while the Committee makes no recommendation for changes in the statutes governing the work of the Fund Board of Governors, it does recommend continuing of the following language to the Legislative Coordinating Council, the Legislature, and the Governor regarding the Health Care Stabilization Fund:

  - The Health Care Stabilization Fund Oversight Committee continues to be concerned about and is opposed to any transfer of money from the HCSF to the State General Fund. The HCSF provides Kansas doctors, hospitals and the defined health care providers with individual professional liability coverage. The HCSF is funded by payments made by or on the behalf of each individual health care provider. Those payments made to the HCSF by health care providers are not a fee. The State shares no responsibility for the liabilities of the HCSF. Furthermore, as set forth in the Health Care Provider Insurance Availability Act, the HCSF is required to be "...held in trust in the state treasury and accounted for separately from other state funds."

  - Further, this Committee believes the following to be true: All surcharge payments, reimbursements, and other receipts made payable to the Health Care Stabilization Fund shall be credited to the Health Care Stabilization Fund. At the end of any fiscal year, all unexpended and unencumbered moneys in such Health Care Stabilization Fund shall remain therein and not be credited or transferred to the State General Fund or to any other fund.

In its consideration of these recommendations, the Committee also makes note of the *gratis* work through administrative support done by the Fund on behalf of the two residency programs.

***Proposed Legislation:*** None.

## Background

The Health Care Stabilization Fund Oversight Committee was created by the 1989 Legislature and is described in KSA 40-3403b. The 11-member Committee consists of four legislators; four health care providers; one insurance industry representative; one person from the public at large, with no affiliation with health care providers or with the insurance industry; and the Chairperson of the Board of Governors of the Health Care Stabilization Fund (HCSF) or another member of the Board designated by the Chairperson. The law charges the Committee to report its activities to the Legislative Coordinating Council and to make

recommendations to the Legislature regarding the Fund. The reports of the Committee are on file in the Legislative Research Department.

## Committee Activities

### Report of Towers Perrin

Towers Perrin, the actuary to the Fund, reported to the Committee that as of June 30, 2008, the Fund held assets of $210.0 million and liabilities (discounted) of $174.5 million, with $35.5 million in reserve. Projections for June 2009 include $212.0 million in assets and liabilities of $179.8 (discounted), with $32.2 million in reserve. (Discounted liabilities assume a 3.5 percent yield.) The actuary then highlighted the estimates of Fund liabilities at June 30, 2008, and June 30, 2009. Projections for losses and expenses for active providers indicate an increase (losses increase an estimated $4.0 million; expenses increase $1.2 million). Another increase is projected in inactive providers (tail coverage), increasing from $49.3 million to $50.5 million. Mr. Sutter noted that with the change in consideration of tail coverage, projections are being made out to 2055 in the model.

The actuary noted that findings reported to the Board in March 2008 included: the Fund is financially sound; loss experience on prior years was generally doing better than previously expected; Fund assets were higher than expected; and experience by class varied significantly. The actuary indicated that a concern shared with the Board was the potential drop in investment income, given the rapid decline in short-term interest rates that occurred in early 2008. Considering this information, he noted, the Board elected to raise surcharge rates by an average of five percent.

The actuary also addressed pending claims, noting a concern regarding the significant increase in the number of open claims and amount in reserves since December 2006 (open claims; 12/31/2006: 169; 12/31/2007: 198; 10/31/2008: 222). The actuary noted, however, that reserve adequacy may have increased in the last few years.

The actuary then highlighted the tail coverage liabilities for active providers, noting that the firm's 2008 review reflected the change in recognition of tail liabilities (in prior years, only the liabilities of inactive providers were estimated). The 2008 review included liabilities of future tail claims from currently active providers with five or more years of Fund compliance; this change in approach increases the Fund liabilities by more than $30 million (estimate includes claims expenses, which add 50 percent to the liability). The current estimates of tail liabilities include: providers with five or more years in FY 2008 staying active until 2037; claims reported through FY 2045; and claims paid through FY 2055.

The actuary then reviewed findings by provider class, noting that while the analysis of experience by Fund class continues to show significant differences in relative loss experience among classes, the variability has narrowed since the initial study in 2005. Class 11 (specialty surgery – neurosurgery) had the highest rate in loss experience which was reflected in the surcharge increase approved by the Board. The actuary then reviewed the FY 2009 surcharge: Fund classes 1, 12, and 14 saw no change; Fund classes 2, 4, 5, 7, 8, 10, and 11 saw a 6.0 percent increase; Fund classes 3, 6, 9, and 13 saw a 4.0 percent increase. Fund classes 15 through 21 (Plan insureds; corporations, facilities; and residency training programs) saw a 35 to 37 percent increase.

The actuary concluded his report noting the implications of the financial crisis. The two implications for the Fund, he concluded, are: the market value of assets has dipped below amortized cost, and near-term, investment yields appear likely to be relatively low.

## Comments

In addition to the report from the Board of Governor's actuary, the Committee received a review of recent legislation and legislative reports. Committee staff noted an interim topic assigned to the Special Committee on Insurance regarding proposed legislation (HB 2782 would have enacted the Kansas Medical Liability Reform Act). The staff provided a briefing on the legislation, indicating that the legislation would have required certain reporting entities, including insurance companies and the Health Care Stabilization Fund, to submit an annual report about their operations and medical malpractice and health care professional liability claims to the Insurance Department. The staff noted that issues reviewed by the Special Committee included making the National Association of Insurance Commissioner's guidelines (model act) Kansas-specific to incorporate defined terms including health care provider and self-insurer, avoiding duplication and unnecessary costs associated with the reporting requirements and data, and addressing the privacy and confidentiality provisions, including HCSF settlement agreements and the Kansas Open Records Act. The staff also highlighted the relevant provisions of the enacted health reform legislation, House Sub. for SB 81.

The Committee also heard from the Board of Governor's staff. The Executive Director provided an overview of the 2007-2008 activities of the Health Care Stabilization Fund Board of Governors. Mr. Wheelen began his report by providing a brief history of the Fund and highlighting the principle features of the Fund, noting that few providers elect the $100,000 per claim coverage ($300,000 aggregate) and most providers continue to choose the highest coverage option ($1 million/claim and annual aggregate of $3 million when combined with the basic level of liability insurance). Some health care providers (namely high risk specialists, large medical centers), purchase excess liability insurance in addition to the HCSF coverage. The Executive Director also highlighted the 16 categories of health care providers statutorily required to participate in the Fund. The Executive Director noted there are about two dozen insurance companies or risk retention groups offering the primary layer of medical liability insurance in Kansas, with 80 percent of the commercial insurance coverage sold by five companies.

The Executive Director next highlighted the Board's statutory report for FY 2008. Among the highlights:

- Surcharge revenue collections amounted to $24,264,946, with the lowest surcharge rate of $50 (chiropractor, first year of Kansas practice who selected the lowest coverage option) and the highest surcharge rate of $14,593 (neurosurgeon, five or more years of Fund liability exposure who selected the highest coverage option).

- There were 34 medical malpractice cases involving 41 Kansas health care providers decided as a result of a jury trial. Fifty-seven cases involving 65 claims were settled resulting in HCSF obligations amounting to $17,452,500 (average compensation per claim was $268,500).

- The total claims paid during the fiscal year amounted to $25,308,355. Of that amount, a payment of $2,203,674 was paid to the Plan. Additionally, $800,000 was paid to claimants on behalf of insurance companies that reimbursed the Fund for these payments. Mr. Wheelen stated that the actual **net claims** paid during FY 2008 totaled $22,304,681.

- The preliminary financial report, as of June 30, 2008, indicated assets amounting to $214,631,127, and liabilities amounting to $194,750,196.

The Executive Director also commented on self-insured health care providers. In addition to the state-owned medical care facilities and

affiliates of KUMC, there currently are 13 self-insured hospitals and surgery centers. He noted that the HCSF does not receive any compensation for its administrative costs attributable to the self-insured programs affiliated with the University of Kansas. The Fund is reimbursed for claims payments up to the maximum $200,000 per claim. The Deputy Director and Chief Attorney, Rita Noll, then addressed the FY 2008 medical professional liability experience. She noted that of the 34 cases tried to juries in FY 2008, 27 cases were tired to juries in Kansas courts and seven cases involving Kansas health care providers were tried to juries in Missouri. The largest number of cases (13) were tried in Sedgwick County. Of the 34 cases, 25 resulted in defense verdicts. During FY 2008, 65 claims in 57 cases were settled, with settlements incurred by the Fund totaling $17.35 million. (These figures do not include settlement contributions by primary or excess insurance carriers.) Individual claim settlement contributions for FY 2008 ranged from a low of $25,000 to a high of $800,000. It also was noted that of the 65 claims, the Fund provided primary coverage for inactive providers in six claims.

The representative also addressed the number and severity of claims being made against the Fund and the status of claims involving the University of Kansas Medical School faculty and residents of the training programs in Kansas City and Wichita. It was noted that five claims were settled during FY 2008 for the KU Foundations and Faculty for a total of $966,328 ($497,624 from the Private Practice Reserve Fund, remainder from the SGF). The total for FY 2007, Ms. Noll stated, had been 15 claims totaling $2.037 million, and she was anticipating a similar experience for FY 2009. FY 2008 reimbursements for the two residency programs (all from the State General Fund) totaled $648,297 ($501,776 for the Wichita Center for Graduate Medical Education, WCGME, and $146,494 for KU). Moneys paid by the Health Care Stabilization Fund for its excess coverage totaled $213,000. Ms. Noll noted there had been only one settlement for WCGME in FY 2008, as compared to four in FY 2007, and characterized the self-insurance program reimbursements experience in FY 2008 as a "good year." Committee members discussed the administrative work provided by the Fund staff for the self-insured programs associated with KU. Ms. Noll stated that, in the case of first dollar coverage, the Fund handles the claim including an evaluation and assistance and also works on risk management prior to the claims. It was noted that no calculation has been made regarding Fund employee time, not the office space utilized for claims and account support; these tasks have been assimilated into Fund office duties since 1990.

The Executive Director also addressed recent legislative issues, including claims reporting (detailed above). It was noted that the Fund currently reports claims information to this legislative committee, publishes information on KANView, and publishes its fiscal year reports on its web site. He indicated the Fund has an obligation to protect individual data and cited HIPAA. The Committee members discussed the privacy provision and the provision specific to review prior to July 1, 2013. The Executive Director requested the Committee indicate its satisfaction with the adequacy of the Fund reporting. The Committee, he continued, also could recommend deferment of any further action on this issue until the NAIC has completed its work on the model bill.

The Executive Director also noted work on the defined term "medical care facility" in light of questions raised regarding HCSF coverage of institutional providers. After a series of meetings and discussions with representatives of the Kansas Department of Health and Environment, hospitals, and the medical profession, the Board adopted policies and procedures that clarify the liability coverage of the Health Care Stabilization Fund and also prescribe the application and renewal process for self-insured health care providers.

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The Executive Director also discussed the premium surcharge, noting the Board's efforts last year to change its practice in regard to planning for future liabilities attributable to inactive health care providers (commonly referred to as "tail coverage"). The change in methodology has increased the Fund's indicated liabilities, which reduced the unassigned reserves. The Board also decided to use undiscounted liabilities for determining reserve requirements and try to achieve unassigned reserves equal to about 25 percent of the indicated liabilities. This unassigned reserves goal has been adopted as a performance measure in the Fund's annual budget request. He also briefed the Committee on issues facing the Fund and the need for legislative response or direction (in addition to the Claims Reporting request):

- Kansas Open Records Act Exemption – The Executive Director stated a concern about maintaining the provisions of confidentiality associated with the settlement agreements approved by the courts. The Fund, however, is subject to the Kansas Open Records Act (KORA). Mr. Wheelen noted the Board believes its individual claims information should be exempt from the Kansas Open Records Act, while aggregate claim information should be public information. The Committee was requested to endorse this principle.

- Information Management – The Committee was updated on the Fund's project. The Board received its requested supplemental expenditure authority (2008 Session) for the services of a consultant and heard from the consultant that: "...HCSF's systems and processes are heavily manual and paper based, provide limited real time and historical information tracking, have led to process inefficiencies, do not provide the functionality needed by users, and are not flexible or expandable enough to grow and adapt to the changing and evolving needs of HCSF." The consultants were not able to obtain cost estimates from vendors that sell information systems and software designed for professional liability insurance companies. Without a reliable estimate, it is difficult, the Executive Director continued, to determine how much budget authority will be needed to proceed. The Board had hoped to use Kansas Savings Incentive Program (KSIP) funds to afford the cost of technology development (there is a now a moratorium on KSIP expenditures). In light of the uncertain KSIP funding availability, the Board will be asking the Legislature to authorize additional expenditure authority in order to afford an information technology consultant. It is estimated that the consultant contract will not exceed $40,000. The Executive Director also requested the Committee to consider an endorsement of its request to exempt the Fund Board of Governors from the state purchasing laws regarding acceptance of the lowest bid, as the Board would best be served by companies that already have experience with professional liability insurance systems. Committee members discussed the timing of the approval of a supplement request and the funding source. None of the moneys would be from the State General Fund. Committee members also discussed working with the Division of Information Systems and Communications (DISC) about the project and agency needs.

Following the formal presentations, it was asked if anyone had any suggested changes to the Health Care Provider Insurance Availability Act. There were no plan amendments suggested by those present.

The Committee also reviewed the current marketplace for medical malpractice insurance. A conferee representing the Kansas Medical Mutual Insurance Company (KaMMCO) noted that, at the beginning of the decade, the national marketplace faced severe losses and saw an increase in rates for providers. The market now is

much more solid, aided by tort reform measures, rate increases paid by providers, the decrease in the number of claims at the national and state level, the formation of new companies, and the increase in competition. The conferee noted that over the past two years, KaMMCO has not increased rates. The Kansas environment is good, with a lower frequency of claims. Additionally, the conferee noted that new companies are entering the Kansas market, often with aggressive rates. The conferee noted that the market is and has been cyclical in nature, noting the potential for a next "crisis," which could include the outcome of two court challenges (noneconomic damages; wrongful death caps). The conferee also noted that, in times of recession, there is an increase in workers compensation and medical professional liability claims. Committee members discussed the rate of claims over the past few years for the conferee's company. The conferee noted that KaMMCO (for Kansas health care providers) has the ability to engage in loss protection and moderate its claims experience. The impacts on KaMMCO and other insurers will be seen in the reduction in investment income and the reliance on the reinsurance markets (particularly for excess lines).

