Kansas Health Care Stabilization Fund

Website http://hcsf.kansas.gov
E-mail hcsf@hcsf.org
Fax: 785-291-3550

300 S.W. 8th Avenue, Second Floor
Topeka, Kansas 66603-3912
Phone 785-291-3777

Bulletin 2014-5

Frequently asked questions regarding House Bill 2516 (L. 2014, Ch. 56) updated 12/29/2014

Q: Why did the Legislature establish the Health Care Provider Insurance Availability Act?

A: The original Availability Act was enacted in 1976 at a time when many physicians and other health care providers could not obtain adequate or affordable professional liability insurance coverage. The Kansas Medical Society, the Kansas Hospital Association, and the Kansas Commissioner of Insurance were instrumental in persuading the Legislature to pass the laws that became the Health Care Provider Insurance Availability Act. The three principal features of the Act have always been: (1) a requirement that all health care providers, as defined under 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 reinsurer of the Availability Plan.

The Availability Act was specifically cited by the Kansas Supreme Court in the *Miller v. Johnson* decision published in October 2012. The Court upheld the Legislature's authority to replace a common law rule with a statutory limit on noneconomic damages in personal injury actions. The Court's media release said, "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."

Q: Who is required to comply with the Health Care Provider Insurance Availability Act?

A: Any profession or facility defined as a "health care provider" under K.S.A. 40-3401 is required to comply with the Act. There are numerous health care providers defined as such under K.S.A. 40-3401(f).

<u>Health Care Providers Prior to HB2516</u>

Specified professionals licensed to practice in Kansas; chiropractors, nurse anesthetists, podiatrists, physicians (M.D.s and D.O.s), including residents in training, and a very limited group of dentists certified by the Kansas Board of Healing Arts to administer anesthesia are required to comply with the Health Care Provider Insurance Availability Act as a condition of licensure.

Specified facilities licensed to operate in Kansas; ambulatory surgery centers, community mental health centers, critical access hospitals, general hospitals, and special hospitals are required to comply with the Availability Act as a condition of licensure.

Specified business entities such as professional corporations and limited liability companies organized by defined health care providers for the purpose of providing health care services are required to comply with the Health Care Provider Insurance Availability Act.

On and after January 1, 2015

Two additional categories of licensed professionals; advanced practice nurses authorized to engage in the practice of nurse midwifery and physician assistants will be required to comply with the Health Care Provider Insurance Availability Act as a condition of licensure.

Three categories of licensed adult care homes; assisted living facilities, nursing facilities, and residential health care facilities will be required to comply with the Availability Act as a condition of licensure.

Q: Are nursing facilities for mental health required to comply with the Health Care Provider Insurance Availability Act?

A: No, because there is a separate statutory definition distinctly separate from "nursing facility" and because the Legislature did not specifically define nursing facilities for mental health as health care providers under the Availability Act. Nursing facilities for mental health are not required to comply with the Availability Act nor are they eligible for coverage under the Health Care Stabilization Fund.

Q: Why did the 2014 Legislature decide to add two new professions and three new facilities to the definition of health care provider?

A: The associations representing adult care homes, nurse midwives, and physician assistants requested the amendments adding the new categories to the definition. The HCSF Board of Governors did not support nor oppose the additions.

Q: How do we know if an adult care home is an assisted living facility, nursing facility, or residential health care facility?

A: There are separate statutory definitions, but each is specifically licensed by the Kansas Department for Aging and Disability Services by type of facility. To determine the type of license held by a particular facility and the state identification number, there is a website hosted by the KDADS at URL link http://www.kdads.ks.gov/LongTermCare/Facility_Reports/disclaimer.htm.

Q: What is required of a health care provider in order to comply with the Availability Act?

