MINUTES

HEALTH CARE STABILIZATION FUND OVERSIGHT COMMITTEE

November 23, 2010
Room 548-S—Statehouse

Members Present

Dick Bond, Chairperson
Senator Vicki Schmidt
Representative Eber Phelps
Darrell Conrade
Dr. Paul Kindling
Dr. Terry "Lee" Mills
Dr. James Rider
Dr. Arthur D. Snow

Members Absent

Senator Laura Kelly
Representative Jim Morrison
* Health Care Provider [resignation]

Staff Present

Melissa Calderwood, Kansas Legislative Research Department
Dorothy Hughes, Kansas Legislative Research Department
Iraida Orr, Kansas Legislative Research Department
Sean Ostrow, Office of the Revisor of Statutes

Others Present

Derek Hein, Hein Law Firm
David Rowe, University of Kansas Medical Center
Chip Wheelen, Health Care Stabilization Fund
Rita Noll, Health Care Stabilization Fund
Russ Sutter, Towers Watson
Kurt Scott, KaMMCO
Jerry Slaughter, Kansas Medical Society
Tom Bell, Kansas Hospital Association

Chairman Dick Bond called the meeting to order at 9:00 a.m. and announced the recent resignation of Committee member, Penney Schwab, due to family health concerns. The Chairman noted that Ms. Schwab had served as one of the health care provider representatives appointed to the Oversight Committee by the Legislative Coordinating Council (LCC), having replaced a hospital administrator in 2008. The Chairman noted that the LCC had not yet acted on a replacement for Ms. Schwab.

The Chairman then recognized Melissa Calderwood, Kansas Legislative Research Department, for an overview of resource documents, including recent legislation, for the Committee's consideration. Ms. Calderwood first reviewed two documents (National Conference of State Legislatures' brief on immediate implementation provisions; Kaiser Family Foundation Timeline) that provide insight on the complexity of the federal health insurance reform law for providers, insurers, policymakers, and consumers, noting that in the recent past, the Kansas Legislature has considered health reform (Attachments 1 and 2). Ms. Calderwood further commented that during the 2010 Session, both the House and Senate considered legislation that would have created a Constitutional amendment, intended to preserve the freedom of choice in health care decisions. She then noted an item of particular interest to the Committee: 2010 SB 414. The Senate Financial Institutions and Insurance Committee introduced the bill to address the allotment issue brought before the Committee at its 2009 meeting. The bill, Ms. Calderwood continued, exempted transfers from the State General Fund (SGF) to the HCSF – reimbursement for costs and expenses for the administration of the self-insurance program for FT faculty, private practice foundation, and corporations, and the KUMC (University of Kansas Medical Center) and WCGME (Wichita Center for Graduate Medical Education) residents. A repayment timeline was established for those deferred SGF payments (Attachments 3 and 4). Ms. Calderwood also provided a brief summation on HCR 5036, a concurrent resolution to create a constitutional amendment affirming the Legislature's authority to limit the amount of recovery for noneconomic damages in personal injury claims; no action was taken during the 2010 Session (Attachment 5). Other documents in the staff review include the Appropriations report for the Fund budget (Attachment 6) and the Oversight Committee's report to the 2010 Legislature (Attachment 7).

Chairman Bond next called on Chip Wheelen, Executive Director, Health Care Stabilization Fund, to began an overview of the 2009-2010 activities of the Health Care Stabilization Fund Board of Governors, as well as an update of the 2010 Legislative Session (Attachment 8). Mr. Wheelen began his report noting the history of the Fund and the complementary relationship with the Health Care Provider Insurance Availability Plan. Health care providers are required, he continued, to purchase professional liability insurance from commercial companies or from the joint underwriting authority (the Availability Plan). Mr. Wheelen noted that 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. One provider category presents a unique challenge – corporations, LLCs, and partnerships formed by health care providers (entities are not licensed) – as the Fund is not a regulator, so commercial insurance agents work in a collaborative process with the Fund. In addition to his review of the commercial insurance market, Mr. Wheelen addressed the Availability Plan, noting that over 400 health care providers are currently participating in the Plan. Mr. Wheelen then reviewed a statutory requirement for a transfer from the Plan to the Fund (in years when premiums exceeds losses and expenses) or a transfer from the Fund to the Plan (the Fund subsidizes the Plan when losses and expenses exceed premiums collected). During the most recent ten-year period, he continued, the Plan's total income has exceeded total losses by $2,716,212. Mr. Wheelen next addressed self-insured providers and highlighted the Fund's statutory duty, serving as a third party administrator, being periodically reimbursed by the State of Kansas for claims paid on behalf of the residents and faculty at KU Medical Center (KUMC, WCGME). He noted that due to the 2009 allotments, the Fund Board of Governors had to write off $2,919,600 as an uncollectible account receivable from the State of

Kansas. Mr. Wheelen highlighted 2010 SB 414's effect on the Fund – beginning in July 2013, the accrued amount for claims paid in FY 2010 - FY 2013 is to be reimbursed in annual installments of 20 percent per year; in addition, the normal reimbursement arrangement will be resumed at that time.

Statutory Report

Mr. Wheelen then highlighted the Board's statutory report (as required by KSA 40-3403(b)) for FY 2010. Among the highlights, **net surcharge revenue** collections amounted to $26,394,273, 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 $16,552 (neurosurgeon, five or more years of Fund liability exposure who selected the highest coverage option. There were 32 medical professional liability cases involving 47 Kansas health care providers decided as a result of a jury trial (only four claims in three cases resulted in Fund obligations amounting to $1,224,821). Fifty-four cases involving 61 claims were settled resulting in HCSF obligations amounting to $19,745,200 (average compensation per claim was $323,692, a 9.9 percent increase to FY 2009). These amounts are in addition to the compensation paid by primary insurers. Due to past and future periodic payment of compensation the amounts previously reported were not necessarily paid during FY 2010; instead, the report indicated, the **total claims** paid during the fiscal year amounted to $26,174,458. Of this reported amount, a payment of $600,000 was paid to claimants on behalf of insurance companies that reimbursed the Fund for these payments. The actual **net claims** paid during FY 2010, therefore, totaled $25,574,458. Mr. Wheelen concluded the statutory report, stating that the financial report, as of June 30, 2010, indicated assets amounting to $228,573,232 and liability amounting to $225,800,123. Mr. Wheelen then discussed with the Committee the net difference between assets and liabilities when the deferred payments from the State are considered–the margin is reduced by $2.15 million.

Rita Noll, Chief Attorney and Deputy Director, was then recognized to address the FY 2010 medical professional liability experience (based on all claims resolved in FY 2010 including judgments and settlements) (Attachment 9). Ms. Noll began her presentation by noting jury verdicts. Of the 32 medical malpractice cases involving 47 Kansas health care providers that were tried to juries during FY 2010, 27 cases were tried to juries in Kansas courts, six cases were tried in Missouri, and one case was tried in Nebraska. The largest number of cases, eight, was tried in Johnson County. Ms. Noll's comment also indicated that, of the 32 cases tried, 21 resulted in complete defense verdicts, plaintiffs won verdicts in seven cases, one case resulted in a "split" verdict, and three cases ended in mistrial. [Ms. Noll's testimony also included nine-year history of total cases, defense verdicts, plaintiff verdicts, split verdicts, and mistrials.]

The Chief Attorney then highlighted the claims settled by the Fund, indicating that during FY 2010, 61 claims in 54 cases were settled involving HCSF monies. Ms. Noll indicated that the number of new cases was down for the year and settlement amounts for the fiscal year totaled $19,745,200 (FY 2009 total was $23,687,284 to settle 81 claims in 72 cases). [These figures do not include settlement contributions by primary or excess insurance carriers.] The average Fund settlement amount per claim for FY 2010 claims is $323,692, an increase from the previous fiscal year (FY 2009: $294,658). Ms. Noll's report indicated that HCSF individual claim settlement contributions during FY 2010 ranged from a low of $10,000 to a high of $800,000. Ms. Noll's report also included FY 1991 to FY 2010 settlement amounts (claims and cases, settled by the Fund) and noted that the most recent 10-year average was $19.8 million per fiscal year. She described FY 2010 as an "average year". Of the 61 claims involving Fund monies [previously noted], the Fund provided primary coverage for in inactive health care providers in 12 claims. The Fund also "dropped down" to provide first dollar coverage for two claims in which the aggregate primary policy limits were reached. Further, the report indicates that the Fund receive tenders of primary insurance carriers'

policy limits in 47 claims (in addition to the $19.75 million incurred by the Fund – primary insurance carriers contributed $9.4 million to the settlement of those claims). Further, seven claims involved contribution from a health care provider or an insurer whose coverage was excess of Fund coverage (total amount of those contributions: $14.97 million). Ms. Noll's report also included FY 1996 to FY 2010 settlement contributions by primary carriers, the HCSF, and excess carriers; claims settled by primary carriers (FY 2000-FY 2010); a report of HCSF total settlements and verdict amounts, as well as the new cases opened for FY 1977 to FY 2010. The Fund was notified of 290 cases during FY 2010, Ms. Noll stated. The most recent 10-year average for new cases, she continued, is 349.

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 2010 settlements ($1,445,658.21 for settlements and attorney fees and expenses) and reimbursements for the KU Foundations and Faculty ($500,000 from the Private Practice Reserve Fund). The report notes that the remaining $945,658.21 was not reimbursed by the State General Fund. Ms. Noll commented that there was a significant decrease in settlement amounts from the prior fiscal year. Ms. Noll next highlighted the settlements and reimbursable amounts for the KU and WCGME residents, noting that there had been no settlements or judgments against WCGME for two years; however, she stated, there is a birth injury trial pending (defense verdict, both residents). Ms. Noll provided the FY program costs (settlements, fees and expenses) for the WCGME and KU residents: $1,201,718.01. No FY 2010 reimbursements were made from the State General Fund (WCGME reimbursement to the HCSF would have been $481,927.32 and reimbursement for KU program costs would have been $719,790.69). Ms. Noll responded to a Committee member's question about residents participating in the Smoky Hill (Family Medicine) program, noting that the residency program is part of the WCGME program.

Actuarial Report

After a brief recess, the Chairman then recognized Russel L. Sutter, Towers Watson, to provide an actuarial report (Attachment 10). It was noted that Mr. Wheelen provided a brief overview to the actuarial report on the Board of Governors surcharge rates for FY 2011 (surcharge rates were not adjusted, largely due, the report notes, to the passage of SB 414 and the eventual reimbursement of the HCSF). Mr. Sutter began his presentation noting that this report may be considered as an addendum to the report provided to the Fund Board of Governors dated April 16, 2010. Mr. Sutter first addressed the forecasts of the Fund's position at June 30, 2010: the Fund held assets of $223.1 million and liabilities (discounted) of $184.0 million, with $39.1 million in unassigned reserves. Projections for June 2011 include $228.1 million in assets and liabilities (discounted) of $189.7 million, with $38.4 million in reserve. The actuary offered some general conclusions: undiscounted liabilities at June 30, 2010, are approximately $8.7 million lower than anticipated in the actuarial firm's 2009 study; the forecasts assume no change in surcharge rates for FY 2011, a 2.0 percent rate for the discounted liabilities, and full reimbursement for KU/WCGME claims for FY 2010 through FY 2013, but delayed payment until 2014. Finally, the actuaries had suggested that the Board consider modest changes by class, including no longer using uniform percentages for classes 15-21 and also suggested leaving surcharge rates unchanged. Mr. Sutter spoke to the current trends with the number of claims decreasing and "good settlements," noting that the external pressures have the ability to impact the Fund including reimbursement for the self-insurance program, short and long-term interest rates being relatively low, and the outcome of the noneconomic damages court case.

A Committee member inquired about the current investment rate. Mr. Wheelen commented that in the recent past (for maturities), the rate had been 4 ½ percent; now, the rate is about two percent. Mr. Sutter noted that the present value basis (2 percent) is reflected in the projected liabilities (from $209 million, undiscounted, to $184 million, discounted). He then reviewed the

liabilities at June 30, 2010, highlighting both inactive providers–tail coverage and future payments. Mr. Sutter cited a vulnerability to the Fund – failure to receive the anticipated reimbursements from the State General Fund. A Committee inquired if the reported liabilities for reimbursements is accounted for in the premiums (surcharge). The actuary indicated that the projections anticipated a 100 percent reimbursement. Mr. Sutter next addressed changes from prior forecasts and then made some observations about the changes in the estimates for active provider losses: settlements were lower than expected during Calendar Year 2009 (expected $26.0 million; actual were $19.3 million); loss reserves on open claims dropped during CY 2009 from $53.3 million to $45.6 million; the number of open claims (in the Fund's layer of coverage) dropped from 239 to 208; and the net increase in claims (settled, plus change in open) was +17, well below the Fund average of 65-70 for FY 2004-FY 2008. As a result, the actuary continued, the actuarial forecast of the prospective year's losses are $28.5 million, the first sub-$30 million forecast in several years. Mr. Sutter also made further observations for the Committee's consideration: since 1999, the Fund's surcharge revenue, he noted, has ranged from 23 percent of the basic coverage premium (2005) to 33 percent (2001). The FY 2009 ratio was 32.5 percent, up from 29.1 percent in FY 2008, and the fourth consecutive year with an increase. The Availability Plan insureds increased from 251 in FY 2001 to 674 in FY 2006, but the number has dropped since then. In FY 2009, his report indicated, there were 532 Plan insureds. Mr. Sutter also commented on the average yield-to-maturity on the Fund's investments at December 2009 was surprisingly high (4.67 percent), given market rates at that time. The rate, Mr. Sutter stated, has been going down since that point.

Committee members then inquired about when claims are generally settled (about 20 percent, according to the actuary, in the year of occurrence, with many at the end of the second year) and the number of providers included in the projections (assumptions include a 1 percent annual growth/ $800,000 level). A Committee member asked about the faculty liabilities, particularly with WCGME in Wichita and Salina. The actuary responded that the matter is experience-rather than exposure-driven.

The actuary next addressed the findings by provider class. Mr. Sutter commented on the differences in relative loss experience among the classes. He noted that variability has narrowed since the initial study in 2005, in part due to the rate changes in FY 2006 through FY 2010. Four classes were identified as "undercharged" (relative rate change indicated – increase was greater than 12 percent): Class 20 [Residency training program], Class 3 [Physicians minor surgery], Class 11 [Surgery specialty–neurosurgery, and Class 15: +68 percent [Availability Plan insureds]. Mr. Sutter spoke to three representative classes (one at a "fair" surcharge amount and two "undercharged," one based on claims experience and one on actions of a few providers). Class 17 (acute care hospitals) – each hospital and physician is adequately paying its share; Class 11 (neurosurgery) – still "underpriced" based on claims experience; and Class 15 (Availability Plan) – many losses caused by a few providers.

With the completion of the actuary's report, the Chairman asked for Committee questions. A Committee member inquired about the relationship between the Availability Plan transfers with the Fund and the 68 percent figure for the surcharge. Mr. Sutter explained that the 68 percent is for the Fund's coverage (i.e. $800,000) and $2.7 million was for the basic layer of coverage. Another Committee member inquired about the Class 11 (neurosurgeons) and whether the relationship (to surcharge) was solely based on the number of claims and class experience. Mr. Sutter replied that the surcharge is solely based on this experience. A Committee member then inquired about future recruitment of health care providers and the impact on the Fund and separately, the experience in other states. The actuary responded that this scenario has been considered. Mr. Wheelen was then recognized and responded to the Committee discussion indicating that at one time, the cost was rather expensive, as we did not have the advantage of tort reform and there had been a reduction

in assets. Mr. Wheelen addressed the issue regarding the number of claims, suggesting that litigants may be waiting to file until after *Miller v. Johnson* is decided.