A conferee from the Kansas Medical Society characterized the current market as a time of relative tranquility, with Kansas experiencing a strong and properly managed Fund and tort reform. The market also was described as being viable and vigorous. The conferee then responded to the statutory questions posed to the Committee each year, noting the Oversight Committee needs to continue meeting and the report it generates is incredibly important. The conferee indicated the actuarial report is superb, and the Medical Society is supportive of the reporting of tail liabilities, viewing this change as appropriate and responsible. He then offered support for the Board of Governors' recommendations. The conferee noted the State's financial condition, describing it as "challenging," especially for FY 2010. He recommended the Committee include language in its report regarding an admonition that the funds from physicians and other health care providers' surcharge payments be held in trust and be used to pay claims.

## Conclusions and Recommendations

The Committee discussed its own role in providing legislative oversight of the Fund, as outlined by statute. The Health Care Stabilization Fund Oversight Committee continues in its belief that the Committee serves a vital role as a link between the Fund Board of Governors, the providers, and the Legislature, and should be continued.

The Committee also reviewed the necessity for the need to contract for an independent actuarial review in 2009. While the Committee continues in its belief that the ability to contract an independent annual review is important for the safety and soundness of the Fund, the Committee does not see a need for an independent review in 2009. The issue will be revisited at the Committee's meeting in 2009.

Further, the Committee also makes the following recommendations:

- **Claims Reporting.** The Committee is satisfied with the adequacy of information currently reported on an annual basis by the Health Care Stabilization Fund Board of Governors. The Committee recognizes the review of claims reporting legislation by the 2008 Interim Special Committee on Insurance and supportive of its recommendation to defer any further action on this issue until the National Association of Insurance Commissioners (NAIC) has completed its work on model legislation.

- **Kansas Open Records Act, Individual Claims.** The Committee shares the concern of the Board of Governors regarding privacy and confidentiality. The Committee recognizes that while the Board of Governors is a public agency, personally-identifiable

medical information is subject to HIPAA and most of the settlement agreements (claims) approved by the courts include provisions for confidentiality. The Committee endorses the recommendation of the Board of Governors and believes that individual claims information should be exempt from the Kansas Open Records Act, while the Board's aggregate claims information should be made public information.

- **Information Management System, Expenditure Authority and Exemption from Purchasing Laws.** The Committee continues in its support of the modernization of information management and technology at the Health Care Stabilization Fund Board of Governors. The Committee notes the previous work done by a consultant for the Board of Governors which indicates that the HCSF's systems and processes are "heavily manual and paper based, provide limited real time and historical information tracking, have led to process inefficiencies, do not provide the functionality needed by users, and are not flexible or expandable enough to grow and adapt to the changing and evolving needs of HCSF." The Committee also notes that the Fund will not be permitted (in the near future) to use KSIP expenditure authority for technology development and is therefore supportive of an increased expenditure authority for state operations in an amount not likely to exceed $40,000 for an information technology consultant. Further, the Committee recognizes that the system will require specifications unique to a professional liability insurance system, and to expedite the quality and outcome of the project, an exemption from KSA 75-3739 and 75-3740 is necessary in this system design.

- **Fund To Be Held In Trust.** Finally, while the Committee makes no recommendation for changes in the statutes governing the work of the Fund Board of Governors, it does recommend continuing of the following language to the Legislative Coordinating Council, the Legislature, and the Governor regarding the Health Care Stabilization Fund:

  - The Health Care Stabilization Fund Oversight Committee continues to be concerned about and is opposed to any transfer of money from the HCSF to the State General Fund. The HCSF provides Kansas doctors, hospitals, and the defined health care providers with individual professional liability coverage. The HCSF is funded by payments made by or on the behalf of each individual health care provider. Those payments made to the HCSF by health providers are not a fee. The State shares no responsibility for the liabilities of the HCSF. Furthermore, as set forth in the Health Care Provider Insurance Availability Act, the HCSF is required to be ". . .held in trust in the state treasury and accounted for separately from other state funds."

  - Further, this Committee believes the following to be true: All surcharge payments, reimbursements, and other receipts made payable to the Health Care Stabilization Fund shall be credited to the Health Care Stabilization Fund. At the end of any fiscal year, all unexpended and unencumbered moneys in such Health Care Stabilization Fund shall remain therein and not be credited to or transferred to the State General Fund or to any other fund.

In its consideration of these recommendations, the Committee also makes note of the *gratis* work through administrative support done by the Fund on behalf of the two residency programs.

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# Kansas Legislator Briefing Book 2010

Kansas Legislative Research Department

Health

M-2
Health Care Stabilization Fund and Kansas Medical Malpractice Law

Other Health reports available

M-1
Obesity

M-3
H1N1 Flu Pandemic

M-4
Radon Occurrence in Kansas

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## Health

### M-2 - Health Care Stabilization Fund and Kansas Medical Malpractice Law

The 1976 Health Care Providers Insurance Availability Act (HCPIA) created the Health Care Stabilization Fund in an effort to stabilize the availability of medical professional liability coverage for health care providers. The law mandates a basic liability requirement for certain health care providers (defined below) and establishes an availability plan in order to provide the required basic professional liability insurance coverage for those providers of health care in Kansas unable to obtain such coverage from the commercial market. The Fund receives its funding from professional liability coverage surcharge payments made by health care providers.

### Health Care Providers

The Health Care Stabilization Fund was created, in part, to provide excess liability coverage for the following defined Health Care Providers in KSA 2006 Supp. 40-3401(f):

- Medical Doctors and Doctors of Osteopathy who are licensed or hold temporary permits with the State Board of Healing Arts;
- Chiropractors;
- Podiatrists;
- Persons engaged in a postgraduate training program approved by the State Board of Healing Arts;
- Registered Nurse Anesthetists;
- Dentists certified by the State Board of Healing Arts;
- Medical care facilities;
- Mental health clinics and centers;
- Psychiatric hospitals (certain facilities);
- Kansas professional corporations or partnerships of defined health care providers;
- Kansas limited liability companies organized for the purpose of rendering professional services by their health care providers;
- Kansas not-for-profit corporations organized for the purpose of rendering professional services by persons who are health care providers; and
- A nonprofit corporation organized to administer the graduate medical education programs affiliated with the University of Kansas School of Medicine.

Health Care Stabilization
Fund Oversight Committee
November 3, 2009
Attachment 2

Health care providers whose practice includes the rendering of professional services in Kansas are subject to the basic professional liability coverage and Fund surcharge requirements. In addition, the coverage and surcharge requirements also apply to health care providers who are Kansas residents and to non-resident health care providers whose practice includes the rendering of professional services in Kansas.

Fund coverage, through basic professional liability coverage, is available from insurers authorized to write business in Kansas or through the Health Care Provider Insurance Availability Plan. The Fund coverage limits currently are comprised of three tiers: $100,000/$300,000; $300,000/$900,000; and $800,000/$2,400,000. (The first dollar amount indicates the amount of loss payment available for each claim, while the second indicates the total annual amount of loss payments for all claims made during a Fund coverage year). For Kansas health care providers, the insurer is responsible for:

- Calculation of the amount of the surcharge based on the Fund coverage limit selected by the health care provider;
- Development of the rating classification code of the provider and the number of years the provider has been in compliance with the Fund;
- Collection of the Fund surcharge payment along with the basic professional liability coverage and remitting the surcharge to the Fund without any reductions for commissions, collections, or processing expenses; and
- With a primary function of excess professional liability coverage, the Fund is "triggered" when the basic professional liability insurer's projected loss exposure exceeds $200,000.

According to the Fund agency, the Fund's legal staff monitor all claims and suits filed against Kansas health care providers, including attending claim settlement conferences where the Fund's coverage has not yet been triggered. In addition to claims protection, the law also requires all basic professional liability insurers to include prior acts coverage which eliminates the need for Kansas health care providers to purchase tail coverage when changing insurers; requires all basic professional liability insurers to provide professional liability insurance for the overall or total professional services rendered by Kansas health care providers; funds "tail" coverage for qualified inactive health care providers in Kansas; and provides special self-insurance coverage for the full-time faculty, private practice foundations and corporations, and the residents of the University of Kansas School of Medicine and the Wichita Council of Graduate Medical Education.

## Fund Administration

The Board of Governors, as defined in KSA 40-3403, consists of ten members appointed by the Commissioner of Insurance in the manner prescribed by statute. Three members are medical doctors in Kansas nominated by the Kansas Medical Society; three members who serve as representatives of Kansas hospitals and are nominated by the Kansas Hospital Association; two members are doctors of osteopathic medicine nominated by the Kansas Association of Osteopathic Medicine; one member who is a chiropractor in Kansas and nominated by the Kansas Chiropractic Association; and one member who is a Registered Nurse Anesthetist and is nominated by the Kansas Association of Nurse Anesthetists.

The law dictates that the Board of Governors:

- Administer the Fund and perform other functions as required by the Health Care Providers Insurance Availability Act;
- Provide advice and testimony to the appropriate licensing or disciplinary authority regarding the qualifications of a health care provider; and
- Publish a report by October 1 of each year providing a summary of the Fund's activity, including amounts collected from surcharges, highest and lowest surcharges, amount paid from the Fund, number of settlements paid from the Fund, and the Fund balance at the end of the fiscal year.

Prior to 1995, the Fund was administered by the Commissioner of Insurance. Beginning in 1995, the administration of the Fund became the responsibility of the Health Care Stabilization Fund Board of Governors, and the Board was recognized as an independent state agency. The following chart illustrates the agency expenditures for administration of the Fund and total paid claims, by fiscal year.

**OPERATING EXPENDITURES**
**Health Care Stabilization Fund**
**FY 2001-FY 2010**

| Fiscal Year | State Operations | % Change | Claims Paid | % Change | FTE |
|---|---|---|---|---|---|
| 2001 | $ 3,289,156 | (8.1)% | $ 22,512,749 | (2.1)% | 16.0 |
| 2002 | 3,579,695 | 8.8 | 23,020,774 | 2.3 | 16.0 |
| 2003 | 4,690,286 | 31.0 | 23,454,385 | 1.9 | 16.0 |
| 2004 | 6,255,737 | 33.4 | 23,245,032 | (0.9) | 16.0 |
| 2005 | 6,389,120 | 2.1 | 25,104,792 | 8.0 | 16.0 |
| 2006 | 5,238,807 | (18.0) | 23,947,225 | (4.6) | 16.0 |
| 2007 | 5,853,999 | 11.7 | 22,467,114 | (6.2) | 17.0 |
| 2008 | 5,928,742 | 1.3 | 24,508,355 | 9.1 | 17.0 |
| 2009 Approved | 5,157,430 | (13.0) | 28,306,048 | 15.5 | 17.0 |
| 2010 Approved | 6,892,958 | 33.7 | 28,250,000 | (0.2) | 17.0 |
| Ten-Year Change Dollars/Percent | $ 3,603,802 | 109.6% | $ 5,737,251 | 25.5% | 1.0 |

The Fund also receives interest on the state agency investments in addition to the surcharge paid by health care providers in Kansas. The investments for the Board of Governors are administered by the Pooled Money Investment Board (PMIB).

## Budget Items, 2009 Session

In FY 2009 and FY 2010, transfers from the State General Fund to the Health Care Stabilization fund for payments from the KU residents, faculty and graduate medical education students were suspended. The moratorium on reimbursements from the State General Fund has reduced the fund balance by a projected $6.0 million over the two year period. (The FY 2010 transfer payments were suspended by the Governor's agency allotment authority in July 2009.)

## Oversight

The Health Care Stabilization Fund Oversight Committee was created by the 1989 Legislature. The composition of the Committee is detailed in KSA 40-3403b. The eleven-member Committee consists of:

- Four legislators;
- Four health care providers;
- One representative of the insurance industry;
- One person from the general public with no affiliation to health care providers or with the insurance industry; and
- The chairperson of the Board of Governors of the Health Care Stabilization Fund or another Board member designated by the Board chairperson.

The law requires the Committee to report its activities to the Legislative Coordinating Council and make recommendations to the Legislature regarding the Health Care Stabilization Fund. Committee reports are on file with the Legislative Research Department.

During its 2008 meeting, the Committee discussed its own role in providing legislative oversight of the Fund, as outlined by statute. The Committee also indicated that it continues in its belief that the Committee serves a vital role as a link between the Fund Board of Governors, the providers, and the Legislature, and should be continued. The Committee also reviewed the necessity for the need to contract for an independent actuarial review in 2009. While the Committee continues in its belief that the ability to contract an independent annual review is important for the safety and soundness of the Fund, the Committee does not see a need for an independent review in 2009.

The Committee also considered the report from the Health Care Stabilization Fund Board of Governors, its actuary, and conferees at its December 2008 meeting and made recommendations on the issues of claims reporting and individual claims information and an exemption from the Kansas Open Records Act. The Committee reviewed and endorsed the agency's request for expenditure authority for information technology (consulting) and indicated its support of the modernization of information and technology at the Health Care Stabilization Fund Board of Governors.

2-4

The Committee reviewed the report from the Fund actuary (the report assists the Board of Governors in its decision to set the level of surcharges for the next fiscal year). The actuary noted that findings reported to the Board in March 2008 included: the Fund is financially sound; loss experience on prior years was generally doing better than previously expected; Fund assets were higher than expected; and experience by [surcharge] class varied significantly. The actuary noted a concern he shared with the Board – a potential drop in investment income, given the rapid decline in short-term interest rates that occurred in early 2008. Considering this information, the Board elected to raise surcharge rates by an average of five percent. The actuary also noted a concern regarding the significant increase in the number of open claims and amount in reserves since December 2006.

The actuary concluded his report noting the implications of the financial crisis for the Fund: the market value of assets has dipped below amortized cost and near-term investment yields appear likely to be relatively low.

## Fund Status

The actuarial report provided to the Oversight Committee indicated that as of June 30, 2008, the Fund held assets of $210.0 million and liabilities (discounted) of $174.5 million, with $35.5 million in reserve. Projections for June 2009 include $212.0 million in assets and liabilities of $179.8 million (discounted), with $32.2 million in reserve. (Discounted liabilities assume a 3.5 percent yield). Projections for losses and expenses (Fund) now include projections for tail coverage for inactive providers, with projections being forecasted to 2055 in the model.

Following is a brief summary of additional Kansas laws that address medical malpractice and the legal proceedings.

