Approved: January 31, 2011
Date

MINUTES OF THE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Vicki Schmidt at 1:30 p.m. on January 13, 2011 in Room 526-S of the Capitol.

All members were present except:
Senator Vicki Schmidt - excused.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes
Katherine McBride, Office of the Revisor of Statutes
Iraida Orr, Kansas Legislative Research Department
Melissa Calderwood, Kansas Legislative Research Department
Carolyn Long, Committee Assistant

Conferees appearing before the Committee:
Tom Bruno, Kansas Athletic Trainers Society
Jerry Slaughter, Kansas Medical Society
Charles L. Wheelen, Health Care Stabilization Fund

Others attending:
See attached list.

Vice-Chairman Brungardt welcomed the Committee to the first meeting of the 2011 Legislative Session.

New committee members, the staff of the Legislative Research Department, Office of the Revisor of Statutes and Chairman's Office were introduced. Also present was Dorothy Hughes, Kansas Legislative Research Department.

Melissa Calderwood, Kansas Legislative Research Department, drew the committee's attention to the draft Report of the Health Care Stabilization Fund Oversight Committee to the 2011 Kansas Legislature (Attachment #1).

Bill Introductions

Tom Bruno, representing the Kansas Athletic Trainers Society, requested introduction of a bill regarding school districts and the enactment of a school sports brain injury prevention act. Moved by Senator Kelly, seconded by Senator Reitz to introduce the bill. Motion carried.

Jerry Slaughter, Kansas Medical Society, requested a bill regarding Health Information and Technology Exchange. Moved by Senator Reitz, seconded by Senator Pilcher-Cook. Motion carried.

The Vice-Chair introduced Mr. Charles L Wheelen, Executive Director of the Health Care Stabilization Fund. Mr. Wheelen noted that the Health Care Provider Insurance Availability Act had two principal features; the creation of the Health Care Stabilization Fund and the establishment of a joint underwriting authority. Mr. Wheelen then outlined a brief history of the Act, it's Principal Features, the Commercial Insurance Market, the criteria for self-insured health care providers, the inclusion of the University of Kansas Medical Center, the effect of Senate Bill 414, fiscal year 2010 data, HCSF revenue and reserves, and brief conclusion relating to it's future (Attachment #2).

The Vice-Chair thanked Mr. Slaughter for appearing.

The next meeting is scheduled for January 18, 2011.

The meeting adjourned at 2:10 p.m.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: January 13, 2011

NAME	REPRESENTING
Chap Wheeler	HCSF Board of Govs
Tom Bruns	Bruno & Associates
PHIL CAUTHON	Kansas Health Institute
Travis Lowe	Little Gov't Relations
[illegible]	UnitedHealth Group
Bruce Wilk	Via Christi
Bernard Koops	Hein Law Firm
Zac Kohl	Federico Consulting
Levi Henry	Sandstone Group
John Keithaber	Ks Chiropractic Assn.
Nancy Zoglemann	Polsinelli
Dan Morin	KMS
Jerry Slaughter	KCMS
David Rarner	Kearney & Assoc.
Leigh Keck	Capitol Strategies

Report of the Health Care Stabilization Fund Oversight Committee to the 2011 Kansas Legislature

CHAIRPERSON: Dick Bond

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

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

STUDY TOPICS

- 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 2010

Health Care Stabilization Fund Oversight

Report

Conclusions and Recommendations

The Committee addressed the two statutory questions posed annually to the Oversight Committee. 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.

Actuarial Review. The Committee reviewed the necessity for the need to contract for an independent actuarial review in 2011. 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, at this time, a need for an independent review in 2011. The Committee members also discussed whether another actuarial review would be made if the Kansas Supreme Court's decision in *Miller v. Johnson* strikes down the constitutionality of the cap on non-economic damages. Should actuarial projections be made for the Fund Board of Governors to reflect the Court's decision, the Oversight Committee requests a copy be made available for its review.

Other Recommendations. The Committee then considered information presented by the Fund representatives and health care provider and insurance representatives, and recommendations were made 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.

