Kansas Health Care Stabilization Fund

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FY2012 STATUTORY ANNUAL REPORT
Prepared by C. Wheelen, Executive Director
Adopted by the Board of Governors October 11, 2012

The following information is reported on behalf of the Health Care Stabilization Fund Board of Governors in accordance with K.S.A. 40-3403(b)(1)(C). This report is for the fiscal year that ended June 30, 2012.

1. Net premium surcharge revenue collections amounted to $29,145,143.

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 with $300,000 annual aggregate).

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 with $2.4 million annual aggregate). 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.

4. There were 21 medical professional liability cases involving 28 health care providers decided as a result of a jury trial. Of these 21 cases, only one resulted in a verdict for the plaintiff, and one case resulted in a mistrial. Compensation awarded in the one verdict for the plaintiff did not result in a Health Care Stabilization Fund payment obligation.

5. Sixty two cases involving 67 claims were settled, which resulted in Health Care Stabilization Fund obligations amounting to $21,431,000. The average Stabilization Fund compensation per claim was $319,866, an 11.4% increase compared to FY2011. 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 periodic payment of compensation and other cash-flow characteristics, the amounts reported above in items four and five were not necessarily paid during FY2012. Total claims paid during the fiscal year amounted to $21,910,074. This was a 14.1% increase compared to the prior fiscal year. There was also a similar increase in expenditures for attorney fees and other costs attributable to claims activity.

7. The balance sheet as of June 30, 2012 accepted by the Board of Governors indicated assets amounting to $258,803,104 and liabilities amounting to $221,335,885.

Part IV

History of the Health Care Provider Insurance Availability Act

The 1976 Legislature passed the original version of the Health Care Provider Insurance Availability Act at a time in Kansas history when many physicians and other health care providers could not purchase affordable professional liability insurance. The Act contained three principal features that have always remained intact. Those features are: (1) a requirement that all health care providers, as defined in K.S.A. 40-3401, maintain professional liability insurance coverage as a condition of licensure, (2) creation of a joint underwriting association, the "Health Care Provider Insurance Availability Plan," to provide professional liability coverage for those health care providers who cannot purchase coverage in the commercial insurance market, and (3) creation of the Health Care Stabilization Fund to (a) provide supplemental coverage above the primary coverage purchased by health care providers and (b) to serve as the reinsurer of the Availability Plan. Responsibility for premium surcharge collections and administering the Stabilization Fund was delegated to the Insurance Commissioner.

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

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

During the second half of the eighties decade there was significant pressure on the Legislature to reform the rules of civil litigation. The controversy surrounding tort reform focused a great deal of attention on the HCSF because there were those who blamed the Fund for the cost of medical liability coverage.

Principal Features of the Contemporary Act

Some of the major provisions of the Health Care Provider Insurance Availability Act were initiated by a 1988 interim study by a special committee of the Legislature. The interim committee report was published in the January 18, 1989 Journal of the House and concluded by saying, "The Committee agreed with the near unanimous position of the conferees that the Health Care Stabilization Fund should be phased out and recommends that the 1989 Legislature enact legislation to abolish the Fund." The interim committee expressed concerns regarding whether there were sufficient reserves in the Fund to afford the accrued liabilities and recommended that, "the providers develop a plan by January 1, 1990, for paying the unfunded liabilities of the Fund and submit that plan to the Insurance Commissioner for his approval."

The 1989 Legislature passed Senate Bill 18 which amended several features of the Availability Act. A major change in the Act created three different options allowing health care providers to choose one of three levels of HCSF coverage to supplement the basic $200,000 per claim coverage they are required to purchase from a commercial insurer or the Availability Plan. The three options are $100,000 per claim, $300,000 per claim, or $800,000 per claim. Annual aggregate limits are three times the per claim coverage.

Another significant change pertained to prior acts "tail" coverage. Until 1989, tail coverage was provided when a health care provider became inactive. In other words, statutory HCSF coverage was somewhat like an occurrence type insurance policy. Because of concerns about the additional Fund liabilities attributable to tail coverage, the Legislature imposed a new requirement that health care providers must be in compliance, that is, pay surcharges into the Fund for at least five years in order to receive prior acts coverage. Provision was made such that any health care provider who lacked five years compliance could make additional payment to the Fund for the tail coverage. The payment had to be "sufficient to fund anticipated claims based upon reasonably prudent actuarial principles."