2-5

## Kansas Medical Malpractice Tort Laws

| Statute of Limitations | Damage Awards' Limits | Pre-trial Screening, Arbitration | Joint and Several Liability | Expert Witnesses | Attorney Fees | Health Care Stabilization Fund |
|---|---|---|---|---|---|---|
| **KSA 60-513.** Two years from act or reasonable discovery. Is permitted up to ten years after reasonable discovery. | **KSA 60-19a02.** $250,000 limit on noneconomic damages recoverable by each party from all defendants.<br><br>**KSA 60-3702.** Punitive damages limited to the lesser of defendant's highest gross income for prior five years or $5 million. If profitability of misconduct exceeds limit, court may award 1.5 times profit instead. Judge determines punitive damages. | **KSA 65-4901; 60-3502.** Voluntary submission to medical screening panel upon request of party; panelists must include medical professional of same specialty as defendant. | No separation of joint and several liability. | **KSA 60-3412.** Fifty percent of the expert's professional time over preceding two years must have been devoted to clinical practice in same field as defendant. | **KSA 7-121b.** Attorney fees must be approved by the court. | **KSA 40-3403.** (discussed above). |

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STATE OF KANSAS
OFFICE OF THE ATTORNEY GENERAL

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July 29, 2009

ATTORNEY GENERAL OPINION NO. 2009-16

Charles L. Wheelen, Executive Director
Health Care Stabilization Fund
300 SW 8th Avenue
Topeka, Kansas 66603-3912

Re: State Departments; Public Officers and Employees--Department of Administration--Application of Allotment System; Application to Statutory Transfers of Funds to Health Care Stabilization Fund

Synopsis: The allotment authority delegated to the Secretary of Administration in K.S.A. 75-3722 authorizes the Secretary to suspend the statutory obligation of the State of Kansas to reimburse the Health Care Stabilization Fund pursuant to relevant sections of the Health Care Provider Insurance Availability Act. Cited herein: K.S.A. 50-3401; 65-3415a; 65-3491; 65-34,114; 65-34,129; 65-34,146; 75-3701; 75-3722; 72-6438.

* * *

Dear Mr. Wheelen:

As Executive Director for the Health Care Stabilization Fund, you pose the following question: Does the allotment authority delegated to the Secretary of Administration in K.S.A. 75-3722 authorize the Secretary to suspend the statutory obligation of the State of Kansas to reimburse the Health Care Stabilization Fund pursuant to relevant sections of the Health Care Provider Insurance Availability Act?

The Kansas allotment system,[1] a budgetary tool that appears to be unique to Kansas, may be implemented by the Secretary of Administration in relation to "any state agency" when "necessary or beneficial to the state."[2]

[1]Persons interested in the legislative history and background are directed to A Opinion No. 82-160.

[2]K.S.A. 75-3722, first paragraph.

Alternatively, when general or special fund resources are "likely to be insufficient to cover the appropriations made against such general fund or special revenue fund,"[3] the Secretary of Administration may "inaugurate the allotment system so as to assure that expenditures for any particular fiscal year will not exceed the available resources of the general fund or any special revenue fund for that fiscal year."[4] In this event, the Secretary is granted broad authority to accomplish this fiscal goal "in such manner that the secretary may determine."[5]

An allotment, in this context, means "a limitation on the use of amounts available to state agencies" for a period of up to 12 months within a fiscal year.[6] One court referred to the allotment system as "the legal fact" by which "appropriations made are subject too reduction."[7] Pursuant to the allotment statute the Secretary may exercise discretion on how much of a "limitation" will be imposed on the use of funds available to any or all state agencies, as well as in the manner of limitation. That is, the limitation may be in a fixed dollar amount down to zero or in a percentage reduction.

Within the Health Care Provider Insurance Availability Act,[8] K.S.A. 2008 Supp. 40-3403(j) provides for a number of statutory transfers of funds to the health care stabilization fund. The transfer of funds about which you inquire are found in sections (j)(1) (transfer of funds from state general fund to health care stabilization fund for reimbursement of defense costs); (j)(2) (transfer of funds from state general fund to health care stabilization fund for reimbursement of malpractice judgments); and (j)(3) (transfer of funds from the University of Kansas Medical Center private practice foundation reserve fund to the health care stabilization fund). The language found in those sections is typical of at least 170 statutes that are written in terms of transfers from one fund to a another, generally referred to as revenue transfers.[9]

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[3]K.S.A. 75-3722, second paragraph. *See Interhab., Inc. v. Schlansky,* No. 02C1335, unpublished opinion filed Feb. 11, 2003. "The budget shortfall [$255.1 milion in fiscal year 2003] was not agency specific as is contemplated under paragraph 1 of K.S.A. 75-3722, but rather was systemic to the state general fund as a whole.]

[4]K.S.A. 75-3722.

[5]K.S.A. 75-3722.

[6]K.S.A. 75-3701(6).

[7]*Interhab v. Schlansky, supra.*

[8]K.S.A. 50-3401 *et seq.*

[9]A legal memorandum that accompanied your opinion request suggested that, based on Attorney General Opinion No. 82-160, the fund transfers in issue should be considered demand transfers and thus immune from the allotment system. Attorney General Robert Stephan concluded that statutorily-prescribed transfers of money from the general fund to another fund, which were referred to in that opinion as demand transfers, did not constitute appropriations and therefore were not subject to the allotment system. Without addressing the rationale or conclusion reached in Attorney General Opinion No. 82-160, suffice it to say that the fund transfers in issue are not statutorily identified as demand transfers as are some other fund transfers. (See *e.g.* K.S.A. 79-2964 regarding county and city revenue sharing fund, "All transfers made in accordance with the provisions of the section shall be considered to be demand

As stated, the allotment system may be applied in any manner the Secretary of Administration determines to ensure expenditures do not outpace general or special fund resources. Nothing in the allotment system statute nor in the Health Care Provider Insurance Availability Act indicates that the statutory transfers of funds specified in K.S.A. 40-3403 are exempt from the allotment system. This is in contrast to the exclusion of the legislature and the court system provided in the allotment statute itself,[10] as well as six statutes that specifically exclude funds from being subject to the allotment system.[11]

Thus, in response to your question, the allotment authority delegated to the Secretary of Administration in K.S.A. 75-3722 authorizes the Secretary to suspend the statutory obligation of the State of Kansas to reimburse the Health Care Stabilization Fund pursuant to relevant sections of the Health Care Provider Insurance Availability Act.

Sincerely,

Steve Six
Attorney General

Camille Nohe
Assistant Attorney General

SS:MF:CN:jm

transfers from the state general fund;" and K.S.A. 79-2959 regarding local ad valorem tax reduction fund, "All transfers made in accordance with the provisions of this section shall be considered to be demand transfers from the state general fund, except that all such transfers during fiscal year 2010 shall be considered to be revenue transfers from the state general fund.")

[10]K.S.A. 75-3722, second paragraph.

[11]K.S.A. 65-3415a; 65-3491; 65-34,114; 65-34,129; 65-34,146 and 72-6438.

## House Budget Committee /Senate Subcommittee Report

**Agency**: Health Care Stabilization Fund Board of Governors **Analyst**: Dear

**Analysis Pg. No.** Vol.- **Budget Page No.** 41

| Expenditure Summary | Agency Estimate FY 2009 | Governor's Recommendation FY 2009 |
|---|---|---|
| Operating Expenditures: | | |
| State General Fund | $ 0 | $ 0 |
| Other Funds | 33,748,549 | 33,496,715 |
| Subtotal - Operating | $ 33,748,549 | $ 33,496,715 |
| Capital Improvements: | | |
| State General Fund | $ 0 | $ 0 |
| Other Funds | 0 | 0 |
| Subtotal - Capital Improvements | $ 0 | $ 0 |
| TOTAL | $ 33,748,549 | $ 33,496,715 |
| FTE Positions | 17.0 | 17.0 |
| Non FTE Uncl. Perm. Pos. | 0.0 | 0.0 |
| TOTAL | 17.0 | 17.0 |

### Agency Estimate

The **agency** estimates FY 2009 operating expenditures of $33,748,549 from the Healthcare Stabilization Fund, an increase of $264,310, or 0.8 percent, above the amount approved by the 2008 Legislature. Of the estimated expenditures, $2,200,686 is for the Administration Program, while the remaining $31,547,863 is for the payment of claims and claims related expenses. The increase is expenditures is attributable to $266,703 in Kansas Saving Incentive Program (KSIP) expenditures requested in FY 2009. Without the KSIP expenditures the agency's FY 2009 request is $33,481,846, a reduction of $2,393 from the agency's FY 2009 approved budget. This amount represents decreases made at the request of the Governor.

### Governor's Recommendation

The **Governor** recommends $33,496,715 for FY 2009 operating expenditures from the Healthcare Stabilization Fund, an increase of $12,476, or 0.8 percent, above the FY 2009 approved budget. The reason for the decrease from the agency estimate is due to reductions from operating expenditures made at the request of the Governor and a KSIP transfer to the State General Fund of $251,834. The Governor also recommends that the transfers to the Health Care Stabilization Fund for payments from the KU residents, faculty and graduate medical education students be stopped and any payments made to date reversed. The total impact of this transfer halt cannot be determined but the Governor estimates the total to be approximately $3,000,0000.

## Recission Bill (House Sub. for Sub. SB 23)

1. **Moratorium on Employer Contributions to the State Health Plan.** Delete $30,261, all from special revenue funds, to accelerate the Governor's fourteen week payroll moratorium on contributions to the State Health Plan to FY 2009 and sweep the available special revenue fund savings to the State General Fund (Floor amendment).

2. **KPERS Death and Disability Moratorium.** Delete $2,976, all from special revenue funds, to accelerate the Governor's proposed moratorium on KPERS Death and Disability to the final four months of FY 2009 and sweep the available special revenue fund savings to the State General Fund (Floor amendment).

3. Delete the transfer of $251,834 from the agency's KSIP fund and suspend KSIP program, for FY 2009.

4. The **Legislature** limited transfers from the State General Fund to the Health Care Stabilization Fund to $2,805,000, which is 6.5 percent, or $195,000, less than the $3.0 million projected FY 2009 amount. The **Governor** subsequently vetoed language limiting transfers from the State General Fund to the Health Care Stabilization Fund.

5. The Division of Budget exercised the agency allotment authority deleting demand transfers from the State General Fund to the Health Care Stabilization Fund in FY 2009.

## Mega Bill (Senate Sub. for HB 2354)

No legislative action taken.

## Omnibus Bill (Senate Sub. for HB 2373)

1. Transfer $251,834 from the Kansas Savings Incentive Program fund of the Health Care Stabilization Fund to the State General Fund, in FY 2009.

### State Finance Council

No State Finance Council actions taken.

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## Final Legislative Approved

| | Gov. Rec. FY 2009 | Legislative Action FY 2009 | Legislative Approved FY 2009 | Omnibus Action FY 2009 | Final Legislative Approved FY 2009 | Finance Council Action FY 2009 | Final Approved FY 2009 |
|---|---|---|---|---|---|---|---|
| All Funds: | | | | | | | |
| State Operations | $ 5,190,667 | $ (33,237) | $ 5,157,430 | $ 0 | $ 5,157,430 | $ 0 | $ 5,157,430 |
| Aid to Local Units | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Assistance | 28,306,048 | 0 | 28,306,048 | 0 | 28,306,048 | 0 | 28,306,048 |
| Subtotal - Operating | $ 33,496,715 | $ (33,237) | $ 33,463,478 | $ 0 | $ 33,463,478 | $ 0 | $ 33,463,478 |
| Capital Improvements | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | $ 33,496,715 | $ (33,237) | $ 33,463,478 | $ 0 | $ 33,463,478 | $ 0 | $ 33,463,478 |
| State General Fund: | | | | | | | |
| State Operations | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 |
| Aid to Local Units | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Assistance | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Subtotal - Operating | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 |
| Capital Improvements | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 |
| FTE Positions | 17.0 | 0.0 | 17.0 | 0.0 | 17.0 | 0.0 | 17.0 |
| Non-FTE Unclass. Perm. Pos. | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 17.0 | 0.0 | 17.0 | 0.0 | 17.0 | 0.0 | 17.0 |

# House Budget Committee Report

**Agency:** Health Care Stabilization Fund Board of Governors **Bill No.** HB - 2373 **Bill Sec.** - 34

**Analyst:** Dear **Analysis Pg. No.** Vol.- **Budget Page No.** 41

| Expenditure Summary | Agency Request FY 2010 | Governor's Recommendation FY 2010 | House Budget Committee Adjustments |
|---|---|---|---|
| Operating Expenditures: | | | |
| State General Fund | $ 0 | $ 0 | $ 0 |
| Other Funds | 34,882,068 | 34,845,104 | 285,074 |
| Subtotal - Operating | $ 34,882,068 | $ 34,845,104 | $ 285,074 |
| Capital Improvements: | | | |
| State General Fund | $ 0 | $ 0 | $ 0 |
| Other Funds | 0 | 0 | 0 |
| Subtotal - Capital Improvements | $ 0 | $ 0 | $ 0 |
| TOTAL | $ 34,882,068 | $ 34,845,104 | $ 285,074 |
| FTE Positions | 17.0 | 17.0 | 0.0 |
| Non FTE Uncl. Perm. Pos. | 0.0 | 0.0 | 0.0 |
| TOTAL | 17.0 | 17.0 | 0.0 |

## Agency Request

The **agency** requests FY 2010 operating expenditures of $34,882,068 from the Healthcare Stabilization Fund, an increase of $1,133,519, or 3.4 percent, above the revised FY 2009 estimate. Of the request, $2,132,068 is for the Administrative Program, while the remaining $32,750,000 is for the payment of claims and claims related expenses.

## Governor's Recommendation

The **Governor** recommends $34,845,104 in operating expenditures for FY 2010, an increase of $1,348,389, or 4.0 percent, above the FY 2009 Governor's recommendation. The Governor's recommendation is $36,964, or 0.1 percent, below the agency's FY 2010 request. The decrease from the agency's requested budget is attributable to reductions in death and disability insurance and health insurance payments totaling $36,964. The Governor recommends the savings be transferred to the State General Fund. The Governor also recommends that the transfers to the Health Care Stabilization fund for payments from the KU residents, faculty and graduate medical education students be stopped. The total impact of this transfer halt cannot be determined but the Governor estimates the total to be approximately $3,000,0000.

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## House Budget Committee Recommendation

The **Committee** concurs with the Governor's recommendation with the following recommendations and notations:

1. **Moratorium on Employer Contributions to the State Health Plan.** Add $30,261, all from special revenue funds, to restore the Governor's recommended deletion to suspend state contributions to the state employee Health Insurance Premium Reserve Fund for all state agencies for seven payroll periods in FY 2010. The employer health insurance moratorium has been accelerated to FY 2009 as part of House Substitute for Substitute for S.B. 23, the current year recision bill.

2. **KPERS Death and Disability Moratorium.** Add $2,979, all from special revenue funds, to restore part of the Governor's recommended deletion of funds related to a nine-month moratorium on state contributions to the KPERS Death and Disability Group Insurance Fund for all state agencies. Four months of the Governor's recommended moratorium on KPERS Death and Disability has been accelerated to FY 2009 as part of House Substitute for Substitute for S.B. 23, the current year recision bill. The action still captures five months of savings from the moratorium in FY 2010.

