Guidance Policies and Procedures

For Administration of the Health Care Provider Insurance Availability Act

Adopted by the Health Care Stabilization Fund Board of Governors

Introduction

The Kansas Health Care Stabilization Fund was created in 1976 by enactment of the Health Care Provider Insurance Availability Act (HCPIAA). The HCPIAA is found in *Kansas Statutes Annotated* 40-3401 through 40-3425.

For almost two decades the Fund was administered by the Commissioner of Insurance. The Legislature transferred authority and responsibility for administering the HCPIAA to the Health Care Stabilization Fund Board of Governors in 1995.

Members of the Board of Governors are appointed by the Commissioner of Insurance. The Board appoints an Executive Director to manage the agency on behalf of the Board, and to assure compliance with policies and procedures adopted by the Board.

General Policy Statements

Kansas Statutes Annotated 40-3403 delegates general responsibility for administration of the Health Care Stabilization Fund to the Board of Governors. The Board has a fiduciary duty to protect the fiscal integrity of the Fund and assure that surcharge revenues collected from health care providers are used appropriately.

Subsection (c) of K.S.A 40-3403 enumerates the various circumstances under which the Fund is liable for payment. Generally, the Board will authorize payment for court approved claims that are the result of personal injury actions against health care providers. The Board will authorize payment in excess of the primary coverage, but not to exceed the amount of Fund coverage purchased by the health care provider. The health care provider must choose one of three levels of Fund excess coverage, but cannot exceed $800,000 per occurrence subject to a $2.4 million annual aggregate limit.

The Board will not authorize payment for any claim that is not the result of a personal injury or death action; nor will the Board authorize payment for any claim against an active health care provider that is not covered by the health care provider's basic professional liability insurance policy. If a health care provider is insured by more than one basic professional liability insurance policy, the Fund will be liable for only one coverage limit for any claim.

In accordance with K.S.A. 40-3401(x), in the event of a claim against a health care provider arising from a decision made in his or her position as a medical director or other administrative position, the Board of Governors will authorize payment of a court approved settlement under the following circumstances: (1) the position held by the health care provider must be a position requiring specialized knowledge or expertise that requires a license to render professional services by the health care provider, (2) the claim must be covered by the health care provider's basic professional liability insurance

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policy, and (3) the claim must be a civil action alleging personal injury or death arising out of the rendering of or the failure to render professional services.

Also in accordance with K.S.A. 40-3401(x), in the event of a claim against an inactive health care provider arising from a decision made in his or her position as a medical director or other administrative position, the Board of Governors will authorize payment for attorney fees and other costs incurred in defending the health care provider and will authorize payment of a court approved settlement under the following circumstances: (1) the position held by the health care provider must have been a position requiring specialized knowledge or expertise that required a license to render professional services by a health care provider, and (2) the claim must be a civil action alleging personal injury or death arising out of the rendering of or the failure to render professional services.

If a health care provider is self-insured for the required basic professional liability insurance, the Board will authorize payment for only those claims attributable to professional services rendered by a service or facility that is recognized as a constituent part of the health care provider's self-insured entity. If the health care provider is a medical care facility or health care facility owned by a self-insured health care system, the Board will authorize payment for only those claims attributable to a facility that is recognized as a facility owned by the self-insured health care system. Procedures for becoming self-insured, and for updating recognized services and facilities are a separate part of this document.

Health care providers must select one of three Fund coverage options described in K.S.A. 40-3403. In the event that a health care provider wishes to increase the level of coverage under the Fund, or wishes to make any other request requiring Board action, a written request to the Board must be received at least one week prior to the next scheduled meeting of the Board.

In accordance with K.S.A. 65-2809, if a health care provider is in compliance with K.S.A. 40-3402 and the health care provider's license expires or is otherwise cancelled and then reinstated within 30 days, the Health Care Stabilization Fund coverage selected in accordance with K.S.A. 40-3403 will remain in effect as long as the following conditions are met: (1) the reinstated license is a category of license that is subject to the provisions of K.S.A. 40-3402, (2) the basic insurance coverage is not terminated or otherwise interrupted, and (3) the health care provider has paid the appropriate surcharge to the Health Care Stabilization Fund.

Notices and Other Reporting Requirements

The Health Care Provider Insurance Availability Act imposes a number of statutory reporting requirements on insurers and health care providers. Examples are the notice of basic coverage, the nonresident certification, and the notice of cancellation of basic coverage. The timeliness of notices and reports will be determined based on the date the

notice or report was postmarked, was sent via tele-facsimile, was sent electronically, or was sent via other delivery method.