Senate Bill 18 also created a new eleven member Health Care Stabilization Fund Oversight Committee with a very specific duty. The new law required the Oversight Committee to meet and make a report to the Legislative Coordinating Council on or before September 1, 1990 and "include recommendations to the legislature for commencing the phase-out of the fund on July 1, 1991." It was the consensus of the 1989 Legislature that the HCSF should be abolished, but the Legislature was uncertain how to accomplish that task.

The original version of SB18 was amended such that full-time physician faculty members and their foundations at the University of Kansas Medical Center "shall be deemed a self-insurer for the purposes of the health care provider insurance availability act." The Availability Act was further amended to delegate responsibility for administration of claims against physician faculty members to the Insurance Commissioner and provisions were made for reimbursement from the state general fund as well as a new "private practice foundation reserve fund." The new fund was to receive $500,000 per year from the private practice corporations at K.U. Medical Center.

The filing of new cases began to level off during the early nineties and Fund assets gradually increased. By 1992 the Fund was considered actuarially sound, and premium surcharges were reduced accordingly. By this time, interest in phasing out the HCSF had waned. Instead, the 1994 Legislature decided to delegate responsibility for administration of the Fund to a Board of Governors appointed by the Insurance Commissioner.

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

FOR IMMEDIATE RELEASE: October 5, 2012

For more information
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A five-member majority of the Kansas Supreme Court today upheld the constitutionality of a Kansas statute limiting a medical malpractice plaintiff's jury award for non-economic damages to $250,000. The Kansas legislature enacted the damages limitation in 1988 as part of an effort to restrict personal injury lawsuits based on a belief that a statutory cap would reduce medical malpractice insurance rates and make insurance more readily available to physicians and others in the state. Two justices dissented from the majority decision.

The medical malpractice plaintiff, Amy C. Miller, sued Dr. Carolyn N. Johnson in Douglas County District Court for mistakenly removing her left ovary during a surgery intended to take the right ovary. The jury found the doctor at fault and awarded Miller $759,679.74 in damages. But $575,000 of that award was for noneconomic loss subject to the $250,000 limit, so the trial judge lowered the judgment to comply with the statute. Non-economic loss typically includes pain and suffering, mental anguish, injury and disfigurement not affecting earning capacity. Miller appealed and challenged the statute's constitutionality, as well as the judge's post-trial ruling that reduced her claim for future medical expenses. Dr. Johnson also appealed, claiming Miller failed to prove malpractice caused her injuries and that the trial judge improperly restricted expert witness testimony.

In the court's majority decision, Justice Dan Biles acknowledged that the constitutionality of statutory caps on jury awards was "a long-standing and highly polarizing question nationwide." He noted two other Kansas Supreme Court decisions had reached contradictory results on the subject in 1988 and 1990. But in the decision filed today, the majority held that K.S.A. 60-19a02 did not violate a medical malpractice plaintiff's right to a jury trial, right to remedy by due course of law, right to equal protection under the law, or the separation of powers doctrine under the Kansas Constitution.

Justices Carol A. Beier and Lee A. Johnson dissented in part. They would have held that the statutory cap violated Miller's constitutional rights to trial by jury and remedy by due course of law, while reserving judgment on the equal protection challenge. All seven members of the court agreed the statute did not violate the constitutional separation of powers doctrine.

In another portion of the decision that drew unanimous agreement, the Supreme Court reinstated $100,000 in future medical expenses the jury awarded Miller that had later been struck by the trial judge in post-trial rulings. The Supreme Court held there was sufficient evidence to support the jury's determination for those future medical expenses. The Court's decision means Miller's damages award will be set at $84,679.74 for medical expenses incurred up to trial, $100,000 for future medical expenses, and $250,000 for noneconomic damages. The Supreme Court

unanimously rejected Dr. Johnson's arguments in her appeal. It remanded the case to Douglas County District Court for further proceedings to conform to the Supreme Court's decision.

On the constitutional challenges, the majority of the court held that "Our court has long recognized that the legislature may modify the common law in limited circumstances," as long as the legislature provides an adequate substitute remedy or quid pro quo. The majority said retreating from that holding now would call into question the constitutionality of the state's longstanding Workers Compensation Act and the Kansas Automobile Injury Reparations Act, which establishes no-fault insurance. The decision relied in part on the statutory cap's relationship to the Health Care Provider Insurance Availability Act. That Act requires that all health care providers maintain liability insurance with designated levels of excess coverage. It further requires every health insurer to contribute to a plan that covers health care providers who cannot acquire insurance through ordinary methods.