Chairman Bond then recognized Mr. Wheelen for further remarks, including an update on the Fund's technology improvements and any requests or recommendations. The Executive Director provided an update on technology improvements over the past two years, noting that the agency has hired a full-time Information Technology Officer and also has entered into a contract with the Information Network of Kansas to host a new website. Mr. Wheelen indicated that the website, in about two months, will provide a link to an electronic compliance form, and the site is to be streamlined with contemporary features. The new website will include a link to the KanPay website which will allow an insurer or agent to submit the health care provider's surcharge payment using a credit card or electronic check. Mr. Wheelen also stated that if the new electronic methods function as well as anticipated, it may become unnecessary to purchase a complete, new management information system. He noted that funding for systems maintenance was approved in the Fund's FY 2011 budget and has been requested in the FY 2012 budget.

Conclusions

Mr. Wheelen next discussed the status of the Fund with the Committee. He noted that currently, HCSF assets exceed liabilities, but only marginally. He cautioned that while the Health Care Stabilization Fund is actuarially sound at this time, its financial integrity could change dramatically, depending on the state Supreme Court decision in *Miller v. Johnson*. If the Court does not uphold the constitutionality of the statutory limits on non-economic damages, the currently assigned reserves, Mr. Wheelen's testimony notes, immediately will become inadequate and the Fund's estimated liabilities will increase substantially. The Board of Governors then would face the necessity to increase premium surcharge rates. Committee members then addressed the Board of Governor's report and encouraged Mr. Wheelen to continue to provide information about the history of the Fund and its special relationship with health care providers. A Committee member discussed having legislative committee chairs (health, insurance, budget) attend future Oversight Committee meetings. Another Committee member inquired about the loss climate in the Kansas City, Missouri area. It was noted that the state of Missouri has an entirely different climate, in terms of civil litigation, and that average medical malpractice insurance costs are much higher. The Committee discussed coverage of health care providers licensed to practice in other states (Missouri and Nebraska) and recruiting "border physicians" to practice in Kansas.

Chairman Bond next recognized Kurt Scott, Kansas Medical Mutual Insurance Company (KaMMCO), to comment on the status of the medical malpractice market in Kansas. Mr. Scott indicated that KaMMCO continues to insure more than one-half of the market for the state's hospitals and physicians and to serve as the servicing carrier for the Availability Plan. Mr. Scott indicated that the last crisis for the Kansas market was in 2002 with the departure of the St. Paul. The environment for medical malpractice insurance now is healthy and profitable. Mr. Scott noted that the frequency of claims is declining and there is opportunity for healthy competition; rates are declining as well, down some 20 to 25 percent from a peak about five years ago. A new company, Midwest Medical, as well as a Missouri company, have entered the marketplace. Mr. Scott noted that health reform is starting to drive change in the marketplace, as seen in the increase of hospitals acquiring physician practices. One recent example seen in Kansas, Mr. Scott continued, was Via Christi's acquisition of the Wichita Clinic. Mr. Scott then discussed the factors at play for the next crisis: anticipated increase claims frequency (artificially low due to the pending decision in *Miller v. Johnson*); inflationary pressures, particularly on investment portfolios; and the impact of mergers and acquisitions. Mr. Scott then provided a brief update on the JUA (Joint Underwriting Association), noting that Availability Plan insureds pay for the $200,000 per claim basic coverage at a rate about one-third more than physicians and hospitals in the private market. With the surcharge factor,

premiums are about 40 to 45 percent higher, and most of the Plan costs, as noted by the actuary, are affected by a few providers generating multiple claims. Mr. Scott then updated the Committee on some recent changes in the Availability Plan's operations, including the recent retirement of the Plan Board chairman; efforts to "modernize" the Plan following an evaluation period; KaMMCO is now providing accounting services (previously done by a private firm); and Plan reserves are now being analyzed by Towers Watson, the Fund's actuary. A Committee member then inquired about the issue of access and relationship to the number of companies in the market. Mr. Scott replied that self-insured hospitals are most likely to become Accountable Care Organizations (ACOs) under health reform) which would put physicians into these self-insured arrangements (less accessible to KaMMCO, medical malpractice insurers). The Committee member also inquired about changes in the Plan population. Mr. Scott commented that the Plan population changes with market disruptions and having a domestic insurance company can help absorb increases in the Plan's enrollment.

Chairman Bond next recognized Jerry Slaughter, Executive Director of the Kansas Medical Society, for additional comments on the current status of the medical malpractice market in Kansas. Mr. Slaughter began his comments noting that the status of the Kansas market must be viewed in the context of *Miller v. Johnson*, as it is anticipated that the Court will strike down the constitutionality (previously upheld) of the cap on noneconomic damages within the next month or so. If legislation is advanced and approved, the Fall of 2012 would be the first opportunity to place the matter on the ballot, he continued. If the ballot measure is approved, the Medical Society and other interested parties would then ask the Legislature to enact a cap. With "no cap," Mr. Slaughter continued, claims could flood the system during the intervening time period. Premiums, he projected, will double. The resulting "difficult situation" would be three years of exposure with claims in the system for some time. The Committee and Mr. Slaughter then discussed this period of resulting "uncertainty." A Committee member inquired about physician retirements, at a time of new health insurance reforms and changes in malpractice costs and exposure levels (*Miller v. Johnson).* Mr. Slaughter addressed the issue of access to health care providers in Kansas, noting that an estimated 230,000 Kansans will gain access under health insurance reform (from uninsured to insured) and put a tremendous demand on the system at exactly the same time when there will be limitations on physician practices and services. Mr. Slaughter concluded that this scenario will create real disruptions in rural and underserved areas.

Chairman Bond next recognized Tom Bell, President of the Kansas Hospital Association, to address the topic of federal health insurance reform and the implications for the Kansas provider community (Attachment 11). Mr. Bell's testimony highlighted nine general categories of reforms from the new federal law: health insurance; Medicaid/CHIP expansion; delivery system and reforms; Medicare/Medicaid payment changes; Quality; Workforce/Graduate Medical Education; Reporting information; Prevention and wellness; and Program integrity and oversight. Mr. Bell commented that while the political discussion in Congress continues regarding health insurance and the individual mandate and Medicaid/CHIP extension, the other reforms will happen. Given the timetable for implementation, there is reason to understand the anxiety among providers. Mr. Bell also reviewed payment system reforms, with some new system changes including the integrated care models of the medical home, "bundled" payments across existing payment systems (e.g. hospital and physician around hospitalization), and accountable care organizations (e.g., physician group practice). The national pilot program (voluntary) for ACOs will begin in 2012, he noted, with groups of providers and hospitals taking the lead. Mr. Bell spoke to the "sea of change" in health care, with the focus on areas including coordination and collaboration, measuring value, and shared savings. There are incentives in health care reform for arrangements like the Via Christi acquisition.

Jerry Slaughter was again recognized by Chairman Bond. Mr. Slaughter began his comments noting that reform efforts have included many positive parts, especially for primary care (Attachment 12). He then noted a number of provisions in the law (Affordable Care Act) that will have

significant impact and consequences for physician practices, coupled with the increased demand to care for more patients, caring for more patients with higher quality and less cost, and the increased reporting, accountability and tracking demands. Mr. Slaughter commented that the changes in payment systems and anticipated affiliations of providers signal the beginning of the end for private, individual physician practices, as collaboration will be critical. One area of concern cited by the Medical Society was that the ACA did not address the Sustainable Growth Rate (SGR) which determines how Medicare will pay for physician services. Mr. Slaughter then addressed issues and concerns relating to access to physicians and health care providers in Kansas. Physician shortages, he noted, will impact dramatically how health care providers communicate with one another. In the short term, there will be a tendency to increase costs. Mr. Slaughter noted that, in this environment where public payors are not keeping up with the costs, physicians and other health care providers are being hurt, particularly in rural and underserved areas, with over 1 million individuals (and growing) receiving care provided by the public.

A Committee member inquired about hospital construction in northwestern Kansas and what effect(s) health reform will have, especially in this area where there is a growing aging population yet declining overall population. The Committee member followed up by questioning what health care providers will staff such facilities. Mr. Bell responded that it is difficult to know and that the majority of those facilities cited by the member are Critical Access Hospitals. He suggested that for future projects it will be critical to act upon them only when the community pitches in, such as in Liberal. Another Committee member addressed Mr. Wheelen, inquiring about impact(s) to the Fund. Mr. Wheelen speculated that there were two potential issues; first, the *Miller v. Johnson* decision and its impact on insurers and the Fund which will be affected far more than the companies at the $200,000 level (basic coverage); second, access to care with a likelihood of more unfortunate outcomes and more settlements.

Following the formal presentations, the Chairman 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 Chairman then invited Committee discussion on recommendations for the Committee report. The Committee first addressed the two statutory questions posed to the Oversight Committee. The Committee members discussed whether another actuarial review would be made if the *Miller v. Johnson* decision strikes down the constitutionality of the cap on non-economic damages. The Chairman requested distribution of any new actuarial report (made to the Board of Governors) factoring in this impact be made to the Oversight Committee. *It was moved by Senator Schmidt and seconded by Dr. Snow that the Oversight Committee should be continued for another year; there was no need at this time for an independent actuarial review; and should actuarial projections be made for the Fund Board of Governors to reflect the Court's decision, a copy be made available to the Oversight Committee for its review. The motion carried.*

The Committee then considered information presented by the Fund representatives and health care provider and insurance representatives and *a motion was made by Senator Schmidt and seconded by Dr. Kindling to address three areas of concern to the Fund and its oversight*:

- *Miller v. Johnson.* The Oversight Committee concurs with the opinion expressed by the Fund Board of Governors' representative. If the Court's decision is to uphold the constitutionality of the statutory limits on non-economic damages in personal injury actions, the Fund's financial condition should remain stable. If not, however, the currently assigned reserves will immediately become inadequate and the estimated liabilities will increase substantially. The result, as noted by the Executive Director for the Health Care Stabilization Fund Board of

Governors, will translate to assets that are insufficient and it will become necessary to increase premium surcharge rates.

- *2010 SB 414.* The Oversight Committee will continue to monitor the planned reimbursement schedule for the Fund's expenses in its administration of self-insurance programs as prescribed in this new law. If financial conditions improve and revenues can be made available, the Committee encourages the legislative budget committees to review payments of this State General Fund obligation to the Fund at an earlier time.

- *Technology Improvements.* The Oversight Committee continues to support the agency's efforts to provide a streamlined website and electronic forms for health care providers and insurers participating in the Fund. The Committee supports the 2012 budget request for systems maintenance.

The motion carried. The Oversight Committee also agreed, in discussion with staff regarding its report, to continue language that previously has been included in the Committee's report to the Legislature. The language follows:

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.

The Oversight Committee then considered its next meeting date and after discussion, the Committee members concluded the next meeting would likely be in early November 2011. The Chairman then thanked the Committee members, staff, and attendees for their participation in this annual review. There being no further business to come before the Committee, the meeting was adjourned at 12 Noon.

Prepared by Melissa Calderwood

Approved by Committee on:

January 10, 2011
(Date)

National Conference of State Legislatures Office of State-Federal Relations
444 North Capitol Street, NW, Suite 515, Washington, D.C. 20001
202-624-5400

NCSL HEALTH REFORM FACT SHEET

KEY PROVISIONS THAT TAKE EFFECT IMMEDIATELY

UNDER SENATE BILL (HR 3590) AS AMENDED BY RECONCILIATION BILL (HR 4872)

INSURANCE REFORMS

PROHIBITS PLANS FROM IMPOSING PRE-EXISTING CONDITION EXCLUSIONS ON CHILDREN—Prohibits health insurers from denying coverage to children with pre-existing conditions. *Effective 6 months after enactment.* (Beginning in 2014, this prohibition would apply to all persons.)

PROHIBITS PLANS FROM IMPOSING LIFETIME LIMITS ON COVERAGE—Prohibits health insurance companies from placing lifetime caps on coverage. *Effective 6 months after enactment.*

PROHIBITS THE IMPOSITION OF RESTRICTIVE ANNUAL LIMITS ON COVERAGE—Tightly restricts new plans' use of annual limits to ensure access to needed care. These tight restrictions will be defined by HHS. *Effective 6 months after enactment.* (Beginning in 2014, the use of annual limits would be prohibited for all plans.)

ELIMINATES CO-PAYMENTS AND DEDUCTIBLES FOR PREVENTIVE CARE UNDER NEW PRIVATE PLANS—Requires new private plans to cover preventive services with no co-payments and with preventive services being exempt from deductibles. *Effective 6 months after enactment.* (Beginning in 2018, this requirement applies to all plans.)

ESTABLISHES A TEMPORARY REINSURANCE PROGRAM FOR EARLY RETIREES—Creates a temporary re-insurance program (until the Exchanges are available) to help offset the costs of expensive health claims for employers that provide health benefits for retirees age 55-64. *Effective 90 days after enactment*

ESTABLISHES A NEW, INDEPENDENT APPEALS PROCESS—Ensures that consumers in new plans have access to an effective internal and external appeals process to appeal decisions by their health insurance plan. *Effective 6 months after enactment.*

ENSURES VALUE FOR PREMIUM PAYMENTS (Medical Loss Ratio)—Requires plans in the individual and small group market to spend 80 percent of premium dollars on medical services, and plans in the large group market to spend 85 percent. Insurers that do not meet these thresholds must provide rebates to policyholders. *Effective January 1, 2011.*

ESTABLISHES AN INTERIM HIGH RISK POOL PROGRAM —Provides immediate access to insurance for Americans who are uninsured because of a pre-existing condition - through a temporary high-risk pool. This program will end when the Health Insurance Exchanges become effective in 2014. *Effective 90 days after enactment.*

EXTENDS COVERAGE FOR YOUNG PEOPLE UP TO 26TH YEAR THROUGH PARENTS' INSURANCE – Requires health plans to allow young people up to their 26th year to remain on their parents' insurance policy, at the parents' choice **regardless of marital status. Note:** Language in H.R. 4872 Reconciliation Act of 2010 amends provisions in H.R. 3590 by adding a provision to clarify dependent coverage as it relates to the income definition under the Internal Revenue Code of 1986. This language defines an adult dependent as any child of the taxpayer who as of the

end of the taxable year has not attained age 27. NCSL has requested clarification of the congressional intent due to the differences in the language of the two bills. *Effective 6 months after enactment.*

PROHIBITS DISCRIMINATION BASED ON SALARY—Prohibits new group health plans from establishing any eligibility rules for health care coverage that have the effect of discriminating in favor of higher wage employees. *Effective 6 months after enactment.*

ASSISTANCE TO STATES TO PROVIDE HEALTH INSURANCE CONSUMER INFORMATION—Provides aid to states in establishing offices of health insurance consumer assistance in order to help individuals with the filing of complaints and appeals. *Effective beginning in FY 2010.*

TAX CREDITS

SMALL BUSINESS TAX CREDITS—Offers tax credits to small businesses to make employee coverage more affordable. Tax credits of up to 35 percent of premiums will be immediately available to firms that choose to offer coverage. *Effective beginning calendar year 2010.* (Beginning in 2014, the small business tax credits will cover 50 percent of premiums.)

MEDICARE

BEGINS TO PHASE-OUT THE MEDICARE PART D DONUT HOLE—Provides a $250 rebate to Medicare beneficiaries who hit the donut hole in 2010. *Effective calendar year 2010.* (Beginning in 2011, institutes a 50% discount on brand-name drugs in the donut hole; also completely closes the donut hole by 2020.)