3. The committee recommends reinstating the transfers from the State General Fund to the Health Care Stabilization Fund in FY 2010.

4. Add $251,834, all from special revenue funds, for the sole purpose of expenditures for technology improvements and professional development in FY 2010. These funds were originally part of the agency's FY 2009 Kansas Savings Incentive Program (KSIP) request.

## House Appropriations Committee Recommendation

The Committee concurs with the Budget Committee recommendation.

## House Appropriations Committee of the Whole Recommendation

The **House Committee of the Whole** concurs with the House Appropriations Committee recommendation.

## Senate Subcommittee Report

**Agency**: Health Care Stabilization Fund Board of Governors **Bill No.** SB - 304 **Bill Sec.** - 40

**Analyst**: Dear **Analysis Pg. No.** Vol.- **Budget Page No.** 41

| Expenditure Summary | Agency Request FY 2010 | Governor's Recommendation FY 2010 | Senate Subcommittee Adjustments |
|---|---|---|---|
| Operating Expenditures: | | | |
| State General Fund | $ 0 | $ 0 | $ 0 |
| Other Funds | 34,882,068 | 34,882,068 | (196,851) |
| Subtotal - Operating | $ 34,882,068 | $ 34,882,068 | $ (196,851) |
| Capital Improvements: | | | |
| State General Fund | $ 0 | $ 0 | $ 0 |
| Other Funds | 0 | 0 | 0 |
| Subtotal - Capital Improvements | $ 0 | $ 0 | $ 0 |
| TOTAL | $ 34,882,068 | $ 34,882,068 | $ (196,851) |
| FTE Positions | 17.0 | 17.0 | 0.0 |
| Non FTE Uncl. Perm. Pos. | 0.0 | 0.0 | 0.0 |
| TOTAL | 17.0 | 17.0 | 0.0 |

### Agency Request

The **agency** requests FY 2010 operating expenditures of $34,882,068 from the Healthcare Stabilization Fund, an increase of $1,133,519, or 3.4 percent, above the revised FY 2009 estimate. Of the request, $2,132,068 is for the Administrative Program, while the remaining $32,750,000 is for the payment of claims and claims related expenses.

### Governor's Recommendation

The **Governor** recommends $34,845,104 in operating expenditures for FY 2010, an increase of $1,348,389, or 4.0 percent, above the FY 2009 Governor's recommendation. The Governor's recommendation is $36,964, or 0.1 percent, below the agency's FY 2010 request. The decrease from the agency's requested budget is attributable to reductions in death and disability insurance and health insurance payments totaling $36,964. The Governor recommends the savings be transferred to the State General Fund. The Governor also recommends that the transfers to the Health Care Stabilization fund for payments from the KU residents, faculty and graduate medical education students be stopped. The total impact of this transfer halt cannot be determined but the Governor estimates the total to be approximately $3.0 million.

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## Senate Subcommittee Recommendation

The **Subcommittee** concurs with the Governor's recommendation with the following adjustments:

1. **Moratorium on Employer Contributions to the State Health Plan.** Add $30,261, all from special revenue funds, to restore the Governor's recommended deletion to suspend state contributions to the state employee Health Insurance Premium Reserve Fund for all state agencies for seven payroll periods in FY 2010. The employer health insurance moratorium has been accelerated to FY 2009 as part of House Substitute for Substitute for S.B. 23, the current year recision bill.

2. **KPERS Death and Disability Moratorium.** Add $2,979, all from special revenue funds, to restore part of the Governor's recommended deletion of funds related to a nine-month moratorium on state contributions to the KPERS Death and Disability Group Insurance Fund for all state agencies. Four months of the Governor's recommended moratorium on KPERS Death and Disability has been accelerated to FY 2009 as part of House Substitute for Substitute for S.B. 23, the current year recision bill. The action still captures five months of savings from the moratorium in FY 2010.

3. Delete $230,091, all from Special Revenue funds, from the FY 2010 Governor's recommended budget in order to reach a target of 10.0 percent below the FY 2009 Governor's recommendation for agency expenditures in FY 2010.

4. The Committee recognizes the importance of technology infrastructure to the efficient and cost effective operation of State agencies, the Committee recommends reviewing the agency request for $212,703 in expenditure authority for technology improvements for the Health Care Stabilization Board at Omnibus.

5. The Committee does not recommend suspending transfers from the State General Fund to the Health Care Stabilization Fund in FY 2010 and instead recommends limiting transfers from the State General Fund to the Health Care Stabilization Fund to $2,805,000. This is 6.5 percent, or $195,000, less than the $3.0 million projected FY 2010 transfer amount.

6. The Committee directs the agency to charge a sufficient fee to fully cover the expenses of the Defense Counsel Seminar and deposit those fees in the Conference Fee Fund.

## Senate Ways and Means Committee Recommendation

The Committee concurs with the Subcommittee recommendation.

## Senate Committee of the Whole Recommendation

The **Senate Committee of the Whole** concurs with the Senate Ways and Means Committee recommendation.

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**Conference Committee Recommendation** - S. Sub for HB 2354

The Conference Committee concurs with the Governor's recommendation with the following adjustments:

1. **Moratorium on Employer Contributions to the State Health Plan.** Add $30,261, all from special revenue funds, to restore the Governor's recommended deletion to suspend state contributions to the state employee Health Insurance Premium Reserve Fund for all state agencies for seven payroll periods in FY 2010. The employer health insurance moratorium has been accelerated to FY 2009 as part of House Substitute for Substitute for S.B. 23, the current year recision bill.

2. **KPERS Death and Disability Moratorium.** Add $2,979, all from special revenue funds, to restore part of the Governor's recommended deletion of funds related to a nine-month moratorium on state contributions to the KPERS Death and Disability Group Insurance Fund for all state agencies. Four months of the Governor's recommended moratorium on KPERS Death and Disability has been accelerated to FY 2009 as part of House Substitute for Substitute for S.B. 23, the current year recision bill. The action still captures five months of savings from the moratorium in FY 2010.

3. Add $251,834, all from special revenue funds, for the sole purpose of expenditures for technology improvements and professional development in FY 2010. These funds were originally part of the agency's FY 2009 Kansas Savings Incentive Program (KSIP) request.

4. The Committee does not recommend suspending transfers from the State General Fund to the Health Care Stabilization Fund in FY 2010 and instead recommends limiting transfers from the State General Fund to the Health Care Stabilization Fund to $2,805,000. This is 6.5 percent, or $195,000, less than the $3.0 million projected FY 2010 transfer amount.

**Omnibus Activity** - S. Sub for HB 2373

1. Transfer $251,834 from the Kansas Savings Incentive Program fund of the Health Care Stabilization Fund to the State General Fund, in FY 2009.

**State Finance Council Action**

1. Add $12,780, all from the agency's special revenue funds, to implement Undermarket Pay Plan adjustments, in FY 2010.

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## Final Legislative Approved

| | Gov. Rec. FY 2010 | Legislative Action FY 2010 | Legislative Approved FY 2010 | Omnibus Action FY 2010 | Final Legislative Approved FY 2010 | Finance Council Action FY 2010 | Final Approved FY 2010 |
|---|---|---|---|---|---|---|---|
| All Funds: | | | | | | | |
| State Operations | $ 1,373,854 | $ 285,074 | $ 1,658,928 | $ 0 | $ 1,658,928 | $ 12,780 | $ 1,671,708 |
| Aid to Local Units | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Assistance | 33,471,250 | 0 | 33,471,250 | 0 | 33,471,250 | 0 | 33,471,250 |
| Subtotal - Operating | $ 34,845,104 | $ 285,074 | $ 35,130,178 | $ 0 | $ 35,130,178 | $ 12,780 | $ 35,142,958 |
| Capital Improvements | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | $ 34,845,104 | $ 285,074 | $ 35,130,178 | $ 0 | $ 35,130,178 | $ 12,780 | $ 35,142,958 |
| State General Fund: | | | | | | | |
| State Operations | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 |
| Aid to Local Units | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Assistance | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Subtotal - Operating | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 |
| Capital Improvements | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 | $ 0 |
| FTE Positions | 17.0 | 0.0 | 17.0 | 0.0 | 17.0 | 0.0 | 17.0 |
| Non-FTE Unclass. Perm. Pos. | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 17.0 | 0.0 | 17.0 | 0.0 | 17.0 | 0.0 | 17.0 |

Article published on October 18, 2009

# For state, a $110 million question

**Money from insurance fund tied up in court**

By DANIEL BARRICK
Monitor staff

October 18, 2009

On the same day last week that pink slips were filtering out to 250 state workers, lawyers for the attorney general's office were in court trying to avoid another big strain on the state budget - the potential loss of $110 million that lawmakers need to balance the state's books.

Lynch, Norelli
Zoom

But unlike last week's job cuts, which stemmed from the governor's need to quickly slash $25 million in personnel costs, the financial consequences of the loss of the $110 million would likely be less urgent. Losing the money, which Gov. John Lynch and legislative leaders want to seize from a state-established medical malpractice fund, would create a big hole in the state's budget as revenues continue to slump. But with 20 months still left in the current budget cycle, lawmakers say they have plenty of time to gauge the best course of action if they lose that money. And they say the uncertain economy raises all sorts of questions about the state budget that will require steady attention in the coming months.

"Am I concerned? You bet," House Speaker Terie Norelli said last week. "But am I afraid we're about to get knocked off a cliff? Not at all. There is not an immediate crisis."

Still, others say the tensions that accompanied last week's layoff announcement barely hint at the difficult decisions that will be necessary if the state loses its claim to the malpractice money. Some, including Republicans in the Legislature, are calling for Lynch to offer specific plans now in preparation for that outcome.

"Frankly, a hole of the magnitude we're talking about is going to require a top-to-bottom re-evaluation of the budget. You can't just tweak here and there," said Charlie Arlinghaus, president of the Josiah Bartlett Center for Public Policy, a free-market think tank in Concord. "The difficulties get worse the longer you delay."

The debate concerns an obscure pot of money called the Joint Underwriting Association. The money is the surplus accrued by a medical malpractice insurance program authorized by the state 35 years ago to help doctors who had trouble purchasing insurance. The JUA must offer insurance to any health-care provider who seeks coverage, and it now insures 900 of them.
Lynch first proposed the idea of seizing $110 million of the malpractice fund's $150 million surplus in his budget address in February. In a year of fiscal pain and declining tax revenues, the cash seemed a godsend to desperate budget writers.

"The budget is counting on that money," said Senate President Sylvia Larsen.

But a group of doctors and hospitals insured by the fund quickly sued the state. They claimed the money rightfully belongs to them and other of the malpractice fund's policyholders. Belknap Superior Court Judge Kathleen McGuire ruled in July that the state's seizure violated constitutional protections against taking private property and against impairing a contract. McGuire said the malpractice fund is independent of the state, has never relied on state money and does not need government approval to conduct its business.

Lawyers with the state appealed that ruling to the state Supreme Court, which heard arguments in the case last week.

**Other options**

The thoroughness of McGuire's ruling against the state - and the skepticism with which justices questioned the state's lawyers last week - has led many State House observers to expect the high court to rule against the state. If that happens, it will leave the state with a $45

Health Care Stabilization
Fund Oversight Committee
November 3, 2009
Attachment 5

million hole in the current budget and may force lawmakers to take $65 million out of the state's "rainy day" fund, leaving just $11 million in reserves.

So where will the money come from to make up for that loss? If Lynch or Democratic leaders in the Legislature have a plan, they're not sharing it. Leading lawmakers in the House and Senate last week emphasized that they are confident they'll win the court case, eliminating the need for a Plan B. But they also downplayed talk of a potential financial crisis if the court does bar them from taking the malpractice money.

"Whether the JUA money is in the mix or not, we are always looking at how revenues are going, how expenses are going, and we are always trying to think of better ways for the state to continue to deliver essential services," said Rep. Marjorie Smith, chairwoman of the House Finance Committee.

Most legislative leaders seemed to hope for an upturn in the economy - and continued belt-tightening in state agencies - to compensate for any big loss of money. And they underscore that New Hampshire is in better financial shape than many other states that have had to take extreme measures to balance their budgets this year.

If lawmakers do decide to turn to new sources of money, some possibilities include:

• Expanded gambling. Lynch recently named a commission to study the pros and cons of increasing the state's gambling options. This spring, lawmakers rejected a proposal to add thousands of slot machines to the state's horse and dog racing tracks. Proponents of expanded gambling say they'll continue to make their case to lawmakers.

"In a parallel fashion, while that debate on the JUA money goes on, it just underscores the question of, do we want to look for new tax dollars or do we want new dollars through a limited expansion of gaming?" said Rich Killion, a spokesman for Fix It Now New Hampshire, a coalition of pro-gambling groups. Killion said the coalition had recently increased its television, radio and online advertising, as a form of "public outreach."

• Reconsidering tax ideas that didn't make it through the budget process in the spring. That list would include a tax on estates worth more than $2 million and another on capital gains over $5,000. Together those taxes were estimated to bring in about $85 million.

The economic climate may make this option unattractive to many lawmakers. Larsen said increasing or adding new taxes would be an unlikely option. "A new tax is difficult to pass in a year when people are already struggling," Larsen said. "So it's a very narrow tightrope we're walking. The clear place (to go for money) would be the rainy day fund. And beyond that, it's tough."

Over the course of two days later this week, the House Ways and Means Committee will meet with economists, businesspeople and financial experts to examine the state's tax structure. Republicans have deemed the hearings a "tax summit," but Democratic Rep. Susan Almy, chairwoman of the committee, said the goal is simply to study the state's overall system for raising money.

Almy stressed that there were no specific plans to come up with new tax ideas in case the state loses its bid to take the JUA money. Like other legislative leaders, Almy said she's confident the state will prevail in its claim for the money. "We aren't going searching for new revenue sources that we don't think we need," Almy said.

• Further personnel cuts, including layoffs or furloughs.

• Cuts in services. This could be a tough sell for lawmakers, especially for many Democrats who said the budget as passed was already "heartbreaking" and cut too deeply into programs like mental health services.

**Hoping for a rebound**

It's helpful to think of the JUA money as two distinct chunks: one $65 million piece, which was expected to help balance the 2008-2009 budget, and another $45 million chunk, which lawmakers hope to pay the state's bills in 2010-2011.

The state managed to close the books on the 2009 fiscal year, which ended in June, without using the $65 million in JUA money. Instead, it relied on a combination of better-than-expected tax receipts, a statewide spending freeze and the use of some federal stimulus money that had been originally budgeted for the next two years. But lawmakers are still hoping to get their hands on that $65 million chunk, if only as a hedge against future shortfalls.