While upholding the constitutionality of the statute, the court's majority cautioned that the legislature's failure to increase the $250,000 cap in the more than 20 years since it was first adopted was "troubling" because inflation had eroded its value by 57 percent. "There is a reasonable question," the majority decision stated, "as to the continued adequacy of the $250,000 limitation that has admittedly devalued over time due to the legislature's failure to adjust it."

In an unusual occurrence, this case was argued to the Supreme Court on two separate dockets, first in 2009 and then 2011 because of changes to the court's composition while the case was pending. After 2009, Justice Eric S. Rosen recused and Senior Judge David S. Knudson sat in his place, while then Chief Justice Robert E. Davis retired following an extended illness and Justice Nancy Moritz was appointed by the governor to fill that vacancy.

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

Approved April 17, 1989.

CHAPTER 143

Senate Bill No. 18

AN ACT relating to medical malpractice claims; amending and supplementing the health care provider insurance availability act; providing for reduced levels of coverage by the health care stabilization fund; amending the Kansas tort claims act regarding application to certain health care providers; relating to private practice corporations or foundations and their full-time physician faculty employed by the university of Kansas medical center and persons who were engaged in residency training programs; amending K.S.A. 40-3402, 40-3415, and 75-6115, and K.S.A. 1988 Supp. 40-3401, 40-3403, 40-3414 and 60-3410 and repealing the existing sections; also repealing K.S.A. 40-3405 and 40-3414, as amended by section 125 of chapter 356 of the 1988 Session Laws of Kansas, K.S.A. 1987 Supp. 40-3403, as amended by section 123 of chapter 356 of the 1988 Session Laws of Kansas and K.S.A. 1988 Supp. 60-3409 and 60-3411.

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

Section 1. K.S.A. 1988 Supp. 40-3401 is hereby amended to read as follows: 40-3401. As used in this act the following terms shall have the meanings respectively ascribed to them herein.

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

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

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

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

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

(f) "Health care provider" means a person licensed to practice any branch of the healing arts by the state board of healing arts, a person who holds a temporary permit to practice any branch of the healing arts issued by the state board of healing arts, a person engaged in a postgraduate training program approved by the state board of healing arts, a medical care facility licensed by the department of health and environment, a health maintenance organization issued a certificate of authority by the commissioner of insurance, an optometrist licensed by the board of examiners in optometry, a podiatrist licensed by the state board of healing arts, a pharmacist licensed by the state board of pharmacy, a licensed professional nurse who is authorized to practice as a registered nurse anesthetist, a licensed professional nurse who has been granted a temporary authorization to practice nurse anesthesia under K.S.A. ~~1987~~ *1988* Supp. 65-1153 and amendments thereto, a professional corporation organized pursuant to the professional corporation law of Kansas by persons who are authorized by such law to form such a corporation and who are health care providers as defined by this subsection, a partnership of persons who are health care providers under this subsection, a Kansas not-for-profit corporation organized for the purpose of rendering professional services by persons who are health care providers as defined by this subsection, a dentist certified by the state board of healing arts to administer anesthetics under K.S.A. 65-2899 and amendments thereto, a physical therapist registered by the state board of healing arts, a psychiatric hospital licensed under K.S.A. 75-3307b and amendments thereto, or a mental health center or mental health clinic licensed by the secretary of social and rehabilitation services, except that health care provider does not include (1) any state institution for the mentally retarded, (2) any state psychiatric hospital or (3) any person holding an exempt license issued by the state board of healing arts.

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

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

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

(j) "Professional liability insurance" means insurance providing

coverage for legal liability arising out of the performance of professional services rendered or which should have been rendered by a health care provider.

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

(l) "Self-insurer" means a health care provider who qualifies as a self-insurer pursuant to K.S.A. 40-3414 and amendments thereto.

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

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

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

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

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

(r) "Person engaged in residency training" means a person engaged in a postgraduate training program approved by the state board of healing arts who is employed by and is studying at the university of Kansas medical center only when such person is engaged in medical activities which do not include extracurricular, extra-institutional medical service for which such person receives extra compensation and which have not been approved by the dean of the school of

medicine and the executive vice-chancellor of the university of Kansas medical center. Persons engaged in residency training shall be considered resident health care providers for purposes of K.S.A. 40-3401 *et seq.*, and amendments thereto.