ELIMINATES CO-PAYMENTS AND DEDUCTIBLES FOR PREVENTIVE CARE UNDER MEDICARE—Eliminates co-payments for preventive services and exempts preventive services from deductibles under the Medicare program. *Effective January 1, 2011.*

HEALTH CARE INFRASTRUCTURE AND WORKFORCE

COMMUNITY HEALTH CENTERS—Increases funding for Community Health Centers to allow for nearly a doubling of the number of patients seen by the centers over the next 5 years. *Effective beginning in fiscal year 2010.*

INCREASING NUMBER OF PRIMARY CARE DOCTORS—Provides new investment in training programs to increase the number of primary care doctors, nurses, and public health professionals. *Effective beginning in fiscal year 2010.*

LONG TERM CARE

CREATES NEW, VOLUNTARY, PUBLIC LONG-TERM CARE INSURANCE PROGRAM— Establishes a national voluntary insurance program for purchasing Community Living Assistance Services and Support (CLASS program), a long-term care insurance program to be financed by voluntary payroll deductions to provide benefits to adults who are actively employed and become functionally disabled. The program allows for an opt-out by employees, and a five year vesting period. *Effective on January 1, 2011.*

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HEALTH REFORM IMPLEMENTATION TIMELINE

In March 2010, President Obama signed comprehensive health reform into law. The following timeline provides implementation dates for key provisions in the law.

2010

Insurance Reforms

- Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. (Effective 90 days following enactment until January 1, 2014)
- Provide dependent coverage for adult children up to age 26 for all individual and group policies.
- Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prior to 2014, plans may only impose annual limits on coverage as determined by the Secretary. Prohibit insurers from rescinding coverage except in cases of fraud and prohibit pre-existing condition exclusions for children.
- Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.
- Provide tax credits to small employers with no more than 25 employees and average annual wages of less than $50,000 that provide health insurance for employees.
- Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. (Effective 90 days following enactment until January 1, 2014)
- Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011)
- Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plans should be excluded from the Exchange based on unjustified premium increases.

Medicare

- Provide a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 and gradually eliminate the Medicare Part D coverage gap by 2020.
- Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result.
- Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office.
- Reduce annual market basket updates for inpatient and outpatient hospital services, long-term care hospitals, inpatient rehabilitation facilities, and psychiatric hospitals and units.
- Ban new physician-owned hospitals in Medicare, requiring hospitals to have a provider agreement in effect by December 31; limit the growth of certain grandfathered physician-owned hospitals.

Medicaid

- Create a state option to cover childless adults though a Medicaid state plan amendment.
- Create a state option to provide Medicaid coverage for family planning services up to the highest level of eligibility for pregnant women to certain low-income individuals through a Medicaid state plan amendment.
- Create a new option for states to provide Children's Health Insurance Program (CHIP) coverage to children of state employees eligible for health benefits if certain conditions are met.
- Increase the Medicaid drug rebate percentage for brand name drugs to 23.1% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans.
- Provide funding for and expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid).
- Require the Secretary of HHS to issue regulations to establish a process for public notice and comment for section 1115 waivers in Medicaid and CHIP.

Prescription Drugs

- Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.

HEALTH CARE STABILIZATION FUND OVERSIGHT COMMITTEE
November 23, 2010
Attachment 2

2010 (continued)

Quality Improvement

- Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute.
- Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency.
- Reauthorize and amend the Indian Health Care Improvement Act.

Workforce

- Establish the Workforce Advisory Committee to develop a national workforce strategy.
- Increase workforce supply and support training of health professionals through scholarships and loans.

Tax Changes

- Impose additional requirements on non-profit hospitals. Impose a tax of $50,000 per year for failure to meet these requirements.
- Limit the deductibility of executive and employee compensation to $500,000 per applicable individual for health insurance providers.
- Impose a tax of 10% on the amount paid for indoor tanning services.
- Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit.
- Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance.

2011

Long-term Care

- Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program).

Medical Malpractice

- Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.

Prevention/Wellness

- Eliminate cost-sharing for Medicare covered preventive services that are recommended (rated A or B) by the U.S. Preventive Services Task Force and waive the Medicare deductible for colorectal cancer screening tests. Authorize the Secretary to modify or eliminate Medicare coverage of preventive services based on recommendations of the U.S. Preventive Services Task Force.
- Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.
- Provide grants for up to five years to small employers that establish wellness programs.
- Establish the National Prevention, Health Promotion and Public Health Council to develop a national strategy to improve the nation's health.
- Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item.

Medicare

- Require pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begin phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.
- Provide a 10% Medicare bonus payment to primary care physicians, and to general surgeons practicing in health professional shortage areas. (Effective 2011 through 2015)
- Restructure payments to Medicare Advantage plans by setting payments to different percentages of Medicare fee-for-service rates.
- Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program.
- Provide Medicare payments to qualifying hospitals in counties with the lowest quartile Medicare spending for 2011 and 2012.
- Freeze the income threshold for income-related Medicare Part B premiums for 2011 through 2019 at 2010 levels, and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple.
- Create an Innovation Center within the Centers for Medicare and Medicaid Services.

Medicaid

- Prohibit federal payments to states for Medicaid services related to health care acquired conditions.
- Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for health home related services including care management, care coordination and health promotion.
- Create the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based longterm care services.
- Establish the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities.

2011 (continued)

Quality Improvement

- Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health.
- Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations.
- Establish a new trauma center program to strengthen emergency department and trauma center capacity.
- Improve access to care by increasing funding by $11 billion for community health centers and by $1.5 billion for the National Health Service Corps over five years; establish new programs to support school-based health centers and nurse-managed health clinics.

Workforce

- Establish Teaching Health Centers to provide payments for primary care residency programs in community-based ambulatory patient care centers.

Tax Changes

- Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through a health reimbursement account or health flexible spending account and from being reimbursed on a tax-free basis through a health savings account or Archer Medical Savings Account.
- Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% of the disbursed amount.
- Impose new annual fees on the pharmaceutical manufacturing sector.

2012

Medicare

- Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care.
- Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.
- Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions.
- Reduce annual market basket updates for home health agencies, skilled nursing facilities, hospices, and other Medicare providers.
- Create the Medicare Independence at Home demonstration program.
- Establish a hospital value-based purchasing program in Medicare and develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.
- Provide bonus payments to high-quality Medicare Advantage plans.
- Reduce rebates for Medicare Advantage plans.

Medicaid

- Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).

Quality Improvement

- Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.

2013

Insurance Reforms

- Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and the District of Columbia to offer qualified health plans. (Appropriate $6 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013)
- Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life. (Effective April 1, 2014)

Prevention/Wellness

- Provide states that offer Medicaid coverage of and remove cost-sharing for preventive services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations with a one percentage point increase in the federal medical assistance percentage (FMAP) for these services.

2013 (continued)

Medicare

- Begin phasing-in federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap (to 25% in 2020, in addition to the 50% manufacturer brand-name discount).
- Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.

Medicaid

- Increase Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100% federal funding.

Quality Improvement

- Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

Tax Changes

- Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016.
- Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and impose a 3.8% assessment on unearned income for higher-income taxpayers.
- Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year increased annually by the cost of living adjustment.
- Impose an excise tax of 2.3% on the sale of any taxable medical device.
- Eliminate the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.

2014

Individual and Employer Requirements

- Require U.S. citizens and legal residents to have qualifying health coverage (phase-in tax penalty for those without coverage).
- Assess employers with 50 or more employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with 50 or more employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee, excluding the first 30 employees from the assessment. Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.

Insurance Reforms

- Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
- Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchanges.
- Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:
    - 100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family in 2010);
    - 200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family in 2010);
    - 300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family in 2010).
- Limit deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits.
- Limit any waiting periods for coverage to 90 days.
- Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits ($5,950/individual and $11,900/family in 2010), and is not more extensive than the typical employer plan.
- Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law.
- Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange.
- Allow states the option of merging the individual and small group markets.
- Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.
- Require qualified health plans to meet new operating standards and reporting requirements.

2014 (continued)
Premium Subsidies
• Provide refundable and advanceable premium credits and cost sharing subsidies to eligible individuals and families with incomes between 133-400% FPL to purchase insurance through the Exchanges.
Medicare
• Reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage in Medicare Part D (effective through 2019). • Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. • Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided. • Require Medicare Advantage plans to have medical loss ratios no lower than 85%.
Medicaid
• Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (MAGI) and provide enhanced federal matching for new eligibles. • Reduce states' Medicaid Disproportionate Share Hospital (DSH) allotments. • Increase spending caps for the territories.
Prevention/Wellness
• Permit employers to offer employees rewards of up to 30%, increasing to 50% if appropriate, of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Establish 10-state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.
Tax Changes
• Impose fees on the health insurance sector.
2015 and later
Insurance Reforms
• Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. (Compacts may not take effect before January 1, 2016)
Medicare
• Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)
Tax Changes
• Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage. (Effective January 1, 2018)

For additional information, see http://www.kff.org/healthreform/8060.cfm.

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SENATE BILL No. 414

AN ACT concerning the health care stabilization fund; amending K.S.A. 2009 Supp. 40-3403 and 40-3404 and repealing the existing sections.

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

Section 1. K.S.A. 2009 Supp. 40-3403 is hereby amended to read as follows: 40-3403. (a) For the purpose of paying damages for personal injury or death arising out of the rendering of or the failure to render professional services by a health care provider, self-insurer or inactive health care provider subsequent to the time that such health care provider or self-insurer has qualified for coverage under the provisions of this act, there is hereby established the health care stabilization fund. The fund shall be held in trust in the state treasury and accounted for separately from other state funds. The board of governors shall administer the fund or contract for the administration of the fund with an insurance company authorized to do business in this state.

(b) (1) There is hereby created a board of governors which shall be composed of such members and shall have such powers, duties and functions as are prescribed by this act. The board of governors shall:

(A) Administer the fund and exercise and perform other powers, duties and functions required of the board under the health care provider insurance availability act;

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

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

(D) have the authority to grant exemptions from the provisions of subsection (m) of this section when a health care provider temporarily leaves the state for the purpose of obtaining additional education or training or to participate in religious, humanitarian or government service programs. Whenever a health care provider has previously left the state for one of the reasons specified in this paragraph and returns to the state and recommences practice, the board of governors may refund any amount paid by the health care provider pursuant to subsection (m) of this section if no claims have been filed against such health care provider during the provider's temporary absence from the state.

(2) The board shall consist of 10 persons appointed by the commissioner of insurance, as provided by this subsection (b) and as follows:

(A) Three members who are licensed to practice medicine and surgery in Kansas who are doctors of medicine and who are on a list of nominees submitted to the commissioner by the Kansas medical society;

(B) three members who are representatives of Kansas hospitals and who are on a list of nominees submitted to the commissioner by the Kansas hospital association;

(C) two members who are licensed to practice medicine and surgery in Kansas who are doctors of osteopathic medicine and who are on a list of nominees submitted to the commissioner by the Kansas association of osteopathic medicine;

(D) one member who is licensed to practice chiropractic in Kansas and who is on a list of nominees submitted to the commissioner by the Kansas chiropractic association;

(E) one member who is a licensed professional nurse authorized to practice as a registered nurse anesthetist who is on a list of nominees submitted to the commissioner by the Kansas association of nurse anesthetists.

(3) When a vacancy occurs in the membership of the board of governors created by this act, the commissioner shall appoint a successor of like qualifications from a list of three nominees submitted to the commissioner by the professional society or association prescribed by this section for the category of health care provider required for the vacant position on the board of governors. All appointments made shall be for a term of office of four years, but no member shall be appointed for more than two successive four-year terms. Each member shall serve until a successor is appointed and qualified. Whenever a vacancy occurs in the membership of the board of governors created by this act for any reason

other than the expiration of a member's term of office, the commissioner shall appoint a successor of like qualifications to fill the unexpired term. In each case of a vacancy occurring in the membership of the board of governors, the commissioner shall notify the professional society or association which represents the category of health care provider required for the vacant position and request a list of three nominations of health care providers from which to make the appointment.

(4) The board of governors shall organize on July 1 of each year and shall elect a chairperson and vice-chairperson from among its membership. Meetings shall be called by the chairperson or by a written notice signed by three members of the board.

(5) The board of governors, in addition to other duties imposed by this act, shall study and evaluate the operation of the fund and make such recommendations to the legislature as may be appropriate to ensure the viability of the fund.

(6) (A) The board shall appoint an executive director who shall be in the unclassified service under the Kansas civil service act and may appoint such attorneys, legal assistants, claims managers and compliance auditors who shall also be in the unclassified service under the Kansas civil service act. Such executive director, attorneys, legal assistants, claims managers and compliance auditors shall receive compensation fixed by the board, in accordance with appropriation acts of the legislature, not subject to approval of the governor.

(B) The board may appoint such additional employees, and provide all office space, services, equipment, materials and supplies, and all budgeting, personnel, purchasing and related management functions required by the board in the exercise of the powers, duties and functions imposed or authorized by the health care provider insurance availability act or may enter into a contract with the commissioner of insurance for the provision, by the commissioner, of all or any part thereof.

(7) The commissioner shall:

(A) Provide technical and administrative assistance to the board of governors with respect to administration of the fund upon request of the board;

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

(c) Subject to subsections (d), (e), (f), (i), (k), (m), (n), (o), (p) and (q), the fund shall be liable to pay: (1) Any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable resident health care providers or resident self-insurers for any personal injury or death arising out of the rendering of or the failure to render professional services within or without this state;

(2) subject to the provisions of subsection (m), any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable nonresident health care providers or nonresident self-insurers for any such injury or death arising out of the rendering or the failure to render professional services within this state but in no event shall the fund be obligated for claims against nonresident health care providers or nonresident self-insurers who have not complied with this act or for claims against nonresident health care providers or nonresident self-insurers that arose outside of this state;

(3) subject to the provisions of subsection (m), any amount due from a judgment or settlement against a resident inactive health care provider, an optometrist or pharmacist who purchased coverage pursuant to subsection (n) or a physical therapist who purchased coverage pursuant to subsection (o), for any such injury or death arising out of the rendering of or failure to render professional services;

(4) subject to the provisions of subsection (m), any amount due from a judgment or settlement against a nonresident inactive health care provider, an optometrist or pharmacist who purchased coverage pursuant to subsection (n) or a physical therapist who purchased coverage pursuant to subsection (o), for any injury or death arising out of the rendering or failure to render professional services within this state, but in no event shall the fund be obligated for claims against: (A) Nonresident inactive health care providers who have not complied with this act; or (B) nonresident inactive health care providers for claims that arose outside of this state, unless such health care provider was a resident health care provider or resident self-insurer at the time such act occurred;

(5) subject to subsection (b) of K.S.A. 40-3411, and amendments thereto, reasonable and necessary expenses for attorney fees incurred in defending the fund against claims;

(6) any amounts expended for reinsurance obtained to protect the best interests of the fund purchased by the board of governors, which purchase shall be subject to the provisions of K.S.A. 75-3738 through 75-3744, and amendments thereto, but shall not be subject to the provisions of K.S.A. 75-4101 and amendments thereto;

(7) reasonable and necessary actuarial expenses incurred in administering the act, including expenses for any actuarial studies contracted for by the legislative coordinating council, which expenditures shall not be subject to the provisions of K.S.A. 75-3738 through 75-3744, and amendments thereto;

(8) periodically to the plan or plans, any amount due pursuant to subsection (a)(3) of K.S.A. 40-3413 and amendments thereto;

(9) reasonable and necessary expenses incurred by the board of governors in the administration of the fund or in the performance of other powers, duties or functions of the board under the health care provider insurance availability act;

(10) return of any unearned surcharge;

(11) subject to subsection (b) of K.S.A. 40-3411, and amendments thereto, reasonable and necessary expenses for attorney fees and other costs incurred in defending a person engaged or who was engaged in residency training or the private practice corporations or foundations and their full-time physician faculty employed by the university of Kansas medical center or any nonprofit corporation organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated with the university of Kansas school of medicine from claims for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider;

(12) notwithstanding the provisions of subsection (m), any amount due from a judgment or settlement for an injury or death arising out of the rendering of or failure to render professional services by a person engaged or who was engaged in residency training or the private practice corporations or foundations and their full-time physician faculty employed by the university of Kansas medical center or any nonprofit corporation organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated with the university of Kansas school of medicine;

(13) subject to the provisions of K.S.A. 65-429 and amendments thereto, reasonable and necessary expenses for the development and promotion of risk management education programs and for the medical care facility licensure and risk management survey functions carried out under K.S.A. 65-429 and amendments thereto;

(14) notwithstanding the provisions of subsection (m), any amount, but not less than the required basic coverage limits, owed pursuant to a judgment or settlement for any injury or death arising out of the rendering of or failure to render professional services by a person, other than a person described in clause (12) of this subsection (c), who was engaged in a postgraduate program of residency training approved by the state board of healing arts but who, at the time the claim was made, was no longer engaged in such residency program;

(15) subject to subsection (b) of K.S.A. 40-3411, and amendments thereto, reasonable and necessary expenses for attorney fees and other costs incurred in defending a person described in clause (14) of this subsection (c);

(16) expenses incurred by the commissioner in the performance of duties and functions imposed upon the commissioner by the health care provider insurance availability act, and expenses incurred by the commissioner in the performance of duties and functions under contracts entered into between the board and the commissioner as authorized by this section; and

(17) periodically to the state general fund reimbursements of amounts paid to members of the health care stabilization fund oversight committee for compensation, travel expenses and subsistence expenses pursuant to subsection (e) of K.S.A. 40-3403b, and amendments thereto.