A: The principal requirements include: (1) professional liability insurance (PLI) coverage with minimum limits of $200,000 per claim subject to not less than $600,000 annual aggregate coverage purchased from a company authorized by the Kansas Commissioner of Insurance to sell PLI to health care providers. These companies are often referred to as "admitted carriers." The PLI policy must be a claims-made policy and there must be separate limits of coverage (at least $200,000 per claim/$600,000 annual aggregate) for each individual health care provider insured under the PLI policy. If the health care provider is a Kansas resident, the insurance company is responsible for collecting the appropriate surcharge payment and is responsible for submitting a notice of basic coverage to the HCSF Board of Governors within 30 days of the effective date of the PLI policy. (continued on page 3)

The health care provider must also choose one of three levels of coverage under the Health Care Stabilization Fund. The insurance company is required to collect the HCSF premium surcharge and remit the surcharge payment to the HCSF. For a number of reasons, most health care providers purchase a basic PLI policy with $200,000 per claim, $600,000 annual aggregate limits and select the $800,000 per claim, $2.4 million annual aggregate coverage under the HCSF. Obviously this provides total coverage amounting to $1.0 million per claim subject to $3.0 million annual aggregate coverage for each health care provider. There are, however, other possible combinations of coverage allowed.

A non-resident health care provider may be insured by a company that is not an admitted carrier, but only if the non-admitted insurance company has submitted a properly executed declaration of compliance with the Health Care Provider Insurance Availability Act. Then the non-resident health care provider may be eligible to render professional services in Kansas. The individual non-resident health care provider is responsible for submitting a non-resident certification with a copy of the PLI certificate of insurance and surcharge payment to the HCSF Board of Governors.

Q: Some of the facilities and professionals that will become defined health care providers on January 1, 2015 are currently insured under occurrence policies or are insured by non-admitted carriers. Can they wait until their next renewal date to change their coverage to a claims-made policy issued by an authorized insurance company?

A: No; those new health care providers will need to cancel their existing coverage and make arrangements for a new claims-made policy with a January 1, 2015 effective date. If the nurse midwife or physician assistant is a Kansas resident, the new policy must be issued by an admitted insurance company. All health care provider facilities will need to obtain their new policy from an admitted carrier.

Q: If one of the new health care providers obtains a new claims-made insurance policy with a January 1, 2015 effective date, will the health care provider be required to purchase prior acts tail coverage?

A: If the health care provider was insured under an occurrence policy, tail coverage should not be necessary because the former policy should cover any claim resulting from an incident that occurred during the policy period. If the health care provider was previously insured under a claims-made policy, the health care provider may want to obtain a tail coverage policy for professional liability exposure prior to January 1, 2015. The Legislature made special provision in HB2516 for any new health care provider who may need prior acts tail coverage. If the tail coverage is not readily available from an insurance company, the health care provider may purchase a tail coverage policy from the Health Care Provider Insurance Availability Plan.

On and after January 1, 2015 the new health care provider will never need to be concerned about tail coverage because other amendments in HB2516 provide automatic tail coverage via the Health Care Stabilization Fund when a health care provider retires or otherwise becomes inactive.

Q: Are separate insurance policies required for general liability versus professional liability?

A: No; a single policy can provide both types of coverage as long as the type of coverage and associated limits are clearly identified. The policy can provide coverage for

health care providers as defined under K.S.A. 40-3401(f) and separately insure other professional staff who are not defined health care providers. Such policies cannot stipulate a total aggregate policy limit that could interfere with the minimum limits for those health care providers insured under the policy. Furthermore the separate limits of coverage for each licensed health care provider must be identified in the policy.

Q: If a health care provider is a facility that employs different types of employees, what kind of coverage is provided pursuant to the Health Care Provider Insurance Availability Act?

A: The Act stipulates that the Health Care Stabilization Fund is liable for "Any amount due from a judgment or settlement which is in excess of the basic coverage" of a health care provider "for any personal injury or death arising out of the rendering of or the failure to render professional services." The Act also stipulates that the amount of HCSF coverage is the amount that was selected by the health care provider at the time of the incident that resulted in a claim. The phrase "professional services" is defined under the Act to mean "patient care or other services authorized under the act governing licensure of a health care provider." In other words, the HCSF does not cover general liability. Furthermore, there are specific provisions in the Act that exclude coverage for sexual acts or criminal acts.