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

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

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

(2) In the event of termination of basic coverage by cancellation, nonrenewal, expiration or otherwise by either the insurer or named insured, notice of such termination shall be furnished by the insurer to the commissioner, the state agency which licenses, registers or certifies the named insured and the named insured. Such notice shall be provided no less than 30 days prior to the effective date of any termination initiated by the insurer or within 10 days after the

date coverage is terminated at the request of the named insured and shall include the name and address of the health care provider or providers for whom basic coverage is terminated and the date basic coverage will cease to be in effect. No basic coverage shall be terminated by cancellation or failure to renew by the insurer unless such insurer provides a notice of termination as required by this subsection.

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

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

(1) Every insurance company authorized to transact business in this state, that is authorized to issue professional liability insurance in any jurisdiction, shall file with the commissioner, as a condition of its continued transaction of business within this state, a form prescribed by the commissioner declaring that its professional liability insurance policies, wherever issued, shall be deemed to provide at least the insurance required by this subsection when the insured is rendering professional services as a nonresident health care provider in this state. Any nonadmitted insurer may file such a form.

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

(c) Every health care provider that is a self-insurer, the university of Kansas medical center for persons engaged in residency training, *the private practice corporations or foundations and their full-time physician faculty employed by the university of Kansas medical center* or a medical care facility or mental health center for self-insurers under subsection (e) of K.S.A. 40-3414 and amendments thereto shall

pay the surcharge levied by the commissioner pursuant to subsection (a) of K.S.A. 40-3404 and amendments thereto directly to the commissioner and shall furnish to the commissioner the information required in subsection (a)(1) *and (a)(2)*.

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

Sec. 3. K.S.A. 1988 Supp. 40-3403 is hereby amended to read as follows: 40-3403. (a) For the purpose of paying damages for personal injury or death arising out of the rendering of or the failure to render professional services by a health care provider, self-insurer or inactive health care provider subsequent to the time that such health care provider or self-insurer has qualified for coverage under the provisions of this act, there is hereby established the health care stabilization fund. The fund shall be held in trust in a segregated fund in the state treasury. The commissioner shall administer the fund or contract for the administration of the fund with an insurance company authorized to do business in this state.

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

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

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

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

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

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of settlements paid from the fund and the amount in the fund at the end of the fiscal year.

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

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

(c) Subject to subsections (d), (e), (f), (i) ~~and~~, (k) *and (m)*, the fund shall be liable to pay: (1) Any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable resident health care providers or resident self-insurers for any personal injury or death arising out of the rendering of or the failure to render professional services within or without this state; (2) *subject to the provisions of subsection (m)*, any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable nonresident health care providers or nonresident self-insurers for any such injury or death arising out of the rendering or the failure to render professional services within this state but in no event shall the fund be obligated for claims against nonresident health care providers or nonresident self-insurers who have not complied with this act or for claims against nonresident health care providers or nonresident self-insurers that arose outside of this state; (3) *subject to the provisions of subsection (m)*, any amount due from a judgment or settlement against a resident inactive health care provider for any

such injury or death arising out of the rendering of or failure to render professional services; (4) *subject to the provisions of subsection (m)*, any amount due from a judgment or settlement against a nonresident inactive health care provider for any injury or death arising out of the rendering or failure to render professional services within this state, but in no event shall the fund be obligated for claims against: (A) Nonresident inactive health care providers who have not complied with this act; or (B) nonresident inactive health care providers for claims that arose outside of this state, unless such health care provider was a resident health care provider or resident self-insurer at the time such act occurred; (5) reasonable and necessary expenses for attorney fees incurred in defending the fund against claims; (6) any amounts expended for reinsurance obtained to protect the best interests of the fund purchased by the commissioner, which purchase shall be subject to the provisions of K.S.A. 75-3738 through 75-3744, and amendments thereto, but shall not be subject to the provisions of K.S.A. 75-4101 and amendments thereto; (7) reasonable and necessary actuarial expenses incurred in administering the act, *including expenses for any actuarial study contracted for by the legislative coordinating council*, which expenditures shall not be subject to the provisions of K.S.A. 75-3738 through 75-3744, and amendments thereto; (8) annually to the plan or plans, any amount due pursuant to subsection (a)(3) of K.S.A. 40-3413 and amendments thereto; (9) reasonable and necessary expenses incurred by the insurance department and the board of governors in the administration of the fund; (10) return of any unearned surcharge; (11) reasonable and necessary expenses for attorney fees and other costs incurred in defending a person engaged or who was engaged in residency training *or the private practice corporations or foundations and their full-time physician faculty employed by the university of Kansas medical center* from claims for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider; (12) *notwithstanding the provisions of subsection (m)*, any amount due from a judgment or settlement for an injury or death arising out of the rendering of or failure to render professional services by a person engaged or who was engaged in residency training *or the private practice corporations or foundations and their full-time physician faculty employed by the university of Kansas medical center*; (13) ~~amounts authorized by the court pursuant to K.S.A. 1986 Supp. 60-3411 and amendments thereto; and~~ (14) reasonable and necessary expenses for the development and promotion of risk management education programs; *(14) notwithstanding the provisions of subsection (m), any amount owed pursuant to a judgment or settlement for any injury or death arising*