(d) All amounts for which the fund is liable pursuant to subsection (c) shall be paid promptly and in full except that, if the amount for which

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

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

(f) The fund shall not be liable to pay in excess of the amounts specified in the option selected by the health care provider pursuant to subsection (l) for judgments or settlements relating to injury or death arising out of the rendering of or failure to render professional services by such health care provider on or after July 1, 1989.

(g) A health care provider shall be deemed to have qualified for coverage under the fund:

(1) On and after July 1, 1976, if basic coverage is then in effect;

(2) subsequent to July 1, 1976, at such time as basic coverage becomes effective; or

(3) upon qualifying as a self-insurer pursuant to K.S.A. 40-3414 and amendments thereto.

(h) A health care provider who is qualified for coverage under the fund shall have no vicarious liability or responsibility for any injury or death arising out of the rendering of or the failure to render professional services inside or outside this state by any other health care provider who is also qualified for coverage under the fund. The provisions of this subsection shall apply to all claims filed on or after July 1, 1986.

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

(j) (1) *Subject to the provisions of paragraph (7) of this subsection (j),* upon the payment of moneys from the health care stabilization fund pursuant to subsection (c)(11), the board of governors shall certify to the director of accounts and reports the amount of such payment, and the director of accounts and reports shall transfer an amount equal to the amount certified, reduced by any amount transferred pursuant to paragraph (3) or (4) of this subsection (j), from the state general fund to the health care stabilization fund.

(2) *Subject to the provisions of paragraph (7) of this subsection (j),* upon the payment of moneys from the health care stabilization fund pursuant to subsection (c)(12), the board of governors shall certify to the director of accounts and reports the amount of such payment which is equal to the basic coverage liability of self-insurers, and the director of accounts and reports shall transfer an amount equal to the amount certified, reduced by any amount transferred pursuant to paragraph (3) or (4) of this subsection (j), from the state general fund to the health care stabilization fund.

(3) The university of Kansas medical center private practice foundation reserve fund is hereby established in the state treasury. If the balance in such reserve fund is less than $500,000 on July 1 of any year,

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

(4) The graduate medical education administration reserve fund is hereby established in the state treasury. If the balance in such reserve fund is less than $40,000 on July 1 of any year, the nonprofit corporations organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated with the university of Kansas school of medicine shall remit the amount necessary to increase such balance to $40,000 to the state treasurer for credit to such reserve fund as soon after such July 1 date as is practicable. Upon receipt of each such remittance, the state treasurer shall credit the same to such reserve fund. When compliance with the foregoing provisions of this paragraph have been achieved on or after July 1 of any year in which the same are applicable, the state treasurer shall certify to the board of governors that such reserve fund has been funded for the year in the manner required by law. Moneys in such reserve fund may be invested or reinvested in accordance with the provisions of K.S.A. 40-3406, and amendments thereto, and any income or interest earned by such investments shall be credited to such reserve fund. Upon payment of moneys from the health care stabilization fund pursuant to subsection (c)(11) or (c)(12) with respect to any nonprofit corporations organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated with the university of Kansas school of medicine the director of accounts and reports shall transfer an amount equal to the amount paid from the graduate medical education administration reserve fund to the health care stabilization fund or, if the balance in such reserve fund is less than the amount so paid, an amount equal to the balance in such reserve fund.

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

(6) Transfers from the state general fund to the health care stabilization fund pursuant to subsection (j) shall not be subject to the provisions of K.S.A. 75-3722 and amendments thereto.

(7) The funds required to be transferred from the state general fund to the health care stabilization fund pursuant to paragraphs (1) and (2) of this subsection (j) for the fiscal years ending June 30, 2010, June 30, 2011, June 30, 2012, and June 30, 2013, shall not be transferred prior to July 1, 2013. The director of accounts and reports shall maintain a record of the amounts certified by the board of governors pursuant to paragraphs (1) and (2) of this subsection (j) for the fiscal years ending June 30, 2010, June 30, 2011, June 30, 2012, and June 30, 2013. Beginning July 1, 2013, in addition to any other transfers required pursuant to subsection (j), the state general fund transfers which are deferred pursuant to this paragraph shall be transferred from the state general fund to the health care stabilization fund in the following manner: On July 1, 2013, and annually

thereafter through July 1, 2017, an amount equal to 20% of the total amount of state general fund transfers deferred pursuant to this paragraph for the fiscal years ending June 30, 2010, June 30, 2011, June 30, 2012, and June 30, 2013. The amounts deferred pursuant to this paragraph shall not accrue interest thereon.

(k) Notwithstanding any other provision of the health care provider insurance availability act, no psychiatric hospital licensed under K.S.A. 75-3307b and amendments thereto shall be assessed a premium surcharge or be entitled to coverage under the fund if such hospital has not paid any premium surcharge pursuant to K.S.A. 40-3404 and amendments thereto prior to January 1, 1988.

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

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

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

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

(m) The fund shall not be liable for any amounts due from a judgment or settlement against resident or nonresident inactive health care providers who first qualify as an inactive health care provider on or after July 1, 1989, unless such health care provider has been in compliance with K.S.A. 40-3402, and amendments thereto, for a period of not less than five years. If a health care provider has not been in compliance for five years, such health care provider may make application and payment for the coverage for the period while they are nonresident health care providers, nonresident self-insurers or resident or nonresident inactive health care providers to the fund. Such payment shall be made within 30 days after the health care provider ceases being an active health care provider and shall be made in an amount determined by the board of governors to be suf-

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ficient to fund anticipated claims based upon reasonably prudent actuarial principles. The provisions of this subsection shall not be applicable to any health care provider which becomes inactive through death or retirement, or through disability or circumstances beyond such health care provider's control, if such health care provider notifies the board of governors and receives approval for an exemption from the provisions of this subsection. Any period spent in a postgraduate program of residency training approved by the state board of healing arts shall not be included in computation of time spent in compliance with the provisions of K.S.A. 40-3402, and amendments thereto.

(n) Notwithstanding the provisions of subsection (m) or any other provision in article 34 of chapter 40 of the Kansas Statutes Annotated to the contrary, the fund shall not be liable for any claim made on or after July 1, 1991, against a licensed optometrist or pharmacist relating to any injury or death arising out of the rendering of or failure to render professional services by such optometrist or pharmacist prior to July 1, 1991, unless such optometrist or pharmacist qualified as an inactive health care provider prior to July 1, 1991.

(o) Notwithstanding the provisions of subsection (m) or any other provision in article 34 of chapter 40 of the Kansas Statutes Annotated to the contrary, the fund shall not be liable for any claim made on or after July 1, 1995, against a physical therapist registered by the state board of healing arts relating to any injury or death arising out of the rendering of or failure to render professional services by such physical therapist prior to July 1, 1995, unless such physical therapist qualified as an inactive health care provider prior to July 1, 1995.

(p) Notwithstanding the provisions of subsection (m) or any other provision in article 34 of chapter 40 of the Kansas Statutes Annotated to the contrary, the fund shall not be liable for any claim made on or after July 1, 1997, against a health maintenance organization relating to any injury or death arising out of the rendering of or failure to render professional services by such health maintenance organization prior to July 1, 1997, unless such health maintenance organization qualified as an inactive health care provider prior to July 1, 1997, and obtained coverage pursuant to subsection (m). Health maintenance organizations not qualified as inactive health care providers prior to July 1, 1997, may purchase coverage from the fund for periods of prior compliance by making application prior to August 1, 1997, and payment within 30 days from notice of the calculated amount as determined by the board of governors to be sufficient to fund anticipated claims based on reasonably prudent actuarial principles.

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

Sec. 2. K.S.A. 2009 Supp. 40-3404 is hereby amended to read as follows: 40-3404. (a) Except for any health care provider whose participation in the fund has been terminated pursuant to subsection (i) of K.S.A. 40-3403 and amendments thereto, the 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. This provision shall not apply to optometrists and pharmacists on or after July 1, 1991 nor to physical therapists on or after July 1, 1995, nor to health maintenance organizations on and after July 1, 1997. 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. The annual premium surcharge upon the university of Kansas medical center for persons engaged in residency training, as described in paragraph (1) of subsection (r) of K.S.A. 40-3401, and amendments thereto, shall be based on an assumed aggregate premium of $600,000. The annual premium surcharge upon the employers of persons engaged in residency training, as described in

paragraph (2) of subsection (r) of K.S.A. 40-3401, and amendments thereto, shall be based on an assumed aggregate premium of $400,000. The surcharge on such $400,000 amount shall be apportioned among the employers of persons engaged in residency training, as described in paragraph (2) of subsection (r) of K.S.A. 40-3401, and amendments thereto, based on the number of residents employed as of July 1 of each year. The annual premium surcharge upon any nonprofit corporation organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated with the university of Kansas school of medicine shall be based upon an assumed aggregate premium of $10,000. The surcharge on such assumed aggregate premium shall be apportioned among all such nonprofit corporations.

(b) In the case of a resident health care provider who is not a self-insurer, the premium surcharge shall be collected in addition to the annual premium for the basic coverage by the insurer and shall not be subject to the provisions of K.S.A. 40-252, 40-955 and 40-2801 et seq., and amendments thereto. The amount of the premium surcharge shall be shown separately on the policy or an endorsement thereto and shall be specifically identified as such. Such premium surcharge shall be due and payable by the insurer to the board of governors within 30 days after the annual premium for the basic coverage is received by the insurer, but in the event basic coverage is in effect at the time this act becomes effective, such surcharge shall be based upon the unearned premium until policy expiration and annually thereafter. Within 15 days immediately following the effective date of this act, the board of governors shall send to each insurer information necessary for their compliance with this subsection. The certificate of authority of any insurer who fails to comply with the provisions of this subsection shall be suspended pursuant to K.S.A. 40-222, and amendments thereto, until such insurer shall pay the annual premium surcharge due and payable to the board of governors. In the case of a nonresident health care provider or a self-insurer, the premium surcharge shall be collected in the manner prescribed in K.S.A. 40-3402, and amendments thereto.

(c) In setting the amount of such surcharge, the board of governors may require any health care provider who has paid a surcharge for less than 24 months to pay a higher surcharge than other health care providers.

Sec. 3. K.S.A. 2009 Supp. 40-3403 and 40-3404 are hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the Kansas register.

I hereby certify that the above BILL originated in the SENATE, and passed that body

_____

_____
President of the Senate.

_____
Secretary of the Senate.

Passed the HOUSE _____

_____
Speaker of the House.

_____
Chief Clerk of the House.

APPROVED _____

_____
Governor.

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Health Care Stabilization Fund, Reimbursements

SB 414 amends the Health Care Provider Insurance Availability Act to exempt transfers from the State General Fund (SGF) to the Health Care Stabilization Fund (HCSF) as required by KSA 2009 Supp. 40-3403(j) from the allotment authority delegated by statute (KSA 75-3722) to the Secretary of Administration.

The bill also makes a technical amendment to the requirement for payment of the annual surcharge, striking the word "fiscal."

Deferral of Payment to the Health Care Stabilization Fund. The bill further amends the Act to provide that the funds required to be transferred to the Health Care Stabilization Fund for the payments specified in law (KSA 2009 Supp. 40-3403(j)) for state Fiscal Years 2010, 2011, 2012, and 2013 shall not be transferred prior to July 1, 2013. The Director of Accounts and Reports will be required to maintain a record of the amounts certified by the Health Care Stabilization Fund Board of Governors for the specified fiscal years. The bill establishes a process for the repayment of the deferred State General Fund payments, as follows: beginning on July 1, 2013 and on an annual basis through July 1, 2017, 20.0 percent of the total amount of the SGF deferred transfers are to be transferred to the Health Care Stabilization Fund. No interest will be allowed to accrue on the deferred payments.

KSA 2009 Supp. 40-3403(j) pertains to the reimbursement for the costs and expenses associated with the administration of a self-insurance program for the full-time faculty, private practice foundations and corporations, and the residents of the University of Kansas School of Medicine and the Wichita Center for Graduate Medical Education. (When the costs, including claims and legal expenses, exceed the amount paid by the Faculty Foundations [Private Practice Foundation Reserve Fund], the SGF, upon certification of the amount of the payments made by the HCSF, transfers the difference to the HCSF.)

HEALTH CARE STABILIZATION FUND OVERSIGHT COMMITTEE
November 23, 2010
Attachment 4

Session of 2010

House Concurrent Resolution No. 5036

By Committee on Judiciary

3-11

A PROPOSITION to amend article 2 of the constitution of the state of Kansas by adding a new section thereto, affirming the legislature's authority to limit the amount of recovery for noneconomic damages in any claim for personal injury.

Be it resolved by the Legislature of the State of Kansas, two-thirds of the members elected (or appointed) and qualified to the House of Representatives and two-thirds of the members elected (or appointed) and qualified to the Senate concurring therein:

Section 1. The following proposition to amend the constitution of the state of Kansas shall be submitted to the qualified electors of the state for their approval or rejection: Article 2 of the constitution of the state of Kansas is amended by adding a new section thereto to read as follows:

"§ **31. Limitation on noneconomic damages** (a) The legislature may enact laws limiting the amount of noneconomic damages awarded for any claim for personal injury. No provision of this constitution shall limit the powers of the legislature herein conferred, including the power of the legislature to specify circumstances in which such limitations would not apply.