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, and other receipts made payable to the Health Care Stabilization Fund shall be credited to the Health Care Stabilization Fund. At the end of any fiscal year, all unexpended and unencumbered moneys in such Health Care Stabilization Fund shall remain therein and not be credited or transferred to the State General Fund or to any other fund.

Proposed Legislation: None.

Background

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

Committee Activities

Report of Towers Watson

A brief overview to the actuarial report provided by the Executive Director for the Fund Board of Governors indicated that surcharge rates for FY 2011 were not adjusted, largely due to, the report notes, the passage of SB 414 and the eventual reimbursement of the Health Care Stabilization Fund (HCSF).

The Towers Watson actuarial report serves as an addendum to the report provided to the Fund Board of Governors dated April 16, 2010. The actuary 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 then 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/ Wichita Center for Graduate Medical Education (WCGME) claims for FY 2010 through FY 2013, but delayed payment until 2014; and the Board should consider modest changes by class, including no longer using uniform percentages for classes 15-21, and leaving surcharge rates unchanged. The actuary 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.

The actuary also noted that the present value basis (2.0 percent) is reflected in the projected liabilities and reviewed the liabilities at June 30, 2010, highlighting both inactive providers – tail coverage and future payments. The actuary cited a vulnerability to the Fund – failure to receive the anticipated reimbursements for administration of the self-insurance programs from the State General Fund. The actuary indicated that the projections noted earlier anticipate a 100 percent reimbursement from the SGF.

Further, the actuary addressed changes from prior forecasts and made some observations about the changes in the estimates for active provider losses: settlements were lower than expected during Calendar Year (CY) 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 stated, the forecast of the prospective year's losses are $28.5 million, the first sub-$30 million forecast in several years. The actuary also observed that since 1999, the Fund's surcharge revenue 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 represents 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, the actuary's report indicated, there were 532 Plan insureds. The actuary 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 has been going down since that point.

Finally, the actuary addressed the findings by provider class. The actuary commented on the differences in relative loss experience among the classes, noting 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]. The actuary spoke to three representative classes: 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.

Comments

In addition to the report from the Board of Governors' actuary, the Committee received an overview of relevant legislation and materials provided by Committee staff. The staff member noted the Committee's prior review of state health reform legislation and law and provided documents detailing federal health insurance

reform provisions, as well as a timeline for the implementation of the various provisions of the Affordable Care Act. Additionally, the analyst noted the Legislature's consideration of a constitutional amendment that was intended to "preserve the freedom of choice in health care decisions."

The analyst then reviewed the progress of 2010 SB 414 (now law), which addressed the allotment issue brought before the Oversight Committee at its 2009 meeting. The bill as enacted exempted transfers from the SGF to the HCSF; reimbursement for the costs and expenses for the administration of the self-insurance program for FT faculty, private practice foundation, and corporations; and the University of Kansas Medical Center (KUMC) and WCGME residents. A repayment timeline was established for those deferred State General Fund (SGF) payments. The analyst also provided a brief summation of HCR 5036, a concurrent resolution proposing a constitutional amendment that affirms the Legislature's authority to limit the amount of recovery for noneconomic damages in personal injury claims; no action was taken on this resolution during the 2010 Session. Other documents in the staff review included the Appropriations Report for the Fund budget and the Oversight Committee's report to the 2010 Legislature.

The Committee then received 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 from the Fund staff. The Executive Director 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 to purchase professional liability insurance from commercial companies or from the joint underwriting authority (the Availability Plan). 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, 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. The Executive Director 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. The Executive Director then highlighted the Board's statutory report, as required by KSA 40-3403b, 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. 54 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.

- The financial report, as of June 30, 2010, indicated assets amounting to $228,573,232 and liability amounting to $225,800,123. The Executive Director 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.

The Chief Attorney and Deputy Director, Rita Noll, next addressed the FY 2010 medical professional liability experience based on all claims resolved in FY 2010, including judgments and settlements. 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.