A health care provider will be tentatively in compliance with the HCPIAA on the effective date of the health care provider's basic coverage insurance policy or thirty calendar days prior to the date the health care provider's notice of basic coverage or nonresident certification was sent, whichever is more recent. Compliance with the HCPIAA will be finalized when it is determined that the notice of basic coverage or nonresident certification meets statutory requirements and the appropriate surcharge is paid.

In the event that a notice of basic coverage or nonresident certification is sent more than thirty days after the effective date of the basic coverage insurance policy, it will be referred to the Director of Compliance for review of exceptional circumstances. If the Director of Compliance does not approve a late notice of basic coverage or nonresident certification, the health care provider may request further consideration by the Board of Governors by submitting a written request to the Executive Director at least ten days prior to the next Board meeting.

In the event that basic coverage is cancelled at the request of an insured health care provider, the notice of cancellation must be sent not more than ten days after the policy is cancelled unless there are exceptional circumstances. Retroactive cancellations exceeding ten days will be referred to the Board's Chief Counsel for review of exceptional circumstances. Examples of exceptional circumstances are: (1) the death or disability of a health care provider, (2) inactivation of a health care provider's license, (3) flat cancellation of a policy because of non-payment of premium and surcharge, or (4) unnecessary duplication of professional liability insurance.

Retroactive cancellations may be approved only if there are no claims pending during the policy period. If the Board's Chief Counsel does not approve a late notice or report, the insurer or health care provider may request further consideration by the Board of Governors by submitting a written request to the Executive Director at least ten days prior to the next Board meeting.

Residents in Training

Persons engaged in residency training pursuant to K.S.A. 40-3401(r) are self-insured by the State of Kansas only when they are involved in providing medical services directly related to institutional graduate medical education. Subsection (d) of K.S.A. 40-3402 allows residents in training who provide extracurricular professional services ("moonlight") to obtain basic coverage under an occurrence form policy if such policy provides coverage substantially the same as a claims made policy otherwise required under K.S.A. 40-3402. Upon completing residency training, if the resident was insured under an occurrence policy for his or her moonlighting employment, the HCSF surcharge collected pursuant to K.S.A. 40-3404 will be assessed at the first year rate and will

increase annually in accordance with the schedule of surcharge rates adopted by the Board of Governors.

Exemptions

Subsection (b) of K.S.A. 40-3403 delegates authority to the Board of Governors to grant temporary exemptions from the basic insurance requirements of K.S.A. 40-3402 and also the HCSF coverage requirements of K.S.A. 40-3404. Such temporary exemptions may be granted only to health care providers who have exceptional circumstances and verify in writing that they will not render professional services during the period of exemption. The Board will consider requests for temporary exemptions only from health care providers who already have an active Kansas license. The Board will consider requests for temporary exemptions for purposes of: (1) obtaining additional education or training, (2) active duty military or other government service, (3) humanitarian service, (4) religious service, (5) maternal or paternal leave, (6) illness or disability, or (7) other compelling reasons.

Health Care Provider Facilities

Medical care facilities, health care facilities, psychiatric hospitals, and community mental health centers that are defined health care providers pursuant to K.S.A. 40-3401 must be located in the State of Kansas in order to be licensed to operate in Kansas, and therefore they are resident health care providers under the HCPIAA.

The HCSF provides "tail" coverage for claims made against an inactive health care provider that were not previously reported to the provider's primary insurance carrier. A health care provider facility becomes an "inactive health care provider" if it discontinues operations and cancels its professional liability insurance. Change of ownership or change of management of a health care provider facility does not meet the definition of "inactive health care provider" under K.S.A. 40-3401.

A new owner or manager of a health care provider facility must obtain basic professional liability insurance that provides "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" (K.S.A. 40-3402).

Business Entities

Health care providers that are subject to the HCPIAA are required to obtain professional liability insurance and participate in capitalizing the Fund by paying premium surcharges. Enforcement of this requirement is normally delegated to the licensing agency. A health care provider cannot renew a license, unless the provider has purchased the necessary insurance coverage or has established itself as a self-insured health care provider.

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Health care providers that organize a business entity for the purpose of rendering health care services are also required to purchase professional liability insurance on behalf of the business organization, and are required to pay a premium surcharge to the Fund for the statutory excess coverage. It is the responsibility of the organizers of a health care business entity to purchase professional liability insurance. Insurers are responsible for submitting the notice of basic coverage and HCSF surcharge payment.