(b) Noneconomic damages, including damages for pain and suffering, are losses for which there is no unit value, mathematical formula or rule of calculation and include, but shall not be limited to, mental anguish, disability, disfigurement, inconvenience, humiliation, loss of capacity to enjoy life, bereavement, loss of society, loss of companionship, loss of reputation and all other losses which are intangible in nature."

Sec. 2. The following statement shall be printed on the ballot with the amendment as a whole:

"Explanatory statement. This amendment would allow the legislature to limit awards for pain and suffering, or noneconomic damages, that a person could recover in a personal injury action. The amendment also allows the legislature to specify circumstances in which the limitations would not apply, for example when the conduct of the party causing the injury was due to criminal acts, or negligence due to substance abuse or impairment. Nothing in

this amendment would affect awards or recovery of actual economic losses, such as lost wages, past or future medical bills, rehabilitation and long term care costs, nor would this amendment affect awards for punitive damages in any way."

"Noneconomic damages" are commonly referred to as pain and suffering, but also can include mental anguish, disability, disfigurement, inconvenience, humiliation, loss of capacity to enjoy life, bereavement, loss of society, loss of companionship, loss of reputation, loss of consortium, and other losses for which there is no unit value, mathematical formula or known rule for calculation. A "personal injury" includes all actionable injuries to an individual as distinguished from injuries to the individual's property, and includes bodily and emotional injuries as well as injuries to reputation and character.

"A vote for this amendment would affirm the authority of the legislature to limit the amount of noneconomic damages a person could recover in any claim for personal injury.

"A vote against this amendment would leave the legislature without the express authority to adopt limits on awards for noneconomic damages in personal injury claims."

Sec. 3. This resolution, if approved by two-thirds of the members elected (or appointed) and qualified to the House of Representatives, and two-thirds of the members elected (or appointed) and qualified to the Senate shall be entered on the journals, together with the yeas and nays. The secretary of state shall cause this resolution to be published as provided by law and shall cause the proposed amendment to be submitted to the electors of the state at the general election in November in the year 2010 unless a special election is called at a sooner date by concurrent resolution of the legislature, in which case it shall be submitted to the electors of the state at the special election.

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Health Care Stabilization Fund Board of Governor's

Expenditure	Actual FY 2009	Approved FY 2010	Approved FY 2011
All Funds:			
State Operations	$ 6,655,856	$ 6,877,894	$ 6,882,158
Aid to Local Units	0	0	0
Other Assistance	25,236,640	28,250,000	28,250,000
Subtotal - Operating	$ 31,892,496	$ 35,127,894	$ 35,132,158
Capital Improvements	0	0	0
TOTAL	$ 31,892,496	$ 35,127,894	$ 35,132,158
State General Fund:			
State Operations	$ 0	$ 0	$ 0
Aid to Local Units	0	0	0
Other Assistance	0	0	0
Subtotal - Operating	$ 0	$ 0	$ 0
Capital Improvements	0	0	0
TOTAL	$ 0	$ 0	$ 0
Percent Change			
Operating Expenditures			
All Funds	4.8 %	10.1 %	0.0 %
State General Fund	0.0	0.0	0.0
FTE Positions	17.0	17.0	18.0
Non-FTE Unclass. Perm. Pos.	0.0	0.0	0.0
TOTAL	17.0	17.0	18.0

Legislature. The budget approved by the Legislature for FY 2010 is $35,127,894, all from special revenue funds. This is an all funds increase of 10.5 percent above the FY 2009 actual budget. The increase is attributable to increased expenditures for the payment of medical malpractice claims and technology expenditures related to the implementation of a new document management system. Starting in FY 2010 the agency began reporting the payment of claims in a separate program from the administrative expenses. The agency indicates that this allows the Legislature to more accurately monitor the Health Care Stabilization Fund (HCSF) budget and apply the expenditure limitation to agency administrative expenses.

The budget approved by the Legislature for FY 2011 is $35,132,158, all from special revenue funds. This is an all funds increase of less than 0.0 percent over the FY 2010 approved budget. The approved budget holds claim expenses steady between FY 2010 and FY 2011; however, several high profile malpractice cases combined with an increase in fees paid to attorney's for the handling of malpractice claims could jeopardize this projection. The claims program remains no-limit. In addition, Senate Bill 414 amends the Health Care Provider Insurance Availability Act to exempt transfers from the State General Fund to the Health Care Stabilization Fund from the allotment authority delegated to the Secretary of Administration. SB 414 also overrides the Governor's allotment order terminating the transfer from the State General Fund to the Health Care Stabilization Fund and defers the payments to five consecutive yearly payments starting in FY 2013. The agency requested and the Legislature granted a request to add 1.0 FTE position to respond to open records requests. The position will be funded from within existing resources by shifting funding from the capital outlay budget.

Health Care Stabilization Fund Board of Governor's

	FY 2010			FY 2011		
	SGF	All Funds	FTE	SGF	All Funds	FTE
Agency Request/Estimate:	$ 0	$ 35,156,628	17.0	$ 0	$ 36,542,940	17.0
Governor's Changes:						
1. Reduce Salaries and Wages to approved amount	$ 0	$ (12,780)	0.0	$ 0	$ (11,665)	0.0
2. Reduce Contractual Services	0	(13,670)	0.0	0	(815,400)	0.0
3. Reduce Commodities expenditures in the Administration Program	0	0	0.0	0	(10,900)	0.0
4. Allotment – Eliminate SGF reimbursement for KU Residents and Faculty malpractice insurance expenses	0	0	0.0	0	0	0.0
5. Reduce Capital Outlay expenditures in the Administration Program	0	0	0.0	0	(574,797)	0.0
Total Governor's Recommendation	$ 0	$ 35,130,178	17.0	$ 0	$ 35,130,178	17.0
Change from Agency Req./Est.	$ 0	$ (26,450)	0.0	$ 0	$ (1,412,762)	0.0
Percent Change from Agency Req./Est.	0.0 %	(0.1) %	0.0 %	0.0 %	(3.9) %	0.0 %
Legislative Action:						
6. Add 1.0 FTE position	$ 0	$ 0	0.0	$ 0	$ 0	1.0
7. Death and Disability Moratorium	0	(2,284)	0.0	0	(2,303)	0.0
8. Under-Market Salary Adjustment	0	0	0.0	0	4,283	0.0
9. SB 414 – Overrides Governor allotment order on SGF payments to HCSF and defers payments to FY 2013	0	0	0.0	0	0	0.0
TOTAL APPROVED	$ 0	$ 35,127,894	17.0	$ 0	$ 35,132,158	18.0
Change from Gov. Rec.	$ 0	$ (2,284)	0.0	$ 0	$ 1,980	1.0
Percent Change from Gov. Rec.	0.0 %	(0.0) %	0.0 %	0.0 %	0.0 %	5.9 %
Change from Agency Req./Est.	$ 0	$ (28,734)	0.0	$ 0	$ (1,410,782)	1.0
Percent Change from Agency Req./Est.	0.0 %	(0.1) %	0.0 %	0.0 %	(3.9) %	5.9 %

1. The Governor recommended deleting $12,780, all from special revenue funds, to reduce the agency requested salaries and wages to the legislatively approved amount in FY 2010. Delete $11,665, all from Special Revenue Funds, to maintain the approved budget for salaries and wages at the same level from FY 2010 to FY 2011.

2. The Governor recommended deleting $13,670, all from special revenue funds, to reduce the agency requested contractual services expenditures to the legislatively approved amount in FY 2010. Delete $815,400, all from Special Revenue Funds, from the contractual services budget to eliminate the estimated increase for legal fees in the Claims Program for FY 2011. The deletion is instructional only since the Claims Program has no limit on expenditures.

3. The Governor recommended deleting $10,900, all from special revenue funds, to maintain the approved budget for commodities at the same level from FY 2010 to FY 2011.

4. As part of the allotment process, the Governor recommended eliminating the transfer of a projected $2.8 million from the State General Fund to the Health Care Stabilization Fund for the reimbursement of expenses incurred for malpractice coverage for KU Residents, KU Faculty and Wichita Center for Graduate Medical Education Residents.

5. The Governor recommended deleting $574,797, all from Special Revenue Funds, for the enterprise management system proposed by the agency. The agency has partially implemented the enterprise management system beginning with a new document management system with $220,000 in additional expenditure authority for

technology improvements approved by the 2009 Legislature which has become part of their agency base budget.

6. The Legislature added 1.0 FTE position for the processing of open-records requests. The position will be funded from existing resources.

7. The Legislature deleted $2,284, all from Special Revenue funds, in FY 2010 from monies freed by the KPERS Death and Disability moratorium. Delete $2,303, all from Special Revenue funds in FY 2011 from monies freed by a 1st quarter moratorium on Death and Disability contributions.

8. The Legislature added $4,283, all from Special Revenue funds, to enhance under-market salaries.

9. Pursuant to 2010, Senate Bill 414, which amends the Health Care Provider Insurance Availability Act to exempt transfers from the State General Fund to the Health Care Stabilization Fund from the allotment authority delegated to the Secretary of Administration. The bill has the effect of overriding the Governor's allotment order terminating the transfer from the State General Fund to the Health Care Stabilization Fund and defers the payments to five consecutive yearly payments starting in FY 2013.

Report of the Health Care Stabilization Fund Oversight Committee to the 2010 Kansas Legislature

CHAIRPERSON: Dick Bond

LEGISLATIVE MEMBERS: Senators Laura Kelly and Vicki Schmidt; and Representatives Eber Phelps and Jim Morrison

NON-LEGISLATIVE MEMBERS: Darrell Conrade, Dr. Paul Kindling, Dr. Terry "Lee" Mills Jr., Dr. James Rider, 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.

December 2009

Health Care Stabilization Fund Oversight Committee

Annual Report

Conclusions and Recommendations:

The Committee discussed its own role in providing legislative oversight of the Health Care Stabilization 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 2010. 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 2010. The issue will be revisited at the Committee's meeting in 2010.

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. On this topic of communication to the Legislature:

- The Committee recommends that the Committee report be directed to the Insurance, Budget, and Health Standing Committees and to the House Speaker, Senate President, Senate Minority Leader, and House Minority Leader.

The Committee notes that additional explanations before the Committee and information about the Fund history are appreciated and helpful.

Further, after receipt of the annual report by the Health Care Stabilization Board of Governors, its actuary, and conferees present at the November meeting, the Committee makes the following recommendations, as requested by the Fund Board of Governors' staff:

- *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, stated below]

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- *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.

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 the following language to the Legislative Coordinating Council, the Legislature, and the Governor regarding the Health Care Stabilization Fund (HCSF):

- 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."

- Furthermore, this Committee believes the following to be true: All surcharge payments, reimbursements, 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.

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

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the Fund. The reports of the Committee are on file in the Legislative Research Department.

Committee Activities

Report of TowersPerrin

TowersPerrin, the actuary to the Fund, indicated that the review of assets and liabilities required consideration of two scenarios (A and B). It was necessary, the actuary noted, 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 KUMC (University of Kansas Medical Center)/WCGME (Wichita Council for Graduate Medical Education); whereas Scenario B assumes only limited reimbursement. Further, for those discounted estimates, a lower yield was being assumed – the previous year had used 3.5 percent; these 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.

The actuary noted that the Fund 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 TowersPerrin'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. The actuary 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).

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

The actuary 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]. The actuary 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, the actuary 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").

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Comments

In addition to the report from the Board of Governors' actuary, the Committee received an overview of relevant legislation and relevant materials provided by Committee staff. The staff member highlighted the most recent Committee report, including 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. Another topic 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. Additionally, Committee staff made available the Health Care Stabilization Fund FY 2009 and FY 2010 Subcommittee reports for review of the recent budget and subcommittee process and recommendations. Finally, Committee staff noted monitoring of activities in other states, particularly with Joint Underwriting Association (JUA) funds and health care provider surcharges or funds. One state 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.

The Committee then received 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 from the Board of Governors' staff. The Executive Director 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).

The Executive Director 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.)

- 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.

- The preliminary financial report as of June 30, 2009 indicated assets amounting to $219,265,889, and liabilities amounting to $226,173,489.

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The Executive Director 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 have been $2,645,978 ($1,456,465-faculty/$1,189,530-residents). He 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. The Executive Director noted the Attorney General's opinion, indicating that the opinion endorses authority for the allotments. He 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). The Executive Director 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).

Mr. Wheelen was asked to translate this loss in terms of the annual surcharge rates for each provider. He replied that the effect is huge for a large medical center, while there is not much of an impact on a family provider and further stated that the current projection for FY 2011 surcharge is a 12 percent increase.

The Chief Attorney and Deputy Director, Rita Noll, next addressed 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.

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. The representative 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 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 Chief Attorney 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). The Fund was notified of 310 new cases during FY 2009.

Ms. Noll also was asked to comment on the Missouri cases; she indicated 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. Ms. Noll also responded to an inquiry about a health care provider living in Kansas (not licensed to practice in Kansas) and practicing only in Missouri; she responded that the practitioner would be covered under private insurance only.

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. She 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 then 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). She 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 Committee then discussed the allotment and appealing for all or certain portions of the reimbursement moneys (residents, faculty, or both). During this discussion, an inquiry was made about whether faculty members make 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, provided 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. (Cited amounts are those paid for the $800,000 excess coverage.) Jerry Slaughter, Executive Director, Kansas Medical Society (KMS), noted that the faculty members pay the surcharge that is applicable to their specialty.

The Executive Director of the Health Care Stabilization Fund next provided an update on issues from the 2009 Session and any requests or recommendations. Mr. Wheelen provided an update on the Fund's technology improvement plans, noting 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. He also noted the difficulty in obtaining cost estimates 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' compensation and medical professional liability). One of those companies already has 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; the 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

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electronic communication of information, the Executive Director 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.

The Executive Director 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, 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, the Executive Director 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 continued, noting 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 of $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 also reviewed the current marketplace for medical malpractice insurance. A conferee representing KaMMCO 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 down dramatically. The number of claims filed is a major cost driver. In terms of market share, the representative 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. The conferee for the Kansas Medical Society first noted the two statutory questions before the Committee. He 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 TowersPerrin. The conferee then talked about the legal environment in Kansas and the potential impact on medical malpractice coverage in Kansas. He 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]. The KMS official indicated if the cap is not upheld, a legislative remedy would be needed [Constitutional amendment]. He 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. The conferee 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. He noted that the Fund moneys subject to the allotment were not appropriations, but instead, transfers. The conferee stated a concern for any future allotments, given the current legal environment. He indicated that the Kansas Medical Society, along with the Kansas Hospital Association, intended to ask the Legislature to review KSA 75-3722 and the allotment structure. The conferee was asked to respond to the six requests from the Board of Governors. He indicated that KMS generally was supportive of the six requests, but indicated that the resolution of the allotment issue is the responsibility of the provider community.

The Executive Director of the Kansas Association of Osteopathic Medicine (KAOM) next addressed the Committee, stating 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. The conferee 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, it was 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.

Conclusions and Recommendations

The Committee discussed its own role in providing legislative oversight of the Health Care Stabilization 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 2010. 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 2010. The issue will be revisited at the Committee's meeting in 2010.

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. On this topic of communication to the Legislature:

- The Committee recommends that the Committee report be directed to the Insurance, Budget, and Health Standing Committees and to the House Speaker, Senate President, Senate Minority Leader, and House Minority Leader.

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The Committee notes that additional explanations before the Committee and information about the Fund history are appreciated and helpful.

Further, after receipt of the annual report by the Health Care Stabilization Board of Governors, its actuary, and conferees present at the November meeting, the Committee makes the following recommendations, as requested by the Fund Board of Governors' staff:

- *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, stated below]

- *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.