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. The 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 average in 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, including both 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, the Fund provided primary coverage for 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 received 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. The total amount of those contributions was $14.97 million. 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 of $1,445,658.21, including attorney fees and expenses, and reimbursements for the KU Foundations and Faculty of $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 then 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.

The Executive Director for the Fund Board of Governors was then recognized 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 in about two months, the website 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.

The Executive Director next discussed the status of the Fund. 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 noneconomic damages, the currently assigned reserves 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. Items discussed by the Committee include: encouraging the Fund representatives to continue to provide information about the history of the Fund and its special relationship with health care providers; arranging to have legislative committee chairs (health, insurance, budget) attend future Oversight Committee meetings; the loss climate in other states; coverage of health care providers licensed to practice in other states; and the recruitment of "border physicians" to practice in Kansas.

The Committee also reviewed the current marketplace of medical malpractice insurance. The Kansas Medical Mutual Insurance Company (KaMMCO) representative 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. The conferee indicated that the last crisis for the Kansas market

was in 2002 with the departure of St. Paul. The environment for medical malpractice insurance now is healthy and profitable. The representative also 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 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. The conferee then provided a brief update on the Joint Underwriting Association (JUA), 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.

Next, Mr. Scott 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; the provision of accounting services by KaMMCO, which was previously done by a private firm; and the analysis of Plan reserves by Towers Watson, the Fund's actuary. In response to a Committee member's question about the issue of access and the 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). Mr. Scott further commented that the Plan population changes with market disruptions and having a domestic insurance company can help absorb increases in the Plan's enrollment.

The Executive Director of the Kansas Medical Society 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 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, the conferee 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*). The conferee 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 and put a tremendous demand on the system at exactly the same time when there will be limitations on physician practices and services. The conferee concluded that this scenario will create real disruptions in rural and underserved areas.

Health Insurance Reform

The President of the Kansas Hospital Association (KHA) next appeared before the Oversight Committee to address the

topic of federal health insurance reform and the implications for the Kansas provider community. 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. The conferee commented that while the political discussion in Congress continues regarding health insurance and the individual mandate and Medicaid/CHIP extension, the other reforms will take effect. Given the timetable for implementation, there is reason to understand the anxiety among providers.

The conferee also reviewed payment system reforms 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, which is voluntary for ACOs, will begin in 2012, with groups of providers and hospitals taking the lead. Finally, the conferee 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.

The Kansas Medical Society representative was again recognized to address health insurance reform. The conferee began his comments noting that reform efforts have included many positive parts, especially for primary care. He then noted a number of provisions in the 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 is that the ACA did not address the Sustainable Growth Rate (SGR), which determines how Medicare will pay for physician services.

The conferee then addressed issues and concerns relating to access to physicians and health care providers in Kansas. Physician shortages dramatically will impact 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.

The Committee discussion included hospital construction in northwestern Kansas and what effect or effects 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 asking what health care providers will staff such facilities. The KHA representative 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 only when the community pitches in, as it did in Liberal. The Committee also asked Mr. Wheelen to respond about impacts 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); and second, access to care with a likelihood of more unfortunate outcomes and more settlements.

Following the formal presentations, it was asked if anyone had suggestions for changes to

the Health Care Provider Insurance Availability Act. No amendments were offered.

Conclusions and Recommendations

The Committee addressed the two statutory questions posed annually to the Oversight Committee. 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.

Actuarial Review. The Committee reviewed the necessity for the need to contract for an independent actuarial review in 2011. 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, at this time, a need for an independent review in 2011. The Committee members also discussed whether another actuarial review would be made if the Kansas Supreme Court's decision in *Miller v. Johnson* strikes down the constitutionality of the cap on non-economic damages. Should actuarial projections be made for the Fund Board of Governors to reflect the Court's decision, the Oversight Committee requests a copy be made available for its review.

Other Recommendations. The Committee then considered information presented by the Fund representatives and health care provider and insurance representatives, and recommendations were made 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.

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):

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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, and other receipts made payable to the Health Care Stabilization Fund, shall be credited to the Health Care Stabilization Fund. At the end of any fiscal year, all unexpended and unencumbered moneys in such Health Care Stabilization Fund shall remain therein and not be credited or transferred to the State General Fund or to any other fund.