For purposes of Fund coverage, professional corporations, not-for-profit corporations, limited liability companies, and partnerships must be incorporated or otherwise organized by health care providers defined as such under K.S.A. 40-3401. The statement of professional purpose of: (1) a professional corporation, (2) a not-for-profit corporation, (3) a limited liability company, or (4) the partnership agreement or contract of a partnership must indicate that the business entity is organized for the purpose of providing services that are consistent with the professional services that may be provided by the incorporators, organizers, or partners.

Professional Corporations A professional corporation incorporated by health care providers pursuant to K.S.A. 17-2709 must submit to the Board: (a) a copy of the articles of incorporation including a statement of professional purpose; and (b) a copy of a certificate from the licensing agency for each incorporator indicating that the incorporator is duly licensed and that the proposed corporate name has been approved.

Not-for-profit Corporations A not-for-profit corporation incorporated by health care providers to provide health care services in Kansas must submit to the Board: (a) a copy of the articles of incorporation including a statement of professional purpose; and (b) a copy of a certificate from the licensing agency for each incorporator indicating that the incorporator is duly licensed and that the proposed corporate name has been approved.

Limited Liability Companies A limited liability company organized by health care providers to provide health care services in Kansas must submit to the Board: (a) a copy of the articles of organization including a statement of professional purpose; and (b) a copy of a certificate from the licensing agency for each member of the company indicating that the member is duly licensed and that the proposed company name has been approved.

Partnerships A partnership formed by health care providers to provide health care services in Kansas must submit to the Board: (a) a copy of the partnership agreement or contract; and (b) a current list of the partners indicating their professional license numbers.

Self-Insured Health Care Providers

Eligibility for Self-Insurance. Any health care provider or health care system that wants to become self-insured must meet the eligibility criteria prescribed in K.S.A. 40-3414 as amended by L. 2015, Ch. 45, §8.

Application for Certificate of Self-Insurance. A health care provider that wants to become self-insured must submit a letter of intent to the Board at least six months prior to the date when the health care provider wants to become self-insured. If the health care provider is an individual professional, the letter must be signed by the health care provider.
If the health care provider is a partnership, the letter must be signed by all partners. If the health care provider is a medical care facility or health care system, the letter must be signed by the legal representative of the governing authority. If the health care provider is a corporation or a limited liability company, the letter must be signed by the chairperson of the board of directors.

Within 60 days of the letter of intent to become self-insured, the health care provider must submit to the Board the following information:

(1) a copy of the health care provider's most recent audited financial statement;
(2) a description of the health care provider's financial condition including any material changes after the most recent audited financial statement;
(3) a copy of the minutes of the meeting of the governing authority which reflects approval of the creation of a separate segregated fund for payment of claims, or a copy of a resolution adopted by the governing authority authorizing creation of a separate segregated fund for payment of claims;
(4) a statement of the amount of liquid assets to be reserved for settlement of claims or payment of judgments against the health care provider; and
(5) a description of the procedures that will be used by the health care provider in the event a claim is filed against the health care provider including: (a) the method of reporting claims to the Board of Governors; (b) the positions and names of individuals responsible for reporting claims to the Board of Governors; and (c) the methods that will be used by the health care provider to investigate and evaluate claims.

Within 90 days of the letter of intent to become self-insured, the health care provider must submit to the Board the following information:

(1) a history of claims for the previous five years identifying paid losses for closed claims and loss reserves for open claims;
(2) an independent actuary's report indicating recommended reserves for self-insurance of the health care provider including reserves for prior acts; and
(3) a copy of the liability insurance policy or declarations page providing insurance coverage for employees who are not health care providers, or an explanation of separate self-insured coverage independent of the self-insurance of health care providers.

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Quarterly Reports of Reserves. A self-insured health care provider must submit a statement every three months which reports the current balance in the segregated fund established for payment of claims.

Notice of Material Change. If a self-insured health care provider experiences a material change in its ownership, financial condition, or procedures for handling self-insured professional liability claims, the health care provider must notify the Board of the material change within 30 days of knowledge of the change.

Renewal of Certificate of Self Insurance. A self-insured health care provider must annually resubmit updated information described above (except for the letter of intent) in order to maintain continuous self-insured status.