"If we look at how 2010 is shaping up," Norelli said, "our need for services continues to increase, and the revenues are not holding up. So we're assuming the use of the JUA money."

A report released this month showed that tax receipts for the new fiscal year were lagging $26 million behind what lawmakers budgeted. If that trend continues, it will certainly shape the way lawmakers respond to any loss of JUA money, said Steven Norton, director of the New Hampshire Center for Public Policy Studies.

"What happens next is a function of revenues over the next three to six months," Norton said. "If revenues remain flat, then that $45 million remains really problematic. If you do see a recovery, then $45 million is a small share of the overall budget."

Norton said Lynch and lawmakers will likely take a detailed look at exactly how the state managed to return millions of dollars in savings to close out the 2009 fiscal year through spending freezes across state departments.

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[redacted]

"Does that [redacted] is any insight into where there might be more money to be saved?" Norton said.

This article is: 14 days old.


Article published on October 16, 2009

# Lawyer to state: Fund isn't yours

**$110 million surplus would go to budget**

By SHIRA SCHOENBERG
Monitor staff

October 16, 2009

Attorney Kevin Fitzgerald, who represents the policyholders of a state-created medical malpractice fund, summed up the complex litigation over $110 million in nine words: "You can't take things that don't belong to you."

Lawyers for the state and for policyholders of the Joint Underwriting Association's medical malpractice fund argued before the state Supreme Court yesterday over who controls the $110 million sought by Gov. John Lynch and the Legislature to balance the state budget.

At issue is surplus money in the malpractice fund, which was created by the state 35 years ago to insure doctors who might otherwise have trouble buying coverage. The premiums paid by the doctors have for years brought more money into the fund than was needed to cover expenses and payouts for claims. During this year's budget process, Lynch and lawmakers used $110 million of surplus from the fund to balance its budget. The policyholders, a group of doctors and hospitals, appealed to the courts.

In July, Belknap County Superior Court Judge Kathleen McGuire sided with the policyholders and declared the Legislature's action unconstitutional. The state appealed to the Supreme Court.

Attorney David Leslie, who represents the state, said yesterday that the policyholders did not have rights to the money. The policyholders, he said, are not stockholders and have no corporate role in the JUA.

"They have no governance role at all," he said.
The state says the JUA was created by the state to promote a public interest and has built up a surplus because it is exempt from state and federal taxes. That gives the state the right to use the money in another way.

"The public purpose of promoting access to health care would be better served by transferring excess funds to the general fund," state attorneys argued in a brief to the court.

The rules regulating the JUA state that if there is a surplus, the JUA's board of directors "shall" authorize that the surplus either be used to reduce future premiums or be distributed to the health care providers covered by the association.

The state has argued that the word "shall" does not mean "must."

"It's nothing more than an expectancy," Leslie said. He said that in 34 years, dividends have been paid out just twice through lower premiums.

Leslie said if the board of directors had decided to pay out a dividend, and the insurance commissioner had approved the payout, the policyholders would have a claim to the money. Without that, he said, they don't.

"No dividend has been declared," he said.

Leslie added that there is no assurance the board would ever declare a dividend.

But by "grabbing" the surplus, Chief Justice John Broderick pointed out, the state is ensuring dividends would never be paid out.

The most pointed questions for Leslie came from Broderick, who asked whether the JUA's board of directors would be allowed to distribute a dividend to the state's general fund.

"If we decide to declare a dividend, the board, with the commissioner, can do it in two ways, and neither of the two ways relates to giving money to the state's general fund," Broderick said. "What am I missing?"

Leslie responded that court precedent shows anyone who argues that a state is taking property unconstitutionally must have the property rights to begin with. The JUA does not, Leslie said.

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Justice Linda Dalianis pursued the question, saying that even if the JUA does not have property rights, "How can the state just grab the money?"

Leslie responded that Dalianis's question was not before the court.

Justice Gary Hicks then pressed, "Can the judicial branch touch the client protection fund to solve its deficit?" referring to a state bar association fund.

Leslie said no.

Fitzgerald, representing the policyholders, argued that the state cannot intrude on private claims to the money in order to balance its budget. He called the state's arguments a "self-interested attempt to rewrite a contract, rewrite history and rewrite the law."

Fitzgerald said that when policyholders signed a contract to buy an insurance policy, included in that contract was the right to any surplus that came from their premiums. The only actions that can be taken with that surplus, he said, are to use it to decrease premiums or to return it to policyholders.

Broderick asked whether the board is "compelled" to take one of those two actions, and Fitzgerald replied yes.

Asked by Broderick what would happen to the money if the Legislature dismantled the JUA, Fitzgerald answered that the policyholders would get it.

"The policyholders get the difference between what they pay and what's needed to run the JUA and pay claims," he said.

One concern voiced by Justice Carol Ann Conboy was whether giving a large dividend to policyholders could disrupt the open market of private insurance companies, which is also against the JUA's rules.

Fitzgerald responded that the state brought no evidence that any disruption would happen.

He added that the state's taking of $110 million could harm the fund. According to an actuarial study, the amount of extra surplus in the fund could be as low as $90 million, he said.

Insurance Commissioner Roger Sevigny said the medical malpractice fund now has about $152 million and is growing quickly with the return from its investments. Sevigny has said that the fund needs to keep $55 million to cover its own needs. He said the $110 million would not be taken all at once, but over a period of time, so the fund would not dip below the required amount.

House Speaker Terie Norelli and Senate President Sylvia Larsen filed a brief in support of the state. The New England Legal Foundation and National Association of Mutual Insurance Companies filed a brief in support of the doctors, as did the New Hampshire Medical Society and American Medical Association.

Attorney William O'Brien, who represents the legal foundation and insurance companies, said he was concerned about the precedent of an alleged "illegal taking" based on the argument that the organization is not paying state taxes.

"I'd think a lot of charities and quasi-government entities would be concerned," he said.

This article is: 16 days old.

Article published on October 19, 2009

**Letter**

# Insurance fund move was legal

**Rep. Mary Jane Wallner, Concord**

For the Monitor

October 19, 2009

In her Oct. 15 column, Sen. Sharon Carson accused the Legislature of raiding the JUA insurance fund ("GOP warned against insurance fund raid," Monitor Forum). But she doesn't mention that the state-sponsored JUA fund was paid to provide a service, medical malpractice insurance, and that the JUA lived up to this promise. It's because of efficient administration and good claims management that there is a surplus.

When home owners buy fire insurance, they don't expect to get a refund every year their house doesn't burn down. And if something does happen, they expect the insurance company to reimburse them no matter how much they paid into the fund already. That is how insurance works.

Finally, the JUA fund was created to preserve the public's access to affordable health care by providing doctors with medical malpractice insurance at market rates. It has lived up to this goal. Using the surplus to cover the state's share of Medicaid costs is both legal and serves the public good.

**Rep. MARY JANE WALLNER**

**Concord**

This article is: 13 days old.

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Article published on July 30, 2009

# Ruling sets state back $110 million

**Medical fund blocked from budget**

## By LAUREN R. DORGAN
## Monitor staff

Striking a major blow to the state's new budget, a judge ruled yesterday that Gov. John Lynch's plan to seize $110 million from the surplus of a state-established medical malpractice fund is unconstitutional.

Belknap County Superior Court Judge Kathleen McGuire found for a group of doctors and hospitals insured by the fund that claimed the money rightfully belongs to them. She found that the state budget plan to seize the money violates state and federal constitutional prohibitions against taking private property and against impairing a contract. McGuire's 27-page ruling dissected the state's claims to an ownership stake in the Joint Underwriting Association and concluded the planned seizure is "unconstitutional and shall not be enforced."

Lynch promptly vowed to appeal the decision to the state Supreme Court. In a statement, Lynch, a Democrat, restated his belief that the money rightfully belongs to the state.

"The Joint Underwriting Authority was established - and given tax-free status as a state entity - in order to provide a service, not a windfall, to doctors. The state established the Joint Underwriting Association to ensure doctors could get access to malpractice insurance and that service has been provided," Lynch said in a statement. "These surplus funds belong to the citizens of New Hampshire, who created the Joint Underwriting Association and gave it tax-exempt status."

The JUA dates to the mid-1970s, when, amid a national crisis affecting medical malpractice insurers, New Hampshire and other states established pools of last resort to help doctors stay in business. The JUA must offer insurance to any provider who seeks coverage; it now insures 900 health care providers out of the state's total 11,000. Since 1986, when the plan was overhauled, the JUA has built up a surplus of $152 million.

McGuire's ruling said the JUA has operated separately from the state - and has received no money from state coffers - throughout its existence. She said it has its own employees, has its own lawyers and sets up its own contracts.

The doctors who sued the state pointed to the fact that their contracts explicitly state they "shall participate in the earnings of the company," and they said the JUA's board has twice distributed dividends to policyholders.

The "policy language is clear and unambiguous," McGuire ruled.

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Attorney Kevin Fitzgerald, who represented the doctors who filed suit, said he thought the thorough nature of the opinion could make it difficult for the Supreme Court to overturn.

To Fitzgerald, the question at issue was, "Can the state try to solve a public financial problem by trying to resort to the taking of private money? I've said to people: If you're a student of history, go back and look at the events around the American Revolution. It was exactly that kind of stuff. It was the overreaching of government into the affairs of private people."

The state had argued that it provided crucial support to the JUA by granting it tax-exempt status and by providing the use of its "police powers" to make up for any shortfall; state law allows the state to assess fees against other insurers as well as against JUA policyholders to help keep the fund solvent.

McGuire was not convinced by either argument.

"Being tax exempt is among the various financial benefits unavailable to private insurers that states may offer to mandatory risk sharing plans such as the JUA to shift to the government a portion of the burden of insuring high-risk individuals or entities who would otherwise be unable to find coverage in the voluntary market," McGuire wrote.

Now, Fitzgerald said, the JUA board could theoretically vote to issue a distribution of the money to members.

It remains unclear how Lynch and lawmakers would fill a $110 million hole in a painful budget that already includes 200 layoffs for state employees, closing state facilities and raising several fees. Asked by reporters what he would do if the courts found against the state, Lynch has repeatedly declined to detail alternatives and instead emphasized his belief in the rightfulness of the state's claim to the money.

"The judge's ruling suggests that a Plan B needs to be developed, and to date, we haven't heard any Plan B," said Steve Norton, executive director of the New Hampshire Center for Public Policy Studies. He said that while state law requires lawmakers to pass a plan for a balanced budget, the budget itself can legally end up in a deficit.

Lawmakers won't have much time to respond. Budget writers planned to use $65 million out of the $110 million the state had planned to seize to make up for revenue shortfalls in fiscal year 2009 - a budget period that ended last month. The rest was used to balance the state's $11.5 billion budget for 2010 and 2011.

The state will continue closing out its 2009 books into the fall, said state Treasurer Cathy Provencher. Having tens of millions of dollars in limbo "will cause some cash-flow challenges, but that's what we're working on now," she said.

Asked about what alternatives are on tap, House Finance Chairwoman Marjorie Smith pointed to plans for new levies on the wealthy - a tax on estates worth more than $2 million and a capital gains tax - that cleared the House but failed in the Senate during the budget process earlier this year.

The two plans were expected to bring in a combined $85 million over two years. Those, she said, are "both very sound, well-vetted proposals" that could bring in revenue "within a relatively short period of time."

Republicans cheered the ruling in statements, with Senate Minority Leader Peter Bragdon calling on Lynch and Democratic leaders to convene a special session to deal with the implications of a $110 million shortfall.

"I once again call on Governor Lynch and the Democratic Leadership to immediately bring the legislature back into session to deal with this $110 million hole in the state budget," Bragdon said in a statement. "Delaying this process through appeals will only exacerbate disastrous fiscal problems facing the State of New Hampshire."

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# Report

to the

# Health Care Stabilization Fund Oversight Committee

On Behalf of the

Health Care Stabilization Fund Board of Governors

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November 3, 2009

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# Report

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November 3, 2009

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SECTION I

Introduction

The Health Care Provider Insurance Availability Act became law in July 1976 in response to a statewide crisis. There were two essential features of the original Availability Act; the creation of the Health Care Stabilization Fund, and the creation of a joint underwriting authority (the Health Care Provider Insurance Availability Plan). There have been numerous amendments to the original Act during its thirty-three year history, but the two fundamental components have remained intact.

History and Significant Events

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. Those who could purchase insurance were oftentimes required to purchase policies with inadequate coverage.

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 Provider 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 Provider 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 assets gradually increased. 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.

The Board of Governors is comprised of five physicians (three M.D.s and two D.O.s), three hospital representatives, one chiropractor, and one certified registered nurse anesthetist. The Board employs an executive director who advises the Board and supervises operations.

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Principal Features of the Contemporary Act

Health care providers are required to purchase professional liability insurance from commercial companies or from the Availability Plan. The insurance policy must provide 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, when combined with the primary level of insurance, results in a total of $1-million per claim with an annual aggregate limit of $3-million. Some health care providers, particularly large medical centers and high risk specialists, purchase excess liability insurance in addition to the HCSF coverage.

There are sixteen categories of health care providers statutorily required to participate in the HCSF: (1) three types of medical care facilities; hospitals, ambulatory surgery centers, and recuperation centers, (2) all three licensees under the Healing Arts Act; D.C.s, D.O.s, and M.D.s, (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 the University of Kansas, (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 Availability Act definition of health care provider.

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SECTION II

The Commercial Insurance Market

The Availability Act promotes marketing of commercial medical liability insurance in two significant ways. First, it limits the commercial insurer's maximum liability per claim to $200,000 as well as limiting the annual aggregate losses to $600,000 for any health care provider. Second, by creating a joint underwriting association, the Act allows insurers to engage in conservative underwriting practices.

Currently, there are dozens of commercial insurance companies and risk retention groups providing the primary layer of medical liability insurance in Kansas. Some of those companies and RRGs offer coverage only to a specific profession or specialty group. As a result, some of them insure only a few health care providers. About eighty percent of the commercial insurance coverage is sold by only five companies.

The Availability Plan

Most Kansas health care providers purchase professional liability insurance from one of the commercial companies, but there are some who cannot. As a result, there are over 500 health care providers participating in the Health Care Provider Insurance Availability Plan. These health care professionals and facilities are not necessarily marginal risks. Some of these health care providers are somewhat unique and simply cannot find a commercial insurance product available for their specialty or service.