If a health care provider facility employs nurses, therapists, or other professional staff that are not defined health care providers under K.S.A. 40-3401(f), and the facility is named as a defendant as a result of alleged negligence by a non-health care provider, then the HCSF will cover the vicarious liability of the health care provider facility. If, however, an individual non-health care provider staff person is named as a defendant, the non-health care provider is not covered by the HCSF. Similarly, because officers and administrators are not defined health care providers, if they are named individually as defendants in a professional liability claim, the HCSF cannot provide coverage. If the health care provider facility is named as a defendant as a result of alleged negligence by an officer or administrator that results in injury to a patient, then the HCSF will cover the vicarious liability of the facility. For these reasons, many health care provider entities purchase separate professional liability coverage for health care staff who are not defined health care providers under K.S.A. 40-3401(f).

Q: Can a health care provider be self-insured?

A: Yes; but the statute allowing self-insurance is very strict. In order to be eligible to apply to the HCSF Board of Governors for permission to self-insure, the individual health care provider facility must have an annual premium of $100,000 or more for the basic $200,000 per claim/$600,000 annual aggregate coverage. If the health care provider is eligible to apply for a certificate of self-insurance, the health care provider must submit documentation that the health care provider has sufficient financial resources including assets reserved exclusively for payment of professional liability claims, and also has appropriate procedures established to process and handle claims.

Q: Can a health care provider purchase excess PLI coverage?

A: Yes; for example, a health care provider could purchase a claims-made PLI policy with limits of $200,000 per claim/$600,000 annual aggregate issued by an admitted carrier, then select the $100,000 per claim/$300,000 annual aggregate level of HCSF coverage, and also purchase an excess policy from a non-admitted excess and surplus lines insurance company. There is a statutory requirement under K.S.A. 40-246b

stipulating that the insured health care provider must be properly informed that the policy form, premium rates, and financial condition of non-admitted excess and surplus lines insurers are not subject to review by the Kansas Commissioner of Insurance and furthermore, non-admitted carriers are not required to contribute to the insurance guaranty fund.

Q: If for some reason a health care provider cannot obtain the basic professional liability insurance coverage required for compliance with the Availability Act, can the health care provider purchase liability insurance from a non-admitted insurance company?

A: No; the Legislature created the Health Care Provider Insurance Availability Plan to assure that all health care providers will always have access to the basic professional liability insurance coverage required under the Availability Act. The Availability Plan is independent from the Health Care Stabilization Fund and is governed by a nine-member Board of Directors appointed by the Commissioner of Insurance. The members of the Board represent insurance companies and agents as well as health care providers. The Board enters into a contract with a servicing carrier that is similar to a third party administrator. To assure that the Availability Plan does not become competitive with commercial insurance companies, the Board typically adopts premium rates that are somewhat higher than commercial premium rates. Furthermore, the Availability Plan normally requires two declination letters from admitted insurance companies before it will insure a health care provider. The professional liability coverage under the Plan provides the minimum limits of coverage required under K.S.A. 40-3402 and the health care provider must select one of the three levels of coverage available under the Stabilization Fund. To obtain contact information for the current servicing carrier, send an email message to hcsf@hcsf.org.

Q: Do insurance agents earn commissions on the entire amount of professional liability coverage?

A: No; there are no commissions earned on the amount of supplemental HCSF coverage. The Legislature did, however, make provision for commissions on PLI coverage obtained via the Health Care Provider Insurance Availability Plan.

Q: Where can I obtain more information about the Health Care Provider Insurance Availability Act?

A: You can send an email message to hcsf@hcsf.org and it will be routed to the appropriate member of the staff. Or you can obtain a significant amount of information, including forms, from the state agency website at www.hcsf.org.