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out of the rendering of or failure to render professional services by a person, other than a person described in clause (12) of this subsection, who was engaged in a postgraduate program of residency training approved by the state board of healing arts; and (15) reasonable and necessary expenses for attorney fees and other costs incurred in defending a person described in clause (14) of this subsection.

(d) All amounts for which the fund is liable pursuant to subsection (c) shall be paid promptly and in full except that, ~~in any case arising out of a cause of action which accrued before July 1, 1986,~~ 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, ~~1986~~ *1989*, subject to an aggregate limitation for all judgments or settlements arising from all claims made in any one fiscal year in the amount of $6,000,000 for each provider.

(f) ~~Except as provided by K.S.A. 1986 Supp. 60-3411 and amendments thereto, the fund shall not be liable to pay in excess of $1,000,000 pursuant to any one judgment or settlement for any party 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, 1986, subject to an aggregate limitation for all judgments or settlements arising from all claims made in any one fiscal year in the amount of $3,000,000 for each provider.~~ *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 the effective date of this act if basic coverage is then in effect; (2) subsequent to the effective

date of this act, at such time as basic coverage becomes effective; or (3) upon qualifying as a self-insurer pursuant to K.S.A. 40-3414 and amendments thereto.

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

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

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

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

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

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

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

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

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

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

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

(m) The fund shall not be liable for any amounts due from a judgment or settlement against resident or nonresident inactive health care providers who first qualify as an inactive health care provider on or after July 1, 1989, unless such health care provider has been in compliance with K.S.A. 40-3402, and amendments thereto for a period of not less than five years. If a health care provider has not been in compliance for five years, such health care provider may make application and payment for the coverage for the period while

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

Sec. 4. K.S.A. 1988 Supp. 40-3414 is hereby amended to read as follows: 40-3414. (a) Any health care provider, or any health care system organized and existing under the laws of this state which owns and operates two or more medical care facilities licensed by the department of health and environment, whose aggregate annual insurance premium is or would be $100,000 or more for basic coverage calculated in accordance with rating procedures approved by the commissioner pursuant to K.S.A. 40-3413 and amendments thereto, may qualify as a self-insurer by obtaining a certificate of self-insurance from the commissioner. Upon application of any such health care provider or health care system, on a form prescribed by the commissioner, the commissioner may issue a certificate of self-insurance if the commissioner is satisfied that the applicant is possessed and will continue to be possessed of ability to pay any judgment for which liability exists equal to the amount of basic coverage required of a health care provider obtained against such applicant arising from the applicant's rendering of professional services as a health care provider. In making such determination the commissioner 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. The certificate of self-insurance may contain reasonable conditions prescribed by the commissioner. Upon ~~not less than five days'~~ notice and a hearing ~~pursuant to such notice~~ *in accordance with the provisions of the Kansas administrative procedure act*, the commissioner may cancel a certificate of self-insurance upon reasonable grounds therefor. Failure to pay any judgment for which the self-insurer is liable arising from the self-insurer's rendering of professional services as a health care provider, the failure to comply with any provision of this act or the failure to comply with any conditions contained in the certificate of self-insurance shall be reasonable grounds for the cancellation of such certificate of self-insurance. The provisions of this subsection shall not apply to the Kansas soldiers' home or to any person who is a self-insurer pursuant to subsection (d) or (e).

(b) Any such health care provider or health care system that holds a certificate of self-insurance shall pay the applicable surcharge set forth in subsection (c) of K.S.A. 40-3402 and amendments thereto.

(c) The Kansas soldiers' home shall be a self-insurer and shall pay the applicable surcharge set forth in subsection (c) of K.S.A. 40-3402 and amendments thereto.