It may be noteworthy that the section of the Health Care Provider Insurance Availability Act which creates the Availability Plan specifically requires that the Plan provide for "assessments against the insurers participating in the plan or plans." Subsection (a) of K.S.A. 40-3413 also stipulates that when the plan earns premiums in excess of losses and expenses, the surplus shall be transferred to the Stabilization Fund. Conversely, in those years when losses and expenses exceed premiums collected, the Fund is required to subsidize the Plan.

The existence of the Availability Plan allows commercial insurers to reject applicants who have a history of claims or are under investigation by a licensing agency. While this may promote a good insurance market for commercial companies, it also creates a potential liability for the Stabilization Fund. Some years have been favorable, resulting in a surplus of income compared to losses and expenses. More often than not, the HCSF must subsidize the Availability Plan.

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The Board's Statutory Report

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 for the fiscal year that ended June 30, 2009.

1. Premium surcharge revenue collections amounted to $24,513,975.

2. The lowest surcharge rate for a health care professional was $50 for a chiropractor in his or her first year of Kansas practice who selected the lowest coverage option ($100,000 per claim and $300,000 annual aggregate limits).

3. The highest surcharge rate for a health care professional was $15,469 for a neurosurgeon with five or more years of Health Care Stabilization Fund liability exposure who selected the highest coverage option ($800,000 per claim and $2.4-million annual aggregate limits). If the Kansas resident neurosurgeon is also licensed to practice in Missouri, the 25% Missouri modification factor would result in a total premium surcharge of $19,336.

4. There were 27 medical malpractice cases involving 43 Kansas health care providers decided as a result of a jury trial. Of these 27 cases, only five resulted in verdicts for the plaintiff and only four resulted in Stabilization Fund obligations. Compensation awarded in those four cases resulted in Stabilization Fund obligations amounting to $1,637,925.

5. Seventy two cases involving 81 claims were settled resulting in Health Care Stabilization Fund obligations amounting to $23,867,284. The average Stabilization Fund compensation per claim was $294,658. These amounts are in addition to compensation agreed to by primary insurers (normally $200,000 per claim).

6. Because of both past and future periodic payment of compensation, the amounts reported above in items four and five were not necessarily paid during FY2009. Total claims paid during the fiscal year amounted to $26,411,640. This amount included $1,175,000 paid to claimants on behalf of insurance companies that tendered their coverage limits to the Fund. Therefore net claims paid from the HCSF during FY2009 amounted to $25,236,640.

7. The preliminary financial report as of June 30, 2009 accepted by the Board of Governors indicated assets amounting to $219,265,889 and liabilities amounting to $226,173,489.

In addition to these statutory reporting requirements, our Chief Attorney, who is also our Deputy Director, has prepared a detailed, historical analysis of claims activity. That analysis is contained in Section III of this report.

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Self-Insured Health Care Providers

You may recall that K.S.A. 40-3414 allows certain health care providers to self-insure the basic layer ($200,000/claim) of coverage. 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. In addition to the state-owned medical care facilities and affiliates of KU Medical Center, there are currently fourteen self-insured hospitals and surgery centers that have been approved by our Board of Governors and have been issued a certificate of self insurance.

University of Kansas Medical Center

In 1989 the Legislature decided to self-insure the basic professional liability of residents in training and the full time faculty members at the University of Kansas Medical Center. The Insurance Commissioner was delegated responsibility for initial payment of claims and related expenses from the Stabilization Fund, to be subsequently reimbursed by faculty foundations and the State of Kansas. This statutory duty was later transferred to the Health Care Stabilization Fund Board of Governors along with general responsibility for administration of the Health Care Stabilization Fund.

Normally, the HCSF Board of Governors serves as a third party administrator and is periodically reimbursed by the State for claims paid on behalf of the residents and faculty at the University of Kansas Medical Center (both Kansas City and Wichita). During the twenty-year history of this self insurance plan, average annual expenditures have been $2,645,994.77 ($1,456,465.25-faculty / $1,189,529.52-residents).

In February 2009 and again in July 2009 the Secretary of Administration imposed State General Fund allotments which discontinued reimbursements to the Stabilization Fund for those liability claims and related expenses paid on behalf of residents and faculty at KUMC. When the Health Care Stabilization Fund Board of Governors questioned the Secretary's authority to discontinue the State's statutory obligation to reimburse the Stabilization Fund, the Attorney General opined that the Secretary acted within lawful power delegated by the Legislature.

During FY2009, the HCSF paid claims and expenses amounting to $3,505,592.60 on behalf of residents and faculty at KU Medical Center (both Kansas City and Wichita). During the first half of FY2009 the HCSF was reimbursed $585,992.29. As a result of the Secretary's first allotment order last February, the HCSF now has an account receivable from the State in the amount of $2,919,600.31. The question for this Committee and the Legislature is whether this account receivable and the additional amount that will accrue during FY2010 should be carried forward as an asset, or should be written off as an uncollectible account.

Our Chief Attorney has prepared a detailed report describing FY2009 claims activity which we administered on behalf of these self insured programs. The report includes historical data as well as new information for the fiscal year that ended June 30, 2009. That document is part of Section III of this report.

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SECTION III

# Medical Professional Liability Experience
# Fiscal Year 2009

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 2009. 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 2009 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 2009 covers the period of time from July 1, 2008 through June 30, 2009.

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.

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## MEDICAL PROFESSIONAL LIABILITY EXPERIENCE

### A. Jury Verdicts

From HCSF data, 27 medical malpractice cases involving 43 Kansas health care providers were tried to juries during fiscal year 2009. Of these, 21 cases were tried to juries in Kansas courts and six cases involving Kansas health care providers were tried to juries in Missouri. These jury trials were held in the following jurisdictions:

| | |
|---|---|
| Sedgwick County | 7 |
| Jackson County, MO | 6 |
| Johnson County | 5 |
| Shawnee County | 2 |
| Cowley County | 1 |
| Finney County | 1 |
| Montgomery County | 1 |
| Riley County | 1 |
| Saline County | 1 |
| Wyandotte County | 1 |
| U.S. District Court, KS | 1 |
| Total | 27 |

Of the 27 cases tried, 20 resulted in complete defense verdicts. Plaintiffs won verdicts in five cases. One case resulted in a "split" verdict, and one case ended in mistrial. Juries returned verdicts for plaintiffs and awarded damages for the following claims:

| Case | Court | Verdict Amount* | HCSF Amount* |
|---|---|---|---|
| Plaintiff v. Hospital | SG CO | $3,614,908.03 | $100,000.00 |
| Plaintiff v. Doctor | SG CO | $637,924.95 | $437,924.95 |
| Plaintiff v. Doctor | JA CO MO | $1,852.00 | |
| Plaintiff v. Doctor | JA CO MO | $530,813.10 | |
| | | Settled: $500,000.00 | $300,000.00 |
| Plaintiff v. Doctor | U.S. District Court | $12,050,000.00 | $800,000.00 |
| Plaintiff v. Doctor | SG CO | $100,000.00 | |
| Plaintiff v. Doctor | RL CO | $3,750.00 | |
| Plaintiff v. Corp. | RL CO | $3,750.00 | |

*Note: Cases may be on appeal.

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

| | FY 09 | FY 08 | FY 07 | FY 06 | FY 05 | FY04 | FY03 | FY02 | FY01 |
|---|---|---|---|---|---|---|---|---|---|
| Total | 27 | 34 | 36 | 29 | 34 | 28 | 27 | 19 | 21 |
| Defense Verdict | 20 | 25 | 31 | 23 | 22 | 23 | 23 | 10 | 13 |
| Plaintiff Verdict | 5 | 4 | 5 | 6 | 7 | 3 | 3 | 6 | 6 |
| Split Verdict | 1 | 1 | | | 3 | 2 | | 2 | |
| Mistrial | 1 | 4 | | | 2 | | 1 | 1 | 2 |

## B. Settlements

**Claims settled by the Fund**. During FY 2009, 81 claims in 72 cases were settled involving HCSF monies. Settlement amounts incurred by the HCSF for the fiscal year totaled $23,867,283.72. This compares to last year's total of $17,352,500.00 to settle 65 claims in 57 cases. These figures do not include settlement contributions by primary or excess insurance 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 2009 claims is $294,658. This amount compares to last year's average of $266,962.

| Fiscal Year | Number of Claims/Cases | Fund Amount | Settlement Average |
|---|---|---|---|
| FY 2009 | 81/72 | $23,867,283.72 | $294,658 |
| FY 2008 | 65/57 | $17,352,500.00 | $266,962 |
| 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 2009 ranged from a low of $3,000 to a high of $800,000. HCSF settlements fall within the following ranges and are compared to individual claim settlements in previous years:

| | FY 09 | FY 08 | FY 07 | FY06 | FY05 | FY04 | FY03 | FY02 | FY01 |
|---|---|---|---|---|---|---|---|---|---|
| $000-$9,999 | 2 | 0 | 0 | 0 | 0 | 0 | 3 | 2 | 1 |
| $10,000-$49,999 | 12 | 6 | 6 | 9 | 5 | 13 | 11 | 7 | 6 |
| $50,000-$99,999 | 10 | 12 | 7 | 12 | 13 | 18 | 18 | 7 | 10 |
| $100,000-$499,999 | 37 | 34 | 27 | 51 | 58 | 37 | 44 | 40 | 24 |
| $500,000-$800,000 | 20 | 13 | 21 | 17 | 14 | 11 | 11 | 11 | 13 |
| Total Claims | 81 | 65 | 61 | 89 | 90 | 79 | 87 | 67 | 54 |

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Of the 81 claims involving Fund monies, the Fund provided primary coverage for inactive health care providers in 20 claims. The Fund received tenders of primary insurance carriers' policy limits in 58 claims. Therefore, in addition to the $23,867,283.72 incurred by the Fund, primary insurance carriers contributed $11,471,170.00 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 three cases in which aggregate primary policy limits were reached. Further, five claims involved contribution from an insurer whose coverage was excess of Fund coverage. The total amount of these contributions was $4,954,830.00.

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

| Fiscal Year | Primary Carriers | HCSF | Excess Carriers |
|---|---|---|---|
| FY 09 | $11,471,170.00 | $23,867,283.72 | $ 4,954,830.00 |
| FY 08 | $10,612,500.00 | $17,352,500.00 | $ 2,425,000.00 |
| 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 insurance carriers settled an additional 88 claims in 78 cases. The total amount of these reported settlements is $7,182,241.00. These figures compare to previous fiscal years as follows:

| FY | Settlement Reported Claims/Cases | Amount Paid by Primary Carrier |
|---|---|---|
| 2009 | 90/80 | $ 7,182,241.00 |
| 2008 | 104/88 | $ 8,486,032.00 |
| 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 |

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## C. HCSF Total Settlements and Verdict Amounts

During fiscal year 2009 the HCSF incurred $23,867,283.72 in 81 claim settlements and became liable for $1,637,924.95 as a result of four jury verdicts for a total 85 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 2009 | 85 | $25,505,208.67 | $300,061.28 |
| FY 2008 | 68 | 19,085,004.00 | 280,661.82 |
| 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 310 cases during fiscal year 2009. The following chart lists the number of new cases opened according to fiscal year.

| FY | Number of Cases |
|---|---|
| 2009 | 310 |
| 2008 | 329 |
| 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 |

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# University of Kansas Foundations and Faculty; Residents Self-Insurance Programs/Primary Coverage Reimbursement to the Health Care Stabilization Fund

## I. KU Foundations and Faculty

### Foundation Self-Insurance Program Costs

| FY 2009 | FY 2008 | FY 2007 | |
|---|---|---|---|
| $1,800,000.00 | $435,000.00 | $1,081,603.33 | Settlement Amounts |
| $ 893,099.94 | $531,327.58 | $ 955,624.30 | Attorney Fees and Expenses |
| $2,693,099.94 | $966,327.58 | $2,037,227.63 | Totals |

### Reimbursements

| FY 2009 | FY 2008 | FY 2007 | |
|---|---|---|---|
| $ 502,375.42 | $497,623.96 | $ 500,000.00 | Reimbursement - Private Practice Reserve Fund |
| $2,190,724.52* | $468,703.62 | $1,537,227.63 | Reimbursement - State General Fund |
| $2,693,099.94 | $966,327.58 | $2,037,227.63 | Totals |

*Amount not reimbursed FY 2009

## II. KUMC and WCGME Residents

### Residents Self-Insurance Program Costs

| FY 2009 | FY 2008 | FY 2007 | |
|---|---|---|---|
| 0 | $200,000.00 | $ 575,833.33 | Settlements, WCGME Residents |
| $200,000.00 | 0 | 0 | Settlements, KU Residents |
| $201523.03 | $301,775.96 | $ 524,886.10 | Fees & Expenses, WCGME Residents |
| $410,969.63 | $146,493.84 | $ 94,248.68 | Fees & Expenses, KUMC Residents |
| $812,492.66 | $648,269.80 | $1,194,968.11 | Totals |

### Reimbursements

| FY 2009 | FY 2008 | FY 2007 | |
|---|---|---|---|
| $201,523.03 | $501,775.96 | $1,100,719.43 | WCGME Reimbursement - General Fund |
| $610,969.63 | $146,493.84 | $ 94,248.68 | KU Reimbursement - State General Fund |
| $812,492.66 | $648,269.80 | $1,194,968.11 | Totals |

$ 83,616.87 Amount reimbursed FY 2009
$728,875.79 Amount not reimbursed FY 2009

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## III. Expenditures by Fiscal Year

| Fiscal Year | Foundations and Faculty* | KU and WCGME Residents** |
|---|---|---|
| | | |
| 2009 | $ 2,693,099.94 | $ 812,492.66 |
| 2008 | 966,327.58 | 648,269.80 |
| 2007 | 2,037,227.63 | 1,194,968.11 |
| 2006 | 1,407,837.70 | 871,719.27 |
| 2005 | 1,706,763.57 | 1,749,032.25 |
| 2004 | 1,825,116.29 | 2,787,112.99 |
| 2003 | 1,113,326.84 | 1,418,927.85 |
| 2002 | 583,566.19 | 723,834.54 |
| 2001 | 1,540,133.41 | 953,304.62 |
| 2000 | 691,253.39 | 735,633.12 |
| 1999 | 1,371,640.73 | 645,997.65 |
| 1998 | 1,018,435.78 | 1,072,324.05 |
| 1997 | 1,111,787.72 | 999,388.16 |
| 1996 | 4,003,062.51 | 1,331,521.75 |
| 1995 | 255,117.85 | 534,124.84 |
| 1994 | 1,959,284.79 | 574,758.65 |
| 1993 | 1,453,444.21 | 650,033.67 |
| 1992 | 645,670.10 | 810,703.77 |
| 1991 | 435,540.69 | 458,561.65 |
| 1990 | 261,035.55 | 120,796.12 |

*Foundations and Faculty:
Amounts up to $500,000 are reimbursed from the Private Practice Reserve Fund.
Amounts over $500,000 are reimbursed from the State General Fund.
FY 09 HCSF received reimbursement only from the Private Practice Reserve Fund.