Finally, while the Committee makes no formal recommendation for changes in the statutes governing the work of the Fund Board of Governors, it does recommend continuing the following language to the Legislative Coordinating Council, the Legislature, and the Governor regarding the Health Care Stabilization Fund (HCSF):

- 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."

- Furthermore, this Committee believes the following to be true: All surcharge payments, reimbursements, other receipts made payable to the Health Care Stabilization Fund shall be credited to the Health Care Stabilization

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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.

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REPORT

to the

HEALTH CARE STABILIZATION FUND OVERSIGHT COMMITTEE

On Behalf of the

Health Care Stabilization Fund

Board of Governors

November 23, 2010

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PART I

Introduction

The Health Care Provider Insurance Availability Act was enacted in 1976 in response to a statewide medical professional liability insurance crisis. There were two principal features of the original Availability Act; the creation of the Health Care Stabilization Fund, and the establishment of a joint underwriting authority. There have been numerous amendments to the original Act during its thirty-four year history, but the two fundamental components have remained intact. For a more complete history, please refer to the Appendix.

Principal Features of the Contemporary Act

Health care providers are required to purchase professional liability insurance from commercial companies or from the joint underwriting authority (the Health Care Provider Insurance Availability Plan). The insurance policy must provide minimum 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, or
$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 incorporated by health care providers, (6) limited liability companies formed by health care providers, (7) partnerships consisting of health care providers, (8) not-for-profit corporations incorporated by health care providers, (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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The licensed health care professionals and medical care facilities are required to comply with the Availability Act as a condition of licensure. Because the corporations, limited liability companies, and partnerships formed by health care providers are not licensed, there is no immediate enforcement method. The HCSF Board of Governors must rely upon insurance company representatives to question licensed health care providers in order to ascertain whether they own an interest in one of the defined business entities that is subject to the Availability Act. Then we must review pertinent documents to determine whether the business meets the statutory criteria.

The Commercial Insurance Market

The Availability Act promotes marketing of commercial medical liability insurance in two principal 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 several 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.

During this calendar year we were contacted by two more insurance companies that are interested in selling professional liability insurance to Kansas health care providers. When we are contacted by such companies, we always invite them to our office or to a webinar to explain the Kansas Health Care Provider Insurance Availability Act so they can make a well-informed decision prior to doing business in Kansas.

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 400 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. Examples are residents in training who want to work outside of their training program (moonlighting) and *locum tenens* health care providers who need to purchase short-term insurance coverage that applies only to their temporary Kansas practice.

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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 promotes a favorable insurance market for commercial companies, it also creates a potential liability for the Stabilization Fund. The Availability Plan is unlike the typical joint underwriting authority which assesses the commercial insurers when losses and expenses exceed premium income. Instead, subsection (a) of K.S.A. 40-3413 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. During the most recent ten-year period, the Plan's total income has exceeded total losses by $2,716,212.

Self-Insured Health Care Providers

K.S.A. 40-3414 allows a health care provider that meets certain criteria to make application to the Board of Governors to become an authorized self-insured. The principal criterion is that the health care provider's annual premium for basic coverage must exceed $100,000. There is a provision that allows a health care system that owns two or more medical care facilities to aggregate premium costs to meet the $100,000 requirement. This statute also provides that prior to issuance of a certificate of self-insurance the Board of Governors shall consider: (1) the financial condition of the applicant, (2) the procedures adopted and followed by the applicant to process and handle claims and potential claims, (3) the amount and liquidity of assets reserved for the settlement of claims or potential claims, and (4) any other relevant factors.

Once a health care provider has met the statutory requirements and a certificate of self-insurance has been issued, the certificate is continuous. The self-insured health care provider must, however, resubmit the required information each year for re-evaluation of eligibility. The Board may cancel an organization's certificate of self-insurance for "reasonable grounds," but must provide notice and opportunity for a hearing in accordance with the Kansas Administrative Procedure Act.

There are currently fourteen self-insured medical care facilities in Kansas. They are:

Shawnee Mission Medical Center (1989)
Stormont Vail Healthcare (1989)
Via Christi Regional Medical Center (1995)
Cotton O'Neil Endoscopy (1997)
Stormont Vail Single Day Surgery (1997)
Salina Regional Health Center (2001)
Providence Medical Center (2002)
St. Francis Hospital and Medical Center (2002)
St. John Hospital (2002)
Promise Regional Medical Center (2005)
St. Luke's South Hospital (2005)
Shawnee Mission Surgery Center (2006)
Cushing Memorial Hospital (2007)
Shawnee Mission Prairie Star (2009)

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K.S.A. 40-3414 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. These medical care facilities are not subject to Board review or approval because they are statutorily self-insured. Furthermore, the Statute creates a unique relationship between the HCSF Board of Governors and KU Medical Center.

University of Kansas Medical Center

In 1989 the Legislature decided to self-insure the basic ($200,000/claim) 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. The financial commitment of the faculty foundations was limited not to exceed $500,000 per year.

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 KU Medical Center (both Kansas City and Wichita). This arrangement was effective and successful for twenty years.

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. As a result, it became necessary for the HCSF Board of Governors to write off $2,919,600 as an uncollectible account receivable from the State of Kansas. This was an indirect tax on Kansas health care providers.

Our Chief Attorney has prepared a detailed report describing FY2010 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, 2010. That document is included in Part II of this report.

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2010 Senate Bill 414

Early in the 2010 Session the Kansas Medical Society requested introduction of a bill that made it unlawful for the Secretary of Administration to withhold reimbursements to the HCSF for claims and expenses paid on behalf of the State. Senate Bill 414 was supported by the HCSF Board of Governors, the Kansas Hospital Association, the University of Kansas Physicians, the Kansas Association of Osteopathic Medicine, and the Kansas Chiropractic Association as well as the Medical Society. But because the Governor's recommended budget proposed that the State withhold reimbursements to the HCSF again in FY2011 as well as FY2010, there was a fiscal note attached to SB414 indicating a cost to the State General Fund.

During Senate Committee of the Whole debate, SB414 was amended to create the equivalent of a line of credit whereby the HCSF will continue to pay claims and expenses on behalf of the State, but will not be reimbursed until FY2014. Beginning in July 2013, the accrued amount for claims paid in fiscal years 2010 - 2013 is to be reimbursed in annual installments of twenty percent per year. In addition, the normal reimbursement arrangement will be resumed at that time.

It is noteworthy that SB414 was passed by the Senate 40-0 and was passed by the House 122-0. The bill became law upon publication in the Kansas Register on April 8, 2010.

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 addresses those reporting requirements for the fiscal year that ended June 30, 2010.

1. Net premium surcharge revenue collections amounted to $26,394,273. This was a 6.1 percent increase compared to FY2009.
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 $16,552 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 a Kansas resident neurosurgeon was also licensed to practice in Missouri, the 25% Missouri modification factor would result in a total premium surcharge of $20,690.

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4. There were 32 medical professional liability cases involving 47 Kansas health care providers decided as a result of a jury trial. Of these 32 cases, only seven resulted in verdicts for the plaintiff. One case resulted in a split verdict and three cases ended in mistrial. Only four claims in three cases resulted in Stabilization Fund obligations. Compensation awarded in those three cases resulted in Stabilization Fund obligations amounting to $1,224,821.
5. Fifty four cases involving 61 claims were settled resulting in Health Care Stabilization Fund obligations amounting to $19,745,200. The average Stabilization Fund compensation per claim was $323,692, a 9.9 percent increase compared to FY2009. These amounts are in addition to compensation paid by primary insurers (typically $200,000 per claim, unless the health care provider has become inactive).
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 FY2010. Total claims paid during the fiscal year amounted to $26,174,458. This amount included $600,000 paid to claimants on behalf of insurance companies that tendered their coverage limits to the Fund. Therefore net claims paid from the HCSF during FY2010 amounted to $25,574,458.
7. The financial report as of June 30, 2010 accepted by the Board of Governors indicated assets amounting to $228,573,232 and liabilities amounting to $225,800,123.

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 Part II of this report.

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PART IV

HCSF Technology Improvements

You may recall that in 2008 we hired a consulting firm to conduct a performance audit of HCSF operations. We contracted with a firm that specializes in consulting with insurance companies. The report by Virchow Krause and Company 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.

Following the Virchow Krause report our Board of Governors decided to invest in technology improvements in order to improve our operational efficiency. The first step was to budget our so-called KSIP funding for hardware and software upgrades as well as system design consulting. Then in 2009 our technology improvement plans had to be suspended because our funding for technology and professional development had been frozen by the Budget Director. Eventually that funding was taken from the Health Care Stabilization Fund and $251,834 was transferred to the State General Fund (another indirect tax on Kansas Health Care Providers).

A sympathetic House Budget Committee recommended an appropriation proviso that allowed us to spend $251,834 from our operating expenditures account in FY2010 for technology improvements and related professional development costs. This recommendation was eventually approved by the Legislature and in July 2009 we resumed our technology improvement project. One of the first things we did was seek the advice of consultants with specific experience developing management information systems for professional liability insurers. Based on their estimates, we included $800,000 in our FY2011 budget request for technology improvements and professional development. That request was rejected by the Budget Director and the Legislature.

In the meantime we entered into discussions with a company located in Johnson County that specializes in electronic documents management. We discovered that a number of other state agencies had already installed the software and were generally pleased with the system. The company was in the process of renewing its statewide contract, so we waited until that was accomplished to contract for the system. At about the same time, we hired a full-time Information Technology Officer.

We also entered into a contract with the Information Network of Kansas to host a new website. Our entire staff has devoted itself to developing a new, streamlined website with contemporary features. The new site is at www.hcsf.org. In about two months from now, our new website will provide a link to an electronic compliance form.

The compliance e-form will interact with our database such that if the insurer enters the health care provider's license number, several of the data fields will automatically populate from the existing HCSF data record. Of course certain fields that must be updated will remain blank and the insurance company representative will enter the information. Then when the e-form is submitted to us, it will be temporarily suspended for auditing. If it is complete and accurate and the surcharge payment has been received, we will simply accept the information and update our data record without a printed document or the time consuming task of data entry. This will be particularly helpful in those instances when the health care provider's compliance is time sensitive.

Our new website will also provide a link to the KanPay website which will allow the insurer or agent to submit the health care provider's surcharge payment using a credit card or electronic check. Of course there is a modest portal fee for this convenience. Users will also be able to pay the premium surcharges in a traditional manner.

In order to be prepared for the electronic compliance form, it has been necessary for us to make several improvements to our database. We hired a professional database developer to make the much needed changes and for the first time ever, to document the structure and design of our database.

The new website has been launched and we are currently in the final stages of testing our compliance e-form. We are planning to have the e-form available to begin calendar year 2011. If these new, electronic methods function as well as we expect them to, it may become unnecessary to purchase a complete, new management information system. While we may be able to avoid the expense of a new MIS, it will be necessary to afford continuous maintenance of our hardware, operating systems, and software. Funding for systems maintenance was approved in our FY2011 budget and has been requested again in our FY2012 budget.

Conclusion

Currently, HCSF assets exceed HCSF liabilities, but only marginally. While it appears that the Health Care Stabilization Fund is actuarially sound at this time, our financial integrity could change dramatically, depending on the Supreme Court decision in the case of Miller v. Johnson. If the Court's decision is to uphold the constitutionality of statutory limits on non-economic damages in personal injury actions, our financial condition will remain stable. If not, our currently assigned reserves will immediately become inadequate and our estimated liabilities will increase substantially. This means our assets will be insufficient and it will become necessary to increase premium surcharge rates. Our Board of Governors is anxiously waiting for the Court's decision.

Health Care Stabilization Fund

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Medical Professional Liability Experience
Fiscal Year 2010

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 2010. 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 2010 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 2010 covers the period of time from July 1, 2009 through June 30, 2010.

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.

HEALTH CARE STABILIZATION FUND OVERSIGHT COMMITTEE
November 23, 2010
Attachment 9

MEDICAL PROFESSIONAL LIABILITY EXPERIENCE

A. Jury Verdicts

From HCSF data, 32 medical malpractice cases involving 47 Kansas health care providers were tried to juries during fiscal year 2010. Of these, 27 cases were tried to juries in Kansas courts, four cases involving Kansas health care providers were tried to juries in Missouri, and one case involving a Kansas health care provider was tried in Nebraska. These jury trials were held in the following jurisdictions:

Johnson County	8
Wyandotte County	5
Sedgwick County	4
Jackson County, MO	3
U.S. District Court	2
Atchison County	1
Cowley County	1
Crawford County	1
Leavenworth County	1
Neosho County	1
Riley County	1
Saline County	1
Sherman County	1
Clay County, MO	1
Gage County, NE	1

Of the 32 cases tried, 21 resulted in complete defense verdicts. Plaintiffs won verdicts in seven cases. One case resulted in a "split" verdict, and three cases ended in mistrial. Juries returned verdicts for plaintiffs and awarded damages for the following claims:

Case	Court	Verdict Amount*	HCSF Amount*
Plaintiff v. Doctor	Johnson County	$87,500.00	
Plaintiff v. Doctor	Sedgwick County	$2,384,288.26	$800,000.00
Plaintiff v. Hospital	Sedgwick County	$437,293.00	$237,293.00
Plaintiff v. Doctor	Johnson County	$90,000.00	
Plaintiff v. Doctor	Wyandotte County	$334,041.85	$134,041.85
Plaintiff v. Doctor	Wyandotte County	$253,486.25	$53,486.25
Plaintiff v. Doctor	Crawford County	$23,375.00	
		$23,077.02 settled	
Plaintiff v. Doctor	Neosho County	$31,410.18**	
Plaintiff v. Doctor	Johnson County	$178,860.90	

*Note: Cases may be on appeal. ** New trial granted.

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

	FY10	FY09	FY08	FY07	FY06	FY05	FY04	FY03	FY02
Total	32	27	34	36	29	34	28	27	19
Defense Verdict	21	20	25	31	23	22	23	23	10
Plaintiff Verdict	7	5	4	5	6	7	3	3	6
Split Verdict	1	1	1			3	2		2
Mistrial	3	1	4			2		1	1

B. Settlements

Claims settled by the Fund. During FY 2010, 61 claims in 54 cases were settled involving HCSF monies. Settlement amounts incurred by the HCSF for the fiscal year totaled $19,745,200. This compares to last year's total of $23,867,283.72 to settle 81 claims in 72 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 2010 claims is $323,692. This amount compares to last year's average of $294,658.

Fiscal Year	Number of Claims/Cases	Fund Amount	Settlement Average
FY 2010	61/54	$19,745,200.00	$323,692
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 2010 ranged from a low of $10,000 to a high of $800,000. HCSF settlements fall within the following ranges and are compared to individual claim settlements in previous years:

	FY10	FY09	FY08	FY07	FY06	FY05	FY04	FY03	FY02
$000-$9,999	0	2	0	0	0	0	0	3	2
$10,000-$49,999	5	12	6	6	9	5	13	11	7
$50,000-$99,999	11	10	12	7	12	13	18	18	7
$100,000-$499,999	29	37	34	27	51	58	37	44	40
$500,000-$800,000	16	20	13	21	17	14	11	11	11
Total Claims	61	81	65	61	89	90	79	87	67

Of the 61 claims involving Fund monies, the Fund provided primary coverage for inactive health care providers in 12 claims. Also, the Fund "dropped down" to provide first dollar coverage for two claims in which aggregate primary policy limits were reached. Primary insurance carriers tendered their policy limits to the Fund in 47 claims. Therefore, in addition to the $19,745,200 incurred by the Fund, primary insurance carriers contributed $9,400,000 to the settlement of these claims. Further, seven claims involved contribution from a health care provider or an insurer whose coverage was excess of Fund coverage. The total amount of these contributions was $14,972,500.