(d) A person engaged in residency training shall be self-insured by the university of Kansas medical center for occurrences arising during such training, and such person shall be deemed a self-insurer for the purposes of the health care provider insurance availability act. The university of Kansas medical center shall pay the applicable surcharge set forth in subsection (c) of K.S.A. 40-3402 and amendments thereto on behalf of such person. Such self-insurance shall be applicable to a person engaged in residency training only when such person is engaged in medical activities which do not include extracurricular, extra-institutional medical service for which such person receives extra compensation and which have not been approved by the dean of the school of medicine and the executive vice-chancellor of the university of Kansas medical center.

(e) (1) A person engaged in a postgraduate training program approved by the state board of healing arts at a medical care facility or mental health center in this state may be self-insured by such medical care facility or mental health center in accordance with this subsection (e) and in accordance with such terms and conditions of eligibility therefor as may be specified by the medical care facility or mental health center and approved by the commissioner. A person self-insured under this subsection (e) by a medical care facility or mental health center shall be deemed a self-insurer for purposes of the health care provider insurance availability act. Upon application by a medical care facility or mental health center, on a form prescribed by the commissioner, the commissioner may authorize such medical care facility or mental health center to self-insure persons engaged in postgraduate training programs approved by the state board of healing arts at such medical care facility or mental health center if the commissioner is satisfied that the medical care facility or mental health center is possessed and will continue to be possessed

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of ability to pay any judgment for which liability exists equal to the amount of basic coverage required of a health care provider obtained against a person engaged in such a postgraduate training program and arising from such person's rendering of or failure to render professional services as a health care provider.

(2) In making such determination the commissioner shall consider (A) the financial condition of the medical care facility or mental health center, (B) the procedures adopted by the medical care facility or mental health center to process and handle claims and potential claims, (C) the amount and liquidity of assets reserved for the settlement of claims or potential claims by the medical care facility or mental health center and (D) any other factors the commissioner deems relevant. The commissioner may specify such conditions for the approval of an application as the commissioner deems necessary. Upon approval of an application, the commissioner shall issue a certificate of self-insurance to each person engaged in such postgraduate training program at the medical care facility or mental health center who is self-insured by such medical care facility or mental health center.

(3) Upon ~~not less than five days'~~ notice and a hearing ~~pursuant to such notice~~ *in accordance with the provisions of the Kansas administrative procedure act*, the commissioner may cancel, upon reasonable grounds therefor, a certificate of self-insurance issued pursuant to this subsection (e) or the authority of a medical care facility or mental health center to self-insure persons engaged in such postgraduate training programs at the medical care facility or mental health center. Failure of a person engaged in such postgraduate training program to comply with the terms and conditions of eligibility to be self-insured by the medical care facility or mental health center, the failure of a medical care facility or mental health center to pay any judgment for which such medical care facility or mental health center is liable as self-insurer of such person, the failure to comply with any provisions of the health care provider insurance availability act or the failure to comply with any conditions for approval of the application or any conditions contained in the certificate of self-insurance shall be reasonable grounds for cancellation of such certificate of self-insurance or the authority of a medical care facility or mental health center to self-insure such persons.

(4) A medical care facility or mental health center authorized to self-insure persons engaged in such postgraduate training programs shall pay the applicable surcharge set forth in subsection (c) of K.S.A. 40-3402 and amendments thereto on behalf of such persons.

(5) As used in this subsection (e), "medical care facility" does not include the university of Kansas medical center.

(f) For the purposes of subsection (a), "health care provider" may include each health care provider in any group of health care providers who practice as a group to provide physician services only for a health maintenance organization, any professional corporations, partnerships or not-for-profit corporations formed by such group and the health maintenance organization itself. The premiums for each such provider, health maintenance organization and group corporation or partnership may be aggregated for the purpose of being eligible for and subject to the statutory requirements for self-insurance as set forth in this section.

(g) The provisions of subsections (a) and (f), relating to health care systems, shall not affect the responsibility of individual health care providers as defined in subsection (f) of K.S.A. 40-3401~~,~~ and amendments thereto~~,~~ or organizations whose premiums are aggregated for purposes of being eligible for self-insurance from individually meeting the requirements imposed by K.S.A. 40-3402~~,~~ and amendments thereto~~,~~ with respect to the ability to respond to injury or damages to the extent specified therein and K.S.A. 40-3404~~,~~ and amendments thereto~~,~~ with respect to the payment of the health care stabilization fund surcharge.