**KU and WCGME Residents: All amounts are reimbursed from the State General Fund.
FY 09 HCSF was reimbursed only $83,616.87.

## IV. Monies Paid by the Health Care Stabilization Fund for Excess Coverage Claims

| | FY 09 | FY 08 | FY 07 | FY 06 | FY 05 |
|---|---|---|---|---|---|
| WCGME Residents | 0 | $ 78,000 | $1,600,000 | 0 | $ 100,000 |
| K.U.M.C. Residents | $ 800,000 | 0 | 0 | 0 | $ 375,000 |
| Faculty, Foundations | $3,262,500 | $135,000 | $1,475,000 | 0 | $ 750,000 |
| Total | $4,062,500 | $213,000 | $3,075,000 | 0 | $1,225,000 |

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SECTION IV

Premium Surcharges

Our Board of Governors has numerous statutory duties and responsibilities. The most important responsibility is delegated in subsection (a) of K.S.A. 40-3404. It says, "the board of Governors shall levy an annual premium surcharge on each health care provider who has obtained basic coverage and upon each self-insurer for each fiscal year." That subsection goes on to say, "Such premium surcharge shall be an amount based upon a rating classification system established by the board of governors which is reasonable, adequate and not unfairly discriminating."

It is extremely important to maintain adequate unassigned reserves in order to be prepared for unforeseen circumstances. For example, an economic recession resulting in substantially lower interest rates would certainly affect future income. Another example is the potential impact of an unfavorable court decision. If, for example, the courts would declare unconstitutional the statutory limit on non-economic damages, our future liabilities would suddenly increase by a significant amount.

For the above reasons, and other factors affecting our actuarial analysis, our Board of Governors decided to increase the FY2010 HCSF premium surcharge rates for the majority of health care providers who practice in Kansas. The surcharge increase for most health care providers ranged from three to eight percent. A few categories of health care providers did not experience any increase in surcharge cost this fiscal year.

An explanation of the new surcharge rates was published in July and a copy of our newsletter that was mailed to health care providers is enclosed with this report. You may wish to focus on the second article on the front page which forewarns health care providers that there will likely be a significant increase in surcharge rates next year. The decision as to whether the State's statutory obligation to reimburse the HCSF should be considered accounts receivable or should be written off as uncollectible will have a major bearing on our Board's surcharge decisions for FY2011.

These decisions are guided by periodic actuarial analysis of our estimated future liabilities. The Availability Act specifically authorizes the Board of Governors to contract with an actuary to obtain the information needed to assure that premium surcharges are "reasonable, adequate and not unfairly discriminating." Our Actuary, Russel L. Sutter of Towers Perrin has prepared an update for the Oversight Committee.

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# Health Care Stabilization Fund

## Fiscal Year 2010 Surcharge Issues

## Presentation to the Health Care Stabilization Fund Oversight Committee

**Presented by:**
**Russel L. Sutter**

November 3, 2009

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

TOWERS
PERRIN

# TABLE OF CONTENTS

This presentation will address the following topics:

- Our projections of unassigned reserves at June 2009 and June 2010
- Our findings regarding Fund loss experience
- The experience and indications by provider class
- A history of surcharge rate changes.

Questions are welcome throughout the presentation.

This presentation may be considered an addendum to our final report dated May 21, 2009. As such, the **Distribution and Use** and **Reliances and Limitations** sections of that report apply to this presentation.

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## CONCLUSIONS

Our forecasts of the Fund's position at June 30, 2009 and June 30, 2010 were as follows (in $millions).

### Scenario A – Full Reimbursement for KU/WCGME

| Category | June 30, 2009 | | June 30, 2010 | |
|---|---|---|---|---|
| | Undiscounted | Discounted | Undiscounted | Discounted |
| Assets | $ 220.1 | $ 220.1 | $ 221.9 | $ 221.9 |
| Liabilities | 212.6 | 187.0 | 217.7 | 191.6 |
| Unassigned Reserves | $ 7.5 | $ 33.1 | $ 4.2 | $ 30.3 |

### Scenario B – Limited Reimbursement for KU/WCGME

| Category | June 30, 2009 | | June 30, 2010 | |
|---|---|---|---|---|
| | Undiscounted | Discounted | Undiscounted | Discounted |
| Assets | $ 219.1 | $ 219.1 | $ 218.7 | $ 218.7 |
| Liabilities | 221.2 | 195.1 | 226.6 | 200.0 |
| Unassigned Reserves | –$ 2.1 | $ 24.0 | –$ 7.9 | $ 18.7 |

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## CONCLUSIONS – CONTINUED

The discounted liabilities at 6/30/09 under Scenario A are approximately $7 million higher than anticipated in our 2008 study, mainly due to use of a lower interest rate.

The estimates above assume

- A 3.0% rate for the discounted liabilities
- Continued full reimbursement for KU/WCGME claims under Scenario A; an 80% reduction in reimbursements in Scenario B.

Given the likelihood of a drop in the Fund's return on investments, the potential for a drop in reimbursements, and our understanding of the Board's goals, we suggested the Board consider an overall increase in surcharge rates of 5% to 10%.

The Board of Governors elected to raise rates for FY2010 as follows

- Classes 1, 6, 12, 13, 14 – No change
- Classes 2, 5 – +3.0%
- Classes 3, 4, 7, 8, 9 – +5.0%
- Classes 10, 11 – +7.0%
- Classes 15-21 – +3 points

The overall impact of these changes was estimated to be +5.3%.

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## LIABILITIES AT JUNE 30, 2009

The split of the Fund's liabilities at June 30, 2009 is as follows (in $millions).

| | Undiscounted | Present Value at 2.0% |
|---|---|---|
| Active Providers – Losses | $100.5 | $ 96.3 |
| Active Providers – Expenses | 14.0 | 13.3 |
| Inactive Providers – Known at 6/30/09 | 9.9 | 9.7 |
| Inactive Providers – Tail | 80.2 | 60.4 |
| Future Payments | 8.3 | 8.1 |
| Claims Handling | 6.2 | 5.1 |
| Other | 4.2 | 4.2 |
| Subtotal – Gross Liabilities | 223.3 | 197.1 |
| Reimbursements | -10.7 | -10.2 |
| Total Net Liabilities | $212.6 | $187.0 |

6-23

## CHANGES FROM PRIOR FORECASTS

The table below shows how our forecasts changed from the 2008 study. All amounts are in $millions.

| Category | Fiscal Years | 2008 Estimate | 2009 Forecast | Change in Estimates |
|---|---|---|---|---|
| Active Provider Losses | 1977-2009 | $579.6 | $570.5 | -$9.1 |
| Active Provider Expenses | 1982-2009 | 68.0 | 68.8 | 0.8 |
| Inactive Provider Claims | 1982-2008 | 50.6 | 50.9 | 0.3 |
| Inactive Providers – Tail | 2010-2046 | 56.2 | 54.2 | -2.0 |
| Reimbursable Claims | 1985-2009 | 54.9 | 55.5 | 0.5 |

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## OBSERVATIONS

Factors influencing the changes noted on the prior page include the following

- Loss reserves and number of open claims increased during CY2008
  - — $51.3 million at 12/31/07 to $57.4 million at 12/31/08
  - — 242 open claims to 275.
- Reported losses on active provider claims for FY1997-FY2006 dropped during the year
  - — An increase in reported losses was expected
  - — Current estimates assume $14.6 million of additional development for FY2007 and prior.
- The average lag between incident date and report date has decreased
  - — This leads to the reduction in the tail liabilities.

# MISCELLANEOUS OBSERVATIONS

Since 1999, the Fund's surcharge revenue has ranged from 23% of basic coverage premium (2005) to 33% of premium (2001). The FY2008 ratio was 29%.

On a percentage basis, growth in providers from FY2006 to FY2008 was highest in classes 13, 6, 11 and 12. Conversely, there were decreases in classes 4 and 15.

Interest income was $9.7 million in FY2008, and $5.0 million in the first half of FY2009. The effective yield on Fund assets has been holding up more than we anticipated. Interest income was over $12 million in FY1999, and under $6 million in FY2006.

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# FINDINGS – INDICATIONS BY PROVIDER CLASS

Our analysis of experience by Fund class continues to show differences in relative loss experience among classes. However, the variability has narrowed since our initial study in 2005, partly due to the rate changes in FY06 through FY09.

| Relative Rate Change Indicated | | |
|---|---|---|
| Decrease > 10% | Increase < 10% or Decrease < 10% | Increase > 10% |
| Class 16 (-35%) | Class 5 (-8%) | Class 17 |
| Class 1 | Class 2 | Class 3 |
| Class 20 | Class 19 | Class 10 |
| Class 12 | Class 9 | Class 11 |
| Class 18 | Class 7 (0%) | Class 15 (+40%) |
| Class 6 | Class 4 | |
| Class 14 | Class 8 (+4%) | |
| Class 13 | | |

The last page of this presentation contains further details on class rates and definitions.

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# HISTORY OF SURCHARGE RATE CHANGES

The table below shows changes in surcharge rates since 1999. Excludes the implementation of the MO surcharge in 2001 and subsequent increase in 2008.

| Fiscal Year | Overall Change | Classes 1-14 Range of Rate Changes | | Classes 15-21 % Basic Coverage Premium* |
|---|---|---|---|---|
| | | Low | High | |
| 1999 | -31% | -31% | | 30% |
| 2000 | +15% | +15% | | 35% |
| 2001 | +10% | +10% | | 38.5% |
| 2002 | +8% | +10% | | 38.5% |
| 2003 | 0% | 0% | | 38.5% |
| 2004 | -2% | 0% | | 35% |
| 2005 | -2% | 0% | | 32% |
| 2006 | +15% | +5% | +25% | 35% |
| 2007 | +6% | 0% | +15% | 35% |
| 2008 | +1% | 0% | +5% | 35% |
| 2009 | +5% | 0% | +6% | 37% |
| 2010 | +5% | 0% | +7% | 40% |

*For $800,000/$2,400,000 coverage

6-28-09

# CLASS DEFINITIONS, DISTRIBUTIONS AND RATES

| | | | FY08 # Providers | FY10 Rate* |
|---|---|---|---|---|
| Class 1 | – | Physicians, No Surgery. Includes dermatology, pathology, psychiatry | 566 | $1,045 |
| Class 2 | – | Physicians, No Surgery | 2,391 | 1,882 |
| Class 3 | – | Physicians, Minor Surgery | 1,246 | 2,462 |
| Class 4 | – | Family Practitioners, including minor surgery and OB | 208 | 2,754 |
| Class 5 | – | Surgery Specialty – Includes urology, colon/rectal, GP with major | 233 | 3,170 |
| Class 6 | – | Surgery Specialty – Includes ER (no major), ENT | 443 | 3,886 |
| Class 7 | – | Anesthesiology | 316 | 3,245 |
| Class 8 | – | Surgery Specialty – Includes general, plastic, ER with major | 290 | 7,459 |
| Class 9 | – | Surgery Specialty – Includes cardiovascular, orthopedic, traumatic | 284 | 7,484 |
| Class 10 | – | Surgery Specialty – Includes OB/GYN | 216 | 10,970 |
| Class 11 | – | Surgery Specialty – Neurosurgery | 45 | 16,552 |
| Class 12 | – | Chiropractors | 894 | 562 |
| Class 13 | – | Registered Nurse Anesthetists | 554 | 1,081 |
| Class 14 | – | Podiatrists | 97 | 2,546 |
| Class 15 | – | Plan insureds | 579 | 40% |
| Class 16 | – | Professional corporations, partnerships | 1,041 | 40% |
| Class 17 | – | Medical care facilities | 187 | 40% |
| Class 18 | – | Mental health centers | 25 | 40% |
| Class 19 | – | Psychiatric hospitals | 0 | 40% |
| Class 20 | – | Residency training program | 701 | 40% |
| Class 21 | – | Other | 0 | 40% |

*For $800,000/$2,400,000 coverage

SECTION V

HCSF Technology Improvement Project

Last year we reported to you that our technology improvement plans had been suspended because our funding for technology and professional development (KSIP account) had been frozen by the Budget Director. Eventually that funding was taken from the Health Care Stabilization Fund and was transferred to the state general fund.

You may recall that last year we also reviewed a consultant's report by Virchow Krause and Company which summarized our operations as follows:

> Overall, Virchow Krause identified that HCSF's systems and processes are heavily manual and paper based, provide limited real time and historical information tracking, have led to process inefficiencies, do not provide the functionality needed by users, and are not flexible or expandable enough to grow and adapt to the changing and evolving needs of HCSF. In addition, the systems are not fully integrated, do not provide electronic workflow and approval capabilities, and lack modern security features.

Unfortunately, our consultants experienced some resistance when they attempted to obtain cost estimates from vendors that sell information systems and software designed for professional liability insurance companies. Apparently, these companies are reluctant to provide cost estimates without a formal request for proposals with detailed specifications. For that reason we initiated communications with two major companies that offer management information systems specifically designed for patient compensation insurance (workers compensation and medical professional liability).

One of those companies has already installed its enterprise management information system at the two commercial insurance companies that sell coverage to about half of all health care providers practicing in Kansas. That company estimated that a similar installation for the HCSF Board of Governors would cost between $600,000 - $750,000. This would accommodate electronic transfer of information between the HCSF and the two major insurers.

Another company which is in the process of installing a management information system for a medical malpractice insurer estimated that first year costs for the HCSF to install a similar system would be $751,548. This solution would likely involve the installation of a web portal for use by commercial insurers that wish to submit information electronically.

For the above reasons, we included $800,000 in our FY2011 budget request for technology improvements and professional development. Approximately $50,000 is for routine replacement of computers and other hardware as well as the cost of seminars, workshops, and other training opportunities for our staff.

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**Recent Events**

For more than three decades the State of Kansas has served as the fiduciary for the Health Care Stabilization Fund. For two decades there has been a successful self-insurance arrangement between the Stabilization Fund and the State of Kansas. And for two decades there has been a successful administrative relationship between the Commissioner of Insurance or the Board of Governors and the University of Kansas Medical Center.

During the 2009 Session on two different occasions the Legislature transferred monies from the Stabilization Fund to the State General Fund. This was done despite the recommendations of the Health Care Stabilization Fund Oversight Committee and regardless of the objections of the Health Care Stabilization Fund Board of Governors.