Revocation of Certificate of Self Insurance. Reasonable grounds for which the Board may revoke a certificate of self-insurance include, but are not limited to, the following:

(1) failure to comply with the Health Care Provider Insurance Availability Act;
(2) failure to comply with other Kansas statutes;
(3) failure to pay judgments or court approved settlements;
(4) failure to pay the premium surcharge required by K.S.A. 40-3402;
(5) failure to submit quarterly statements of reserves;
(6) failure to comply with any conditions contained in the certificate issued by the Board;
(7) failure to annually resubmit the required information described above;
(8) change in ownership; or
(9) change in financial condition.

Requests for Records or Other Information

Records Custodian. The Chief Attorney is the official custodian of records maintained by the Health Care Stabilization Fund (HCSF) Board of Governors. The Executive Director will act as official custodian of records in the Chief Attorney's absence.

The official custodian will provide guidance to the Board's staff regarding the Kansas Open Records Act and will decide whether records in the custody of the Board are open records. The official custodian may authorize categories of records that can be routinely provided to requestors. The official custodian may designate a member of the Board's staff to respond to routine requests for open records.

Open records will not be removed from the Board's office location, but copies of open records may be removed. Any person requesting on-site review of open records must provide photo identification prior to examination of the open record. The official custodian or designee will supervise all on-site examination of open records.

Response to Requests. The HCSF Board of Governors will respond to a written request for a public record within three business days following the date of the request. A request

for information received via facsimile or electronic mail message may be considered a written request if other criteria are met. A written request must identify the name and address of the requestor and must clearly identify the specific record requested.

A request for records received via telephone communication will not be considered sufficient to warrant a response. A request for electronic records stored in a database will not be made available unless the requestor clearly identifies one or more individual data records that can be readily converted to a digital image or a printed page. If for some reason the request cannot be accommodated within the three-day period, the requestor will be informed of the delay and the reason. If the request is for information that is not a public record, the requestor will be informed within three business days following the date of the request that the request is denied.

Records and Information Not Available to the Public. Records that are not subject to the Kansas Open Records Act include, but are not limited to: (1) medical records or other personally identifiable health care information, (2) personnel records pertaining to employees of the Board, and (3) attorney work product or any other records pertaining to civil litigation, criminal prosecution, or administrative adjudication. Such information will not be made available for public examination nor will copies be reproduced for any requestor.

Fees. Response to a request for one or more copies of a public record will be contingent upon payment of the appropriate fee by the requestor. The official custodian may waive the payment of a fee when the request is submitted by a health care provider that has paid the appropriate HCSF premium surcharge. A single image of a record that can be attached to an electronic mail message may also be provided without charge. Otherwise, the following fees will be collected from the requestor.

Staff Time for Record Retrieval:	$4.00 per quarter hour
Custodian Time for Record Review:	$16.00 per quarter hour
Photocopies:	$0.25 per page
Postage:	U.S. Postal Service Rate
Fax Transmission:	
Local Transmission	$0.25 per page
Long Distance Transmission	$0.50 per page

Definition of Terms and Phrases
Applicable to Policies and Procedures
Adopted by the Health Care Stabilization Fund Board of Governors

Statutory definitions for the Health Care Provider Insurance Availability Act are contained in K.S.A. 40-3401. The following definitions are for clarification of legislative intent, and are established by the HCSF Board of Governors for purposes of guidance policies and procedures adopted by the Board.

"Board" means the Health Care Stabilization Fund Board of Governors.

"Fund" means the Health Care Stabilization Fund.

"Health care facility" means:
(1) a licensed nursing facility as defined in K.S.A. 39-923;
(2) a licensed assisted living facility as defined in K.S.A. 39-923; or
(3) a licensed residential health care facility as defined in K.S.A. 39-923.

"Health care system" means an organization that owns and operates two or more licensed medical care facilities located in Kansas or an organization that owns and operates two or more licensed health care facilities located in Kansas.

"Medical care facility" means:
(1) a licensed ambulatory surgical center located in Kansas as further defined in K.S.A. 65-425;
(2) a licensed critical access hospital located in Kansas as further defined in K.S.A. 65-468;
(3) a licensed general hospital located in Kansas as further defined in K.S.A. 65-425;
(4) a licensed recuperation center located in Kansas as further defined in K.S.A. 65-425; or
(5) a licensed special hospital located in Kansas as further defined in K.S.A. 65-425.

"Personal injury action" means a civil action or claim for personal injury or death arising out of the rendering of or the failure to render professional services.

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