Health Care Stabilization Fund

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Briefing For The

Senate Public Health and Welfare Committee

By Charles L. Wheelen, HCSF Executive Director

January 13, 2011

Introduction

The Health Care Provider Insurance Availability Act (K.S.A. 40-3401 *et seq.*) is an example of a successful public-private partnership. The Act promotes a cooperative relationship among Kansas health care providers, professional liability insurance companies, and the State of Kansas. It creates a stable environment for a sector of the commercial insurance market that can otherwise be extremely cyclical and at times, unreliable.

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-five year history, but those two fundamental components have remained intact.

History and Significant Events

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

The 1976 Legislature responded to the crisis by passing the original version of the Health Care Provider Insurance Availability Act, which, among other things, created the Health Care Stabilization Fund. Responsibility for premium surcharge collections and administering the Stabilization Fund was delegated to the Insurance Commissioner. To accommodate those doctors who could not buy commercial insurance coverage, a joint underwriting authority was created.

Unlike commercial insurance policies, the HCSF provided unlimited coverage. In other words, a doctor or hospital could be sued for any amount of money, and there was no limit on the amount a jury could award to a plaintiff, or the amount that could be agreed to in a settlement. Yet there was a statutory $10-million limit on the Fund reserves.

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

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

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

The controversy surrounding tort reform focused a great deal of attention on the HCSF because there were those who blamed the Fund for the cost of medical liability insurance. Some legislators insisted that the State should immediately divest from the HCSF. But some legislators were concerned that Fund liabilities would exceed Fund assets and Kansas taxpayers would be left with an obligation to pay claims from general tax revenues. The compromise was passage of legislation that provided for a gradual phase-out of the Stabilization Fund. In addition, the Legislature reduced the Fund coverage to $1-million per claim with annual aggregate limits of $3-million.

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 diminished. Instead, the 1994 Legislature decided to remove the Fund from the Insurance Department and delegate responsibility for administration to a Board of Governors.

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. Currently the Board employs eighteen staff members.

Principal Features of the Contemporary Act

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.

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.

Health care providers are also required to select one of three options for additional coverage via the HCSF. Those options are: (1) $100,000 per claim with $300,000 annual aggregate, (2) $300,000 per claim with $900,000 annual aggregate, or (3) $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.

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. The JUA is called the Health Care Provider Insurance Availability Plan.

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 Kansas health care providers.

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

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.

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.

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 FY2010 and FY2011 as well as FY2009, 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.

Fiscal Year 2010 Data

For a complete report with detailed information, please visit the Health Care Stabilization Fund website at www.hcsf.org and on the home page, select "Annual Report." This provides a link to a copy of our most recent report to the Legislature's HCSF Oversight Committee. The following is a brief summary of FY2010 data.

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.

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).

Because of both past and future periodic payment of compensation, the amounts reported in the paragraph above 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.

The June 30, 2010 financial report accepted by the Board of Governors indicated assets amounting to $228,573,232 and liabilities amounting to $225,800,123. The assets included an account receivable from the State of Kansas in the amount of $2,147,376.

HCSF Revenue and Reserves

All expenditures for payment of claims, claims related expenses, and operating costs of the agency are paid from revenue collected from health care providers. There has never been a State general fund appropriation to support the Health Care Stabilization Fund nor the Availability Plan.

K.S.A. 40-3404(a) 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 important to maintain reasonable 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 review all open cases to determine whether sufficient reserves have been assigned to them. In addition, estimated liabilities would suddenly increase by a significant amount.

Conclusion

The Health Care Provider Insurance Availability Act has achieved legislative intent by stabilizing the medical professional liability insurance market in Kansas. In addition, it assures that when it is decided that a patient should be compensated because of an unfortunate medical outcome, resources are available for immediate payment of the settlement or jury award.

Currently, HCSF assets exceed HCSF liabilities, but only modestly. 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 the premium surcharge rates. Our Board of Governors is anxiously waiting for the Court's decision.