Total settlement amounts for claims involving Fund contribution for the last sixteen fiscal years are as follows:

Fiscal Year	Primary Carriers	HCSF	Excess Carriers
FY 10	$ 9,400,000.00	$19,745,200.00	$14,972,500.00
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 110 claims in 92 cases. The total amount of these reported settlements is $8,958,622.00. These figures compare to previous fiscal years as follows:

Fiscal Year	Settlement Reported Claims/Cases	Amount Paid by Primary Insurance Carriers
2010	110/92	$ 8,958,622.00
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

C. HCSF Total Settlements and Verdict Amounts

During fiscal year 2010 the HCSF incurred $19,745,200 in 61 claim settlements and became liable for $1,224,821 as a result of four jury verdicts for a total 65 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 2010	65	$20,970,021.10	$322,615.71
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 290 cases during fiscal year 2010. The following chart lists the number of new cases opened in each fiscal year.

FY	Number of Cases
2010	290
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

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 2010	FY 2009	FY 2008	
$ 625,000.00	$1,800,000.00	$435,000.00	Settlement Amounts
$ 820,658.21	$ 893,099.94	$531,327.58	Attorney Fees and Expenses
$1,445,658.21	$2,693,099.94	$966,327.58	Totals

Reimbursable Amounts

FY 2010	FY 2009	FY 2008	
$ 500,000.00	$ 502,375.42	$497,623.96	Reimbursement - Private Practice Reserve Fund
**$ 945,658.21	*$2,190,724.52	$468,703.62	Reimbursement - State General Fund
$1,445,658.21	$2,693,099.94	$966,327.58	Totals

*Amount not reimbursed FY 2009
**Amount not reimbursed FY 2010

II. KU and WCGME Residents

Residents Self-Insurance Program Costs

FY 2010	FY 2009	FY 2008	
0	0	$200,000.00	Settlements, WCGME Residents
$ 202,500.00	$200,000.00	0	Settlements, KU Residents
$ 481,927.32	$201,523.03	$301,775.96	Fees & Expenses, WCGME Residents
$ 517,290.69	$410,969.63	$146,493.84	Fees & Expenses, KU Residents
$1,201,718.01	$812,492.66	$648,269.80	Totals

Reimbursable Amounts

FY 2010	FY 2009	FY 2008	
$ 481,927.32	$201,523.03	$501,775.96	WCGME Reimbursement - State General Fund
$ 719,790.69	$610,969.63	$146,493.84	KU Reimbursement - State General Fund
***$1,201,718.01	$812,492.66	$648,269.80	Totals - State General Fund
	*$ 83,616.87		*Amount reimbursed FY 2009
	**$728,875.79		**Amount not reimbursed FY 2009

***No amounts reimbursed FY 2010

III. Expenditures by Fiscal Year

Fiscal Year	Foundations and Faculty*	KU and WCGME Residents**
2010	$1,445,658.21	$1,201,718.01
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 and FY 10 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. FY 10 HCSF received no reimbursement.

Amounts to be received from the State General Fund are carried forward as receiveables.

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

	FY 10	FY 09	FY 08	FY 07	FY 06
WCGME Residents	0	0	$ 78,000	$1,600,000	0
K.U. Residents	0	$ 800,000	0	0	0
Faculty, Foundations	$970,000	$3,262,500	$135,000	$1,475,000	0
Total	$970,000	$4,062,500	$213,000	$3,075,000	0

PART III

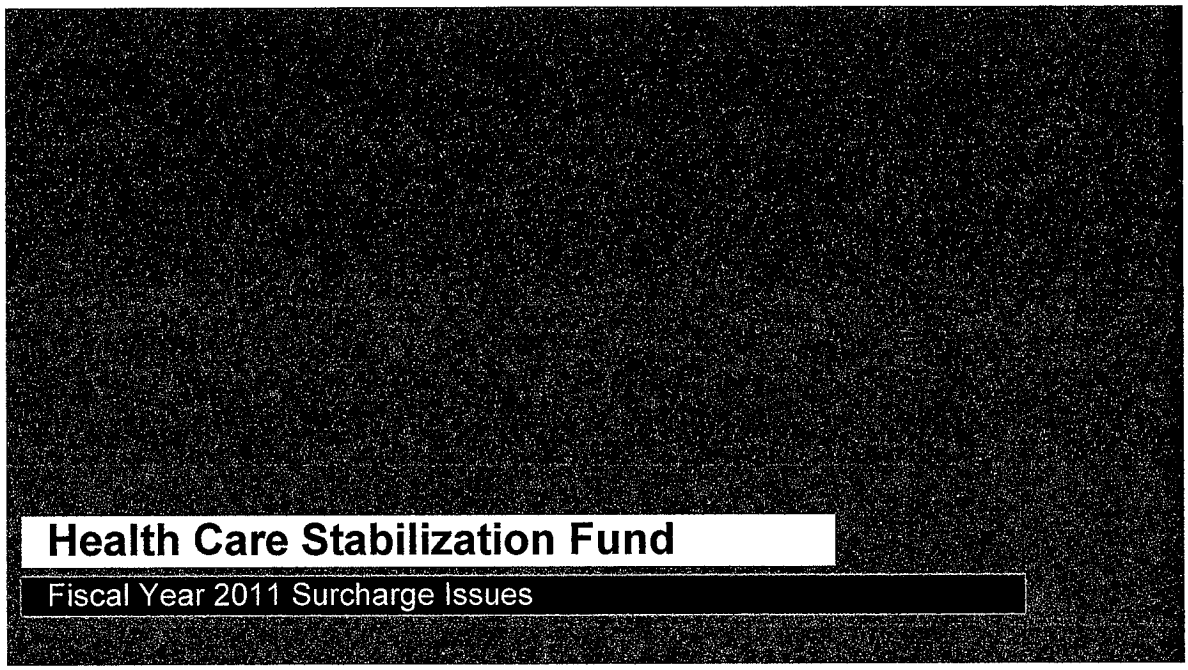
Premium Surcharges

The HCSF Board of Governors has numerous statutory duties and responsibilities. The most important responsibility is delegated in K.S.A. 40-3404(a). 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 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, the economic recession resulting in substantially lower interest rates has already reduced the future return on investments when those investments mature. 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, we would immediately reexamine all open cases to determine whether sufficient reserves have been assigned to them. In addition, estimated liabilities would suddenly increase by a significant amount.

You may recall that the Board of Governors decided to increase the FY2010 HCSF premium surcharge rates for the majority of health care providers who practice in Kansas. The revenue goal was achieved and the Fund's financial position improved somewhat. This year the Board decided it was unnecessary to adjust surcharge rates for fiscal year 2011. In large part, this was because of passage of SB414 and the expectation that eventually the State will reimburse the HCSF for self insurance of the KU Medical Center physician faculty and residents.

These decisions are guided by periodic actuarial analysis of the Fund's estimated 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." The Fund's Actuary, Russel L. Sutter of Towers Watson has prepared the following update for the Oversight Committee.



Health Care Stabilization Fund

Fiscal Year 2011 Surcharge Issues

A presentation to the HealthCare Stabilization Fund Oversight Committee
by Russel L. Sutter

November 23, 2010

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 WATSON

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Table of Contents

- This presentation will address the following topics:
  - Our projections of unassigned reserves at June 2010 and June 2011
  - 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 report dated April 16, 2010. 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, 2010 and June 30, 2011 were as follows (in $millions)

Category	June 30, 2010		June 30, 2011	
	Undiscounted	Discounted	Undiscounted	Discounted
Assets	$ 223.1	$ 223.1	$ 228.1	$ 228.1
Liabilities	209.0	184.0	215.4	189.7
Unassigned Reserves	$ 14.0	$ 39.1	$ 12.7	$ 38.4

- The forecasts were based on a review of Fund loss data as of December 31, 2009. The liabilities exclude amounts other than losses and loss expenses.

Conclusions – Continued

- The undiscounted liabilities at 6/30/10 are approximately $8.7 million lower than anticipated in our 2009 study
- The estimates above assume
  - No change in surcharge rates for FY2011
  - A 2.0% rate for the discounted liabilities
  - Full reimbursement for KU/WCGME claims for FY2010 through FY2013, but delayed until FY2014
- We suggested that the Board consider modest changes by class, perhaps with no longer using uniform percentages for classes 15-21. We also suggested leaving surcharge rates unchanged
- The Board of Governors did not change surcharge rates for FY2011

Liabilities at June 30, 2010

- The split of the Fund's estimated liabilities for unpaid losses and loss expenses at June 30, 2010 is as follows (in $millions)

	Undiscounted	Present Value at 2.0%
Active Providers – Losses	$ 94.6	$ 90.8
Active Providers – Expenses	14.3	13.6
Inactive Providers – Known at 6/30/10	10.0	9.8
Inactive Providers – Tail	79.6	60.3
Future Payments	12.9	12.3
Claims Handling	6.1	5.1
Other	3.6	3.6
Subtotal – Gross Liabilities	221.1	195.5
Reimbursements	-12.1	-11.5
Total Net Liabilities	$209.0	$184.0

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Changes from Prior Forecasts

- The table below shows how our forecasts changed from the 2009 study. All amounts are in $millions

Category	Fiscal Years	2009 Estimate	Current Forecast	Change in Estimates
Active Provider Losses	1977-2010	$600.5	$584.1	-$16.4
Active Provider Expenses	1982-2010	73.5	74.0	+0.5
Inactive Provider Claims	1982-2010	57.1	57.3	+0.2
Inactive Providers – Tail	2011-2047	54.8	53.4	-1.4
Reimbursable Claims	1985-2010	58.5	60.3	+1.8

Observations

- Factors influencing the changes noted on the prior page for active provider losses include the following
  - Settlements were lower than expected during CY2009
    - — Expected $26.0 million; actual were $19.3 million
  - Loss reserves on open claims dropped during CY2009 from $53.3 million to $45.6 million
  - The number of open claims dropped from 239 to 208
  - The net increase in claims (settled plus change in open) was +17, well below Fund average of 65-70 for FY2004-2008.
  - As a result, our forecast of the prospective year's losses are $28.5 million, the first sub-$30 million forecast in several years

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Miscellaneous Observations

- Since 1999, the Fund's surcharge revenue has ranged from 23% of basic coverage premium (2005) to 33% of premium (2001). The FY2009 ratio was 32.5%, up from 29.1% in FY2008, and the 4th consecutive year with an increase
- Availability Plan insureds increased from 251 in FY2001 to 674 in FY2006, but have dropped since then. In FY2009, there were 532 Plan insureds
- The average yield-to-maturity on the Fund's investments at December 2009 was surprisingly high (4.67%), given market rates at that time

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Findings – Indications by Provider Class

- Our analysis of experience by Fund class continued 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 FY10.

Relative Rate Change Indicated		
Decrease > 12%	Increase < 12% or Decrease < 12%	Increase > 12%
Class 16 (-32%)	Class 10 (-12%)	Class 20
Class 9	Class 19	Class 3
Class 1	Class 2	Class 11
Class 6	Class 5	Class 15 (+68%)
Class 14	Class 17	
Class 18	Class 8	
Class 12	Class 4 (+10%)	
Class 7		
Class 13		

- Page 11 has further details on class experience 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%
2011	0%	0%	0%	40%

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

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Class Definitions, Distributions and Rates

		FY09 # Providers	FY11 Rate*
Class 1	Physicians, No Surgery. Includes dermatology, pathology, psychiatry	584	$1,045
Class 2	Physicians, No Surgery	2,559	1,882
Class 3	Physicians, Minor Surgery	1,292	2,462
Class 4	Family Practitioners, including minor surgery and OB	181	2,754
Class 5	Surgery Specialty – Includes urology, colon/rectal, GP with major	256	3,170
Class 6	Surgery Specialty – Includes ER (no major), ENT	44	3,886
Class 7	Anesthesiology	319	5,245
Class 8	Surgery Specialty – Includes general, plastic, ER with major	316	7,459
Class 9	Surgery Specialty – Includes cardiovascular, orthopedic, traumatic	297	7,464
Class 10	Surgery Specialty – Includes OB/GYN	284	10,976
Class 11	Surgery Specialty – Neurosurgery	48	16,552
Class 12	Chiropractors	908	562
Class 13	Registered Nurse Anesthetists	602	1,081
Class 14	Podiatrists	98	2,546
Class 15	Availability Plan insureds	532	40%
Class 16	Professional corporations, partnerships	1,063	40%
Class 17	Medical care facilities	195	40%
Class 18	Mental health centers	24	40%
Class 19	Psychiatric hospitals	0	40%
Class 20	Residency training program	669	40%
Class 21	Other	0	40%
		10,620	

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

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Health Reform - *What Does it Mean for Hospitals?*

Health Care Stabilization Fund Oversight Committee

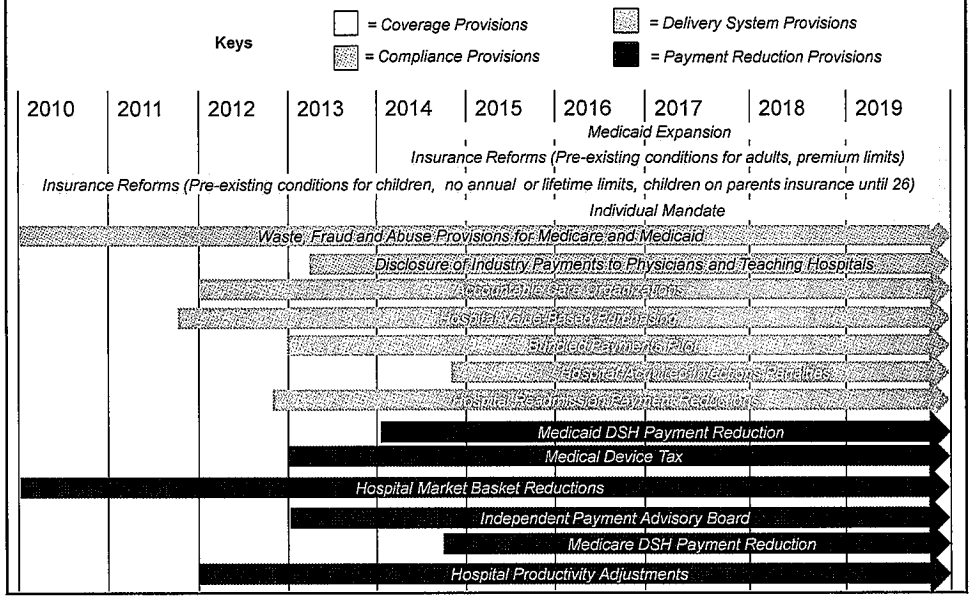
November 23, 2010

Presented by Tom Bell

9 General Categories

- Health insurance
- Medicare/CHIP expansion
- Delivery system and reforms
- Medicare/Medicaid payment changes
- Quality
- Workforce/ Graduate Medical Education
- Reporting information
- Prevention and wellness
- Program integrity and oversight

Health Reform Implementation Timeline



Direction for Payment and Delivery System Reform

Current Fee-For Service Payment Systems	Previously Recommended Tools	New System Changes
• Ambulatory surgical centers • Clinical laboratory • Durable medical equipment • Home health care • Hospice • Hospital acute inpatient • Inpatient rehabilitation facility • Long-term care hospital • Outpatient dialysis • Outpatient hospital • Physician • Psychiatric hospital • Skilled nursing facility	• Using comparative-effectiveness information • Linking payment to quality • Reporting resource use • Bundling individual services within a payment system (e.g., dialysis) • Creating pressure for efficiency through updates	• Medical home • Payments "bundled" across existing payment systems (e.g., hospital and physician around hospitalization) • Accountable care organization (e.g., physician group practice demo)