As a result of the HCSF transfers by the Legislature, the Stabilization Fund is no longer used exclusively for those purposes expressed in the Health Care Provider Insurance Availability Act. Furthermore, the allotments imposed by the Secretary of Administration have jeopardized the actuarial soundness of the Stabilization Fund. The fiduciary duty of the State of Kansas to hold the Stabilization Fund in trust has been abrogated. This raises the question whether the taxpayers of Kansas could be held financially liable for obligations created pursuant to the Health Care Provider Insurance Availability Act.

Subsection (b)(5) of K.S.A. 40-3403 delegates responsibility to the HCSF Board of Governors to "make such recommendations to the legislature as may be appropriate to ensure the viability of the fund." Therefore, the Board of Governors recommends that the Legislature take actions necessary to restore the fiduciary relationship between the State of Kansas and the Health Care Stabilization Fund, and to restore the actuarial integrity of the Stabilization Fund.

The Legislature should immediately enact legislation that would prevent any future allotment orders that could discontinue or otherwise interfere with reimbursements to the HCSF for claims and expenses paid on behalf of residents and faculty at KU Medical Center. In addition, when the State of Kansas recovers from the current budget crisis, the Legislature should reimburse the Stabilization Fund for FY2009 and FY2010 claims and expenses paid on behalf of residents and faculty at KU Medical Center, and should also reimburse $285,074 to the Stabilization Fund for the two transfers taken from the Fund in FY2009.

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**Specific Requests**

It is respectfully requested that the Oversight Committee make the following recommendations in its report to the 2010 Legislature:

1. The Legislature should protect the taxpayers of Kansas from Health Care Stabilization Fund liabilities by restoring the fiduciary relationship between the State and the HCSF.

2. The Legislature should never transfer funds from the HCSF for any purpose other than those expressed in the Health Care Provider Insurance Availability Act.

3. The Legislature should immediately enact legislation that exempts reimbursements from the State of Kansas to the Health Care Stabilization Fund from the allotment authority delegated to the Secretary of Administration.

4. The Legislature should make arrangements for eventual reimbursement to the HCSF those funds that should have been reimbursed by the State for claims paid by the HCSF on behalf of residents and faculty at KU Medical Center during fiscal years 2009 and 2010.

5. The Legislature should make arrangements for eventual reimbursement to the HCSF the amount of $285,074 for the two transfers to the state general fund in FY2009.

6. The Legislature should grant the HCSF Board of Governors FY2011 request for expenditure authority in the amount of $800,000 for technology improvements and professional development.

**Conclusion**

The Health Care Provider Insurance Availability Act has accomplished precisely what the Legislature intended: (1) It stabilizes the health care delivery system by assuring that physicians and other health care professionals always have access to professional liability insurance, (2) it promotes a stable market for commercial insurers that offer the primary layer of insurance coverage, (3) it moderates the cyclical nature of the commercial insurance market, (4) it assures that the interests of health care providers are appropriately represented when there is litigation involving the Fund, and (5) when there is a settlement or judgment in favor of a plaintiff, the injured party is promptly compensated.

We appreciate your willingness to serve on this Oversight Committee. We urge you to endorse our recommendations and forward them to the Legislature. Thank you.

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# FYI from the Health Care Stabilization Fund

JULY 2009



## FY2010 Surcharge Rates Adopted by Board of Governors

The Health Care Stabilization Fund Board of Governors recently implemented the schedule of premium surcharges for the fiscal year beginning July 1, 2009. Most physicians and hospitals will experience a modest increase ranging from three to eight percent. The percentage increase is based on a thorough actuarial analysis of the five-year loss ratio for each category of health care provider.

Chiropractors, podiatrists, nurse anesthetists, and some low-risk physician specialties will continue to pay the same premium surcharge they paid in fiscal year 2009. Most primary care physicians who perform minor surgery or other invasive procedures will pay five percent more in fiscal year 2010 as will most surgical specialists.

Health Care Stabilization Fund premium surcharges are collected by the primary insurer if the health care provider is a Kansas resident.

If the health care provider is a non-resident who is licensed to practice in Kansas, he or she must complete a non-resident certification form and remit the surcharge payment directly to the HCSF Board of Governors. Because the Board of Governors decided to make some changes effective July 1 this year, it is important for all insurers and non-resident health care providers to review the new brochures outlining these changes. The link to HCSF brochures and forms is www.hcsf.org/Brochures/brochures.htm.

The Board's decisions are based on the principle that HCSF assets should always equal or exceed the Fund's liabilities. This is because liabilities can be adversely affected in the event of an unplanned circumstance, such as an unfavorable court decision, that alters the rules in professional liability lawsuits. See the related article pertaining to court decisions on page three.

## Board Contemplates FY2011 Surcharge Increase

All health care providers should plan for a minimum surcharge increase of 12% in the fiscal year beginning July 1, 2010. This is the result of a decision by the Kansas Secretary of Administration to discontinue reimbursements to the Stabilization Fund for claims paid on behalf of residents in training and full-time faculty at the University of Kansas Medical Center (both Kansas City and Wichita).

In 1989 the Legislature decided to self-insure the residents in training and certain full-time faculty and the faculty foundations at KU Medical Center. The law governing the Health Care Stabilization Fund was amended to make the HCSF liable for all basic coverage claims ($200,000 or less) and associated expenses attributable to professional liability of the KUMC residents and faculty. The law was also amended to provide for periodic reimbursements to the HCSF from other state funds.

For over twenty years the HCSF Board of Governors has served as the third-party administrator for the KUMC professional liability self insurance program. The partnership between the HCSF Board of Governors and KU Medical Center has been successful and cost-effective. Until this year, the Stabilization Fund has been routinely reimbursed by the State of Kansas for claims and associated expenses paid on behalf of KUMC residents in training and faculty.

*(Continued on page 2)*

## Board Contemplates FY2011 Surcharge Increase

*(Continued from page 1)*

The Governor's Budget Report to the 2009 Legislature recommended that the State General Fund reimbursements to the HCSF be discontinued for both FY2009 and FY2010. The HCSF Executive Director repeatedly expressed opposition to the Governor's recommendations during hearings in both the House and Senate budget committees, asserting that the denial of reimbursements to the HCSF is the functional equivalent of a tax on health care providers. The Legislature agreed to reject the Governor's budget recommendations for both fiscal years, but the Secretary of Administration nonetheless exercised the statutory authority to suspend the other laws as well as the Legislature's appropriation acts. The only way the Legislature could alter the Secretary's decision would have been a statutory amendment.

Following the legislative session, the HCSF Board of Governors formally requested an opinion from Kansas Attorney General Stephen N. Six. The letter asks, "Does the allotment authority delegated to the Secretary of Administration in K.S.A. 75-3722 authorize the Secretary to suspend the statutory obligation of the State of Kansas to reimburse the Health Care Stabilization Fund pursuant to relevant sections of the Health Care Provider Insurance Availability Act?" The Attorney General is not required by law to respond, but it appears likely there will be an opinion issued prior to the next legislative session.

In the meantime, the state fiscal year ended on June 30, 2009 and a final accounting of the impact of the Secretary's FY2009 allotment order became possible. The total cost of claims and associated expenses attributable to the KUMC self insurance program amounted to $3,505,593. Because some reimbursements were received prior to the Secretary's allotment order, the net FY2009 loss to the HCSF was $2,919,600. This is the amount of additional surcharge revenue that must be collected from health care providers in order to offset the losses resulting from the allotment order.

Recently the Secretary of Administration and the new Governor have announced a number of allotments for the new fiscal year that began July 1, 2009. First on the list was the Health Care Stabilization Fund with an estimated State General Fund "revenue gain" of $2,805,000. The actual cost to the HCSF will not be known until after June 30, 2010 (the end of FY2010).

Because of the State's budget situation, it appears unlikely the Legislature will appropriate funds to compensate for the HCSF losses. Unless something extraordinary occurs, health care providers can expect a significant increase in surcharge rates at this time next year.

## Separate Policies Create Dilemma

The Health Care Provider Insurance Availability Act requires that professional liability insurance policies sold in Kansas cover the health care provider wherever he or she engages in his or her licensed occupation. In other words, one policy should be adequate for most health care professionals.

There may, however, be situations that result in two separate insurance policies. For example, a physician or nurse anesthetist may be covered by a policy purchased by a hospital that covers their liability exposure only when he or she is practicing in that medical care facility. The physician or CRNA would likely need to purchase another professional liability policy for their office-based practice or to work at other hospitals.

Each insurer that sells a basic $200,000 per claim professional liability policy to a Kansas resident health care provider is required by law to collect the appropriate premium surcharge and remit the surcharge to the Health Care Stabilization Fund for the amount of excess coverage selected by the health care provider. In the event the health care provider is named as a defendant in a malpractice lawsuit, the HCSF coverage is limited to the excess coverage selected for the insurance policy that is liable for the claim. The HCSF Board of Governors has adopted the following policy statement.

*If for some reason a health care provider is insured by more than one basic professional liability insurance policy, the Fund will be liable only once for any claim. If a health care provider has selected different levels of excess coverage for two or more policies of basic coverage, the Fund liability will be consistent with the excess coverage selected for the basic coverage policy that is liable for the claim.*

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## Court Decisions can have Major Affect on Professional Liability

One of the reasons the HCSF Board of Governors must assure that the Fund is actuarially sound is because of the possibility of a court decision that could increase HCSF liabilities. Two cases before the Kansas appellate courts could have a significant impact on the future cost of professional liability insurance in Kansas.

At issue is the Kansas "cap" on non-economic damages. Kansas law provides that a jury award for a category of damages known as non-economic damages, which includes pain and suffering, is limited to $250,000. Awards for actual damages, such as medical costs and lost wages, are not limited.

In the case Miller v. Johnson, a jury in Douglas County found in favor of the plaintiff and awarded damages which included $250,000 for past non-economic loss and $150,000 for future non-economic loss. The judge applied the statutory limitation on non-economic damages, reducing the total award for non-economic damages to $250,000.

The Miller case was appealed and is pending in the Kansas Supreme Court. Briefs have been filed and the case is awaiting assignment for a hearing date.

Another case challenging the constitutionality of the cap on non-economic damages has been appealed to the Kansas Court of Appeals. In McGinnes v. Zayat, a Sedgwick County jury found for the plaintiffs and awarded damages, including $1,000,000 for pain and suffering, which was reduced to the $250,000 statutory limit. The case has been briefed and is waiting a hearing date.

Included in their arguments in both cases on appeal, plaintiffs contend the statutory limitation on non-economic damages is unconstitutional because it violates the right to trial by jury and violates due process and equal protection under the law. The defense maintains that the statutory limitation on this category of damages is not unconstitutional and that setting a monetary limit for non-economic damages is within the province of the legislature.

If the cap is found to be unconstitutional, there would be no limit on how much money a jury could award for pain and suffering. Large jury awards have the potential to exceed health care providers' insurance coverage, resulting in personal liability. The absence of a limit on non-economic damages would likely result in higher costs for professional liability coverage.

## Professional Liability Coverage for Business Entities

The Health Care Provider Insurance Availability Act requires defined health care providers to purchase professional liability insurance. There are four types of business entities which meet the definition of a "health care provider" under the Act and are therefore required to purchase professional liability insurance. They include the following:

- a **professional corporation** organized pursuant to the professional corporation law of Kansas by persons who are authorized by such law to form such a corporation and who are health care providers as defined by the Act,
- a Kansas **limited liability company** organized for the purpose of rendering professional services by its members who are health care providers as defined by the Act and who are legally authorized to render the professional services for which the limited liability company is organized,
- a **partnership** of persons who are health care providers as defined by the Act, and
- a Kansas **not-for-profit corporation** organized for the purpose of rendering professional services by persons who are health care providers as defined by the Act.

There are advantages to incorporation under professional corporation laws and coverage by the Heath Care Stabilization Fund (HCSF). In the event that negligence is attributable to an employee of the business entity the liability would be insured and covered by the HCSF. In addition, there is a provision in the Availability Act which prevents vicarious liability among health care providers covered by the HCSF. More specifically, the business entity cannot be held liable for the negligence of another health care provider, for example a physician, if both health care providers have HCSF coverage.

If however, a group of health care providers incorporates as a general corporation for some purpose other than providing health care services, the corporation would not be subject to the Availability Act.

If you have a partnership, corporation, limited liability company or not-for-profit corporation which is required to carry professional liability coverage, notify your primary carrier or insurance agent. The carrier or agent will submit the required documentation to the HCSF for review and a determination of whether the entity qualifies for coverage.

**Risk Management: Beware the Contract or Covenant**

Some health care providers may be unaware they are exposing themselves to professional liability by way of an ordinary contractual agreement. If, for example, a lease agreement between a medical group landlord and a hospital satellite office requires that a physician in the group practice respond to any medical emergencies that arise on the premises, each physician in the group could potentially become liable for a negative outcome involving someone who wasn't even an established patient.

Before entering into a contract, health care providers should carefully analyze whether the agreement involves anything that requires patient care. If possible, a contract should be reviewed by legal counsel to identify any unnecessary exposure to professional liability as well as to assure that other provisions in the agreement are lawful and in the interests of the health care provider or group. If such a contract is entered into, the health care provider's primary insurance carrier should be informed of the agreement.

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# TESTIMONY

## Health Care Stabilization Fund Oversight Committee
## November 3, 2009

My name is Bob Williams, Executive Director of the Kansas Association of Osteopathic Medicine. Thank you for this opportunity to address the committee regarding the Health Care Stabilization Fund.

The Kansas Association of Osteopathic Medicine (KAOM) supports the Health Care Stabilization Fund Board of Governors' position to restore the fiduciary relationship between the State of Kansas and the Health Care Stabilization Fund, and to restore the actuarial integrity of the Stabilization Fund by enacting legislation to prevent any future allotment orders which could interfere with reimbursements to the Health Care Stabilization Fund.

As has been pointed out by the Health Care Stabilization Fund Executive Director, Chip Wheelen, the Health Care Stabilization Fund Board of Governors, in concert with the Kansas Insurance Commission, have made every effort over the past two decades to assure the Health Care Stabilization Fund was actuarially sound. Recent actions by the Secretary of Administration and the Kansas Legislature have undone their close scrutiny by jeopardizing the actuarial soundness of the Stabilization Fund. If the Health Care Stabilization Fund were a "private" entity, such actions would not be tolerated by the Kansas Insurance Commission and the Kansas Legislature would be petitioned to enact legislation to prevent placing an insurance fund in actuarial jeopardy. The recommendations by the Board of Governors' will assure the stability and actuarial soundness of the Health Care Stabilization Fund for future generations by preventing the raiding of the Health Care Stabilization Fund for purposes other than what it was intended.

Thank you.

Health Care Stabilization
Fund Oversight Committee
November 3, 2009
Attachment 7