(h) Each private practice corporation or foundation and their full-time physician faculty employed by the university of Kansas medical center shall be deemed a self-insurer for the purposes of the health care provider insurance availability act. The private practice corporation or foundation of which the full-time physician faculty is a member shall pay the applicable surcharge set forth in subsection (a) of K.S.A. 40-3404, and amendments thereto, on behalf of the private practice corporation or foundation and their full-time physician faculty employed by the university of Kansas medical center.

Sec. 5. K.S.A. 40-3415 is hereby amended to read as follows: 40-3415. The board of governors, the commissioner, the attorney general, *the health care stabilization fund oversight committee* and the officers and employees of the state agencies which license, register, certify or otherwise regulate health care providers are authorized and directed to consult with and assist each other in maintaining compliance with the provisions of this act.

New Sec. 6. (a) There is hereby created a health care stabilization fund oversight committee to consist of eleven members, one of whom shall be the commissioner of insurance or the commissioner's designee, one of whom shall be appointed by the president of the state senate, one of whom shall be appointed by the minority leader of the state senate, one of whom shall be appointed by the speaker of the state house of representatives, one of whom shall be

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appointed by the minority leader of the state house of representatives and six of whom shall be persons appointed by the legislative coordinating council. The four members appointed by the president and minority leader of the state senate and the speaker and minority leader of the state house of representatives shall be members of the state legislature. Of the six members appointed by the legislative coordinating council, four shall either be health care providers or be employed by health care providers, one shall be a representative of the insurance industry and one shall be appointed from the public at large who is not affiliated with any health care provider or the insurance industry, but none of such six members shall be members of the state legislature.

(b) The legislative coordinating council shall designate a chairperson of the committee from among the members thereof. The committee shall meet upon the call of the chairperson. It shall be the responsibility of the committee to make a report to the legislative coordinating council on or before September 1, 1990, and to perform such additional duties after September 1, 1990, as the legislative coordinating council shall direct. The report required to be made to the legislative coordinating council shall include recommendations to the legislature for commencing the phase-out of the fund on July 1, 1991, an analysis of the market for insurance for health care providers, an analysis of the impact and recommendation on the advisability of the imposition of limitations on attorney fees involving actions arising out of the rendering or failure to render professional services by a health care provider for which the fund has liability and recommendations for legislation necessary to implement or alter the phase-out of the fund.

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

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

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

Sec. 7. K.S.A. 75-6115 is hereby amended to read as follows: 75-6115. *(a)* The Kansas tort claims act shall not be applicable to

claims arising from the rendering of or failure to render professional services by a health care provider *other than a hospital owned by a municipality and the employees thereof.* Claims for damages against a health care provider that is a governmental entity or an employee of a governmental entity *other than a hospital owned by a municipality and the employees thereof,* arising out of the rendering or failure to render professional services by such health care provider, may be recovered in the same manner as claims for damages against any other health care provider.

(b) As used in this section:

(1) "Health care provider" shall have the meaning provided by K.S.A. 40-3401, and amendments thereto.

(2) "Hospital" means a medical care facility as defined in K.S.A. 65-425, and amendments thereto, and includes within its meaning any clinic, school of nursing, long-term care facility, child-care facility and emergency medical or ambulance service operated in connection with the operation of the medical care facility.

Sec. 8. K.S.A. 1988 Supp. 60-3410 is hereby amended to read as follows: 60-3410. The provisions of K.S.A. ~~1986~~ *1988* Supp. 60-3406 through ~~60-3409~~ *60-3408 and amendments thereto* shall apply only to medical malpractice liability actions which are based on causes of action accruing on or after July 1, 1986.

New Sec. 9. If any provisions of this act or the application thereof to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provisions or application and, to this end, the provisions of this act are severable.

Sec. 10. K.S.A. 40-3402, 40-3405, 40-3414, as amended by section 125 of chapter 356 of the laws of 1988, 40-3415, and 75-6115, K.S.A. 1987 Supp. 40-3403, as amended by section 123 of chapter 356 of the laws of 1988 and K.S.A. 1988 Supp. 40-3401, 40-3403, 40-3414, 60-3409, 60-3410 and 60-3411 are hereby repealed.

Sec. 11. This act shall take effect and be in force from and after July 1, 1989, and its publication in the statute book.

Approved May 12, 1989.

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