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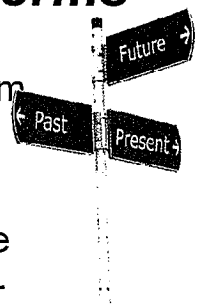
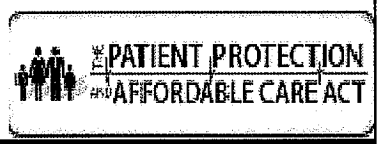
Key Implementation Areas

Delivery System Reforms



- Integrated care models of delivery system reform (ACOs, bundling, medical home, CMS Center for Innovation)
- Major hospital payment changes (update reductions, VBP, readmissions, hospital-acquired conditions (HACs), variation)
- National Quality Strategy
- Reducing health disparities



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Health Reform Implications for Hospitals

Accountable Care Organizations

- Voluntary national pilot program beginning in 2012
- Groups of providers and hospital can take the lead
- All in the ACO would share in the Medicare cost savings they achieve
- Secretary would reset spending benchmarks every three years

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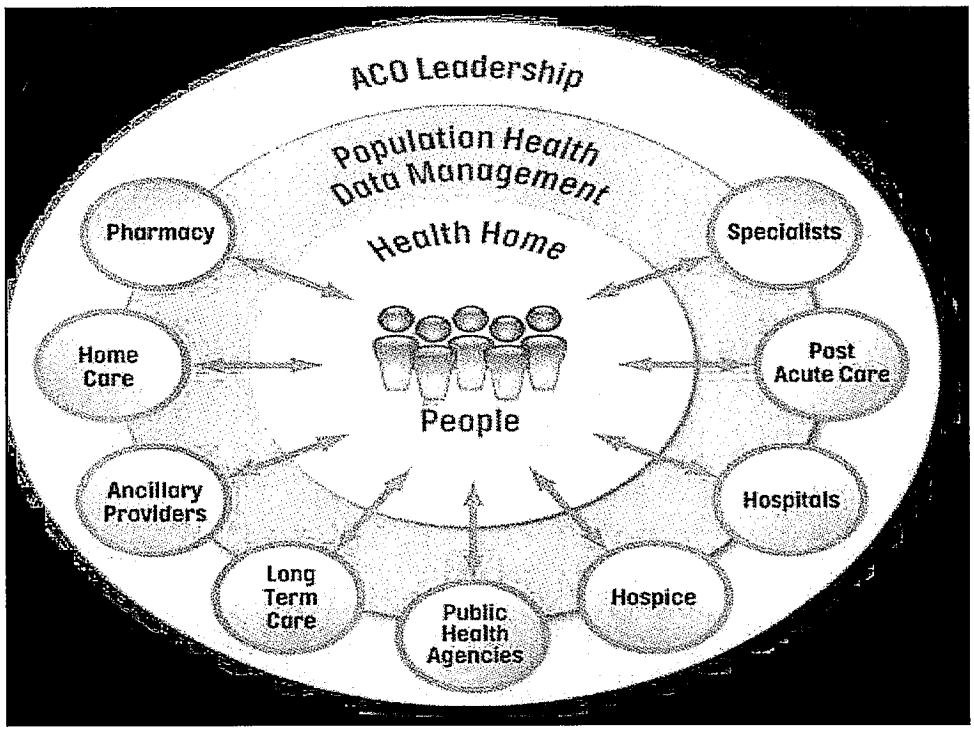

Health Reform
Payment Bundling

- Five year national pilot program beginning in 2013
- Participation voluntary
- All Acute and non-acute services from 3 days prior to admission to 30 days post discharge for 8 conditions
- Composed of hospitals, physician groups, SNFs, and HHAs

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Health Reform

Value Based Purchasing

- Beginning in FY 2013 would establish a "budget neutral" program for all PPS hospitals
- Establishes a demonstration program for CAHs
- Up to 2 percent of Medicare IP payments would be reallocated based on quality performance
- Efficiency measures to be added
- Prohibits use of readmissions measures

Health Reform

Hospital-Acquired Conditions

- Hospitals in the top 25th percentile of rates of hospital-acquired conditions receive a 1% reduction in payment the hospital would have otherwise received, starting in 2015.

- The law also provides that a report on hospital-acquired conditions will be provided to hospitals and will be made available to the public.

Health Reform
Coverage Expansion

Over 10 years will expand coverage to 34 million – 95% of all Americans

- State-based health insurance Exchanges
- Non-profit health insurance co-ops
- Medicaid expansion
  - 133% FPL beginning 2014
- Subsidies for families up to 400% FPL
- Employer and individual mandates

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Health Reform
Coverage Expansion

What it means in Kansas

- Current estimates of 335,000 uninsured
- 190,000 (57%) will gain coverage
  - Of which 131,000 will be Medicaid
- 143,000 (5% of population) will opt out or be non-US citizens

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Regulatory Environment

- Coding Adjustment
- Low-Cost County Adjustment
- Low-Volume Hospital Adjustment
- Modifications to the 3-Day Payment Window
- Extension of MDH for 1
- Paying CAHs 101% under Method 2
- Transfer policy
- Payment of CRNA services
- Provider taxes as allowable costs
- Physician Supervision
- Quality Reporting
- Changes to Partial Hospitalization

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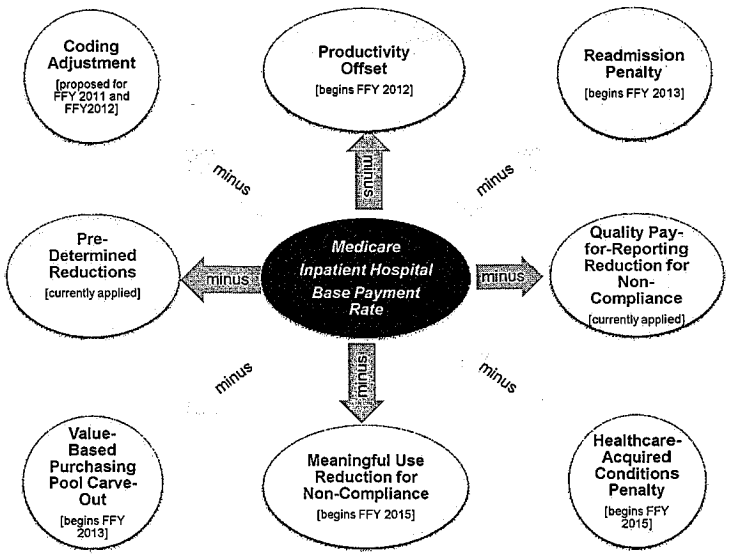
Medicare Hospital Base Payment Rate



Strategic Issues for Hospital Leaders

Success in the post-reform era will require work on many strategies simultaneously –

- Enhance efforts to improve quality and patient safety to reduce variation in care
- Increase clinical and operational efficiencies
- Increase efforts to improve patient satisfaction
- Develop new organization competencies for clinical integration and foster better alignment with physicians

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Strategic Issues for Hospital Leaders

- Develop strategies to reduce avoidable readmissions
- Identify community partners and conduct community needs assessment
- Assess and strengthen your plan for health information technology and EHR
- Examine readiness for episodic payment, care redesign across the continuum

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A Sea of Change in Health Care

- **Coordination and Collaboration** – Overcome fragmentation so that care across the continuum is convenient and coordinated for people
- **Data Collection and Use** – Need consistent data across care settings to measure progress when no such information exists today
- **Measure Value** – Better savings, quality improvements and increased satisfaction
- **Population Health Focus** – Reward wellness rather than services provided
- **Time** – Long-term commitment, so efforts toward transformation need to start now
- **Shared Savings** – Aligning reimbursement so providers can capture income based on savings delivered

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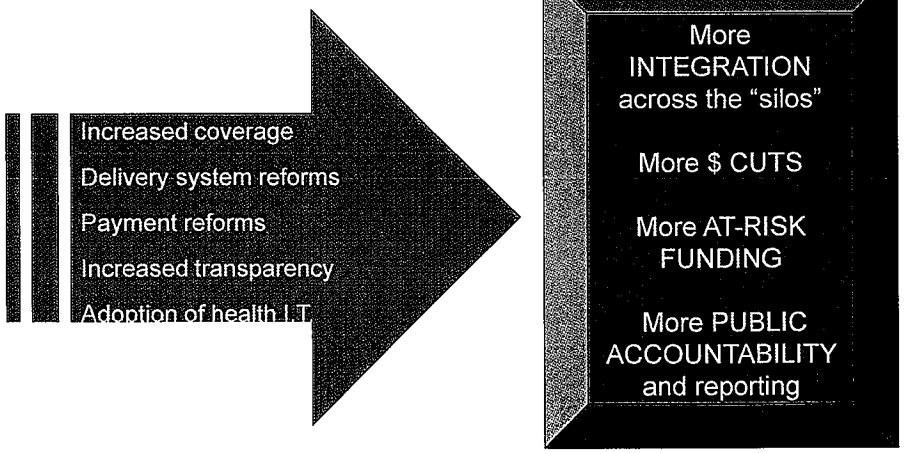

KANSAS MEDICAL SOCIETY
Established 1859

To: HCSF Oversight Committee

From: Jerry Slaughter
Executive Director

Date: November 23, 2010

Subject: Impact of federal health reform on physicians

We were asked to briefly summarize the impact of the recently-enacted health reform legislation on physician practices. As you know, the health reforms passed earlier this year consisted of two principal elements: the "Patient Protection and Affordable Care Act" (H.R. 3590), and the "Health Care Education Affordability Reconciliation Act" (H.R. 4872). Both of these companion bills are now collectively referred to as the "Affordable Care Act" or the "ACA."

It is worth noting that even though this legislation has been signed into law, the health reform debate and process is far from over. In many respects, it has just begun. We don't yet know how the litigation over the individual mandate to purchase insurance will turn out. And, after the recent elections, it is expected that the new congress will attempt to repeal, or failing that, modify certain aspects of the legislation. While outright repeal is probably not possible, it is almost certain that congress will begin a process of amending the legislation that will most likely never end. One thing is almost certain: the improbable projections that health spending will be significantly slowed by the legislation will no doubt prove to be an illusion. That reality alone will require congress in coming years to consider greater controls on services, prices, and inputs to the system.

While much of the attention up to now has been focused on the higher profile parts of the ACA, including the individual mandate and the various insurance reforms, attention will now begin to turn to the less well known provisions that for most health care providers really represents the essence of the reform package. I would like to emphasize that the following list is by no means exhaustive of the provisions in the reform legislation, but just a sampling of those elements that will affect physicians.

Before summarizing those provisions, it should be mentioned that the sheer number of new entities created by the ACA, their immense reach, and the broad powers delegated to the Secretary of HHS to establish a regulatory framework around them, makes any definitive assessment of the full impact of this legislation nearly impossible at this juncture. Many of the details concerning implementation of the ACA will not be known until federal agencies and state agencies issue guidelines on the new law and implementation begins in earnest.

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Additionally, the number of newly-insured individuals as a result of the combination of Medicaid expansions and growth in the number of privately insured individuals will likely exceed 200,000 Kansans by 2014. It will undoubtedly be very challenging for the existing health workforce to absorb that kind of growth without some difficulty along the way. This enhanced demand to care for more patients, with higher quality, less cost, increased reporting, accountability and tracking demands will put more stress on physicians, particularly those in private practices.

Having said all that, the following are some of the more obvious elements of the reform legislation that will have an impact on physician practices:

Quality and Accountability Provisions
HHS Secretary to establish and update annually a national strategy for quality improvement to improve the delivery of health care services, patient health outcomes, and population health

Comparative Effectiveness Research: creates Patient-Centered Outcomes Research Institute to identify research priorities and establish and research project agenda

Continues voluntary Medicare quality reporting payment incentives (Physician Quality Reporting System (PQRS); and beginning 2015 implements financial penalties for not reporting.

HHS initiatives on care coordination, chronic disease management, medication and care compliance initiatives; non-payment for preventable hospital readmissions and healthcare acquired conditions, appropriate use of best clinical practices, evidence-based medicine, and health information technology

Reforms will dramatically increase compliance obligations and potential liability under federal fraud and abuse statutes; more emphasis and funding for enforcement, more whistleblowers, and the suspension of the government's need to prove "intent" will exacerbate compliance issues for physicians.

Medicare Physician Payment
A major disappointment for physicians was that the ACA did not address the deeply flawed formula called the Sustainable Growth Rate (SGR), which determines how Medicare will pay for physician services. It remains unsettled, and congress must repeatedly act to avert planned cuts that the SGR calculation produces on an annual basis. Other provisions that addressed physician Medicare and Medicaid payments:

Primary Care Bonus – physicians in family medicine, internal medicine, geriatrics and pediatrics whose Medicare charges for certain primary care services will be eligible for a temporary 10% bonus payment for those services from 2011-2015

Medicaid Primary Care Payment Parity with Medicare - temporarily requires that Medicaid payment rates to primary care physicians for certain primary care services be no less than 100 percent of Medicare payment rates in 2013 and 2014

Innovative Practice Models and the Patient Centered Medical Home – promotion of practice models that could enhance payment for primary care through a Center for Medicare and Medicaid Innovation within CMS; also promotes the patient-centered medical home

Rural General Surgery Bonus – general surgeons who perform major surgical procedures in designated rural areas will be eligible for a temporary 10% bonus payment for those services from 2011-2015

Geographic Payment Differentials – extends the "floor" on Medicare's geographic payment adjustment for physician practice expenses component in rural areas

Graduate Medical Education
Provides grants and Graduate Medical Education funding for Teaching Health Centers to train primary care physicians in community based settings, beginning in 2010.

National Health Care Workforce Commission
Establishes a National Health Care Workforce Commission, to provide recommendations to Congress and Administration on national health workforce priorities, goals, and policies. Included is a mandate to make recommendations for eliminating the barriers to entering and staying in primary care, including provider compensation.

Administrative Simplification
National rules will be developed and implemented between 2013 and 2016 to standardize and streamline health insurance claims processing requirements, making it easier to track claims and hopefully improve provider revenue cycles

Alternative Delivery Models
The legislation promotes the development of Accountable Care Organizations (ACO), which will incentivize hospitals, doctors, and other providers to achieve savings for the Medicare program through bundled payment models. This will likely drive physicians to consolidate with other practices, become hospital employees, or align with hospitals and health systems for capital, administrative, and technical resources. Many observers are predicting that the ACA is the beginning of the end of private, independent physician practices in many areas of the country.

Independent Payment Advisory Board (IPAB)
Establishes IPAB which must submit recommendations to Congress, beginning in 2014, to reduce the growth of Medicare expenditures while maintaining or improving the quality of care delivered. The Secretary of HHS would be required to implement these recommendations unless Congress passed an alternative proposal that provided an equivalent amount of budgetary savings. If the bill's anticipated savings do not

materialize, there could be immense pressure to use the IPAB as a tool to enforce difficult spending and benefits decisions outside of the legislative process.

Health Insurance Exchanges

Because they will be the portal through which virtually all private insurance is accessed, the control and operation of the health exchanges mandated by the law presents a great deal of uncertainty about how providers will participate and be compensated under those arrangements. If states do not choose to operate the exchanges, the process defaults to federal control and operation, which would probably be viewed by most providers as much less desirable than a locally controlled exchange.