Kansas Health Care Stabilization Fund

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Report to the

Health Care Stabilization Fund Oversight Committee

October 15, 2014

on behalf of the

Health Care Stabilization Fund Board of Governors

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by

Charles L. Wheelen, HCSF Executive Director

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Rita L. Noll, HCSF Deputy Director and Chief Attorney

Statutory Annual Report

The following information is reported on behalf of the Health Care Stabilization Fund Board of Governors in accordance with K.S.A. 40-3403(b)(1)(C). This report is for the fiscal year that ended June 30, 2014.

1. Net premium surcharge revenue collections amounted to $24,231,068.

2. The lowest surcharge rate for a health care professional was $50 for a chiropractor in his or her first year of Kansas practice who selected the lowest coverage option ($100,000 per claim with $300,000 annual aggregate).

3. The highest surcharge rate for a health care professional was $14,058 for a neurosurgeon with five or more years of Health Care Stabilization Fund liability exposure who selected the highest coverage option ($800,000 per claim with $2.4 million annual aggregate). If a Kansas resident neurosurgeon was also licensed to practice in Missouri, the 30% Missouri modification factor would result in a total premium surcharge of $18,275.

4. There were 27 medical professional liability cases involving 35 health care providers tried to juries. Of these 27 cases, one resulted in a mistrial. Three of the cases (11.1%) resulted in verdicts for the plaintiff, but only two of those resulted in HCSF obligations. The other 23 cases (85.1%) resulted in verdicts for the defense.

5. During the past fiscal year 525 open HCSF claims were closed. Of those claims, only 66 claims (12.6%) resulted in Fund obligations. Fifty two cases involving 63 claims were settled, which resulted in Health Care Stabilization Fund obligations amounting to $24.0 million. The average Stabilization Fund compensation per settlement was $381,046, a 9.0% increase compared to FY2012. These amounts are in addition to compensation paid by primary insurers (typically $200,000 per claim).

6. Because of periodic payment of compensation and other cash-flow characteristics, the amounts reported above in items four and five were not necessarily paid during FY2014. Total claims paid during the fiscal year amounted to $25,029,266.

7. The balance sheet as of June 30, 2014 accepted by the Board of Governors indicated assets amounting to $265,988,612 and liabilities amounting to $202,561,375.

Evolution of the Health Care Provider Insurance Availability Act

The Health Care Provider Insurance Availability Act was passed in 1976 at a time in Kansas history when many physicians and other health care providers could not purchase affordable professional liability insurance. In some cases, insurers were not willing to provide adequate coverage limits and some physicians could not obtain liability insurance at all.

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

Unlike commercial insurance policies, the original HCSF provided unlimited coverage. In other words, a doctor or hospital could be sued for any amount, and there was no limit on the amount a jury could award to a plaintiff, or the amount that could be agreed to in a settlement. Yet there was a statutory limit on the reserves that could be maintained in the Fund. In a few years, the accrued liabilities of the HCSF exceeded the $10 million cap on reserves for payment of claims and expenses.

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 for any one health care provider. Another major amendment removed the statutory limit on the Fund's balance and prescribed that the premium surcharges should be based on estimated liabilities. In other words, the Legislature decided the HCSF should be actuarially sound.

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

Principal Features of the Contemporary Act

Significant amendments to the Health Care Provider Insurance Availability Act were initiated as the result of a 1988 interim study by a special committee of the Legislature. The interim committee report was published in the January 18, 1989 Journal of the House and concluded by saying, "The Committee agreed with the near unanimous position of the conferees that the Health Care Stabilization Fund should be phased out and recommends that the 1989 Legislature enact legislation to abolish the Fund."

The 1988 interim committee reported that there were insufficient reserves to afford the accrued HCSF liabilities and recommended that, “the providers develop a plan by January 1, 1990, for paying the unfunded liabilities of the Fund and submit that plan to the Insurance Commissioner for his approval.”

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

Another significant change pertained to “tail” coverage. Until 1989, tail coverage was immediately provided when a health care provider became inactive. In other words, statutory HCSF coverage was similar to an occurrence type insurance policy. Any professional liability claims that arose after a health care provider had retired or otherwise discontinued his or her Kansas practice were still covered by the HCSF.

Because of concerns about the additional Fund liabilities attributable to tail coverage, the Legislature imposed a new requirement that health care providers must be in compliance, that is, pay surcharges into the Fund for at least five years in order to receive tail coverage. Provision was made such that any health care provider who lacked five years compliance could make additional payment to the Fund for the tail coverage. The payment had to be “sufficient to fund anticipated claims based upon reasonably prudent actuarial principles.” In other words, tail coverage for health care providers with fewer than 1,825 days participation in the Fund became voluntary.

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

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

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

Recent Developments

In October 2012 the Kansas Supreme Court announced that it upheld the constitutionality of a Kansas statute that limits the amount a plaintiff can recover for noneconomic damages in a personal injury lawsuit. The media release issued by the Court's Education-Information Officer stated, "Our court has long recognized that the legislature may modify the common law in limited circumstances, as long as the legislature provides an adequate substitute remedy or quid pro quo." The media release went on to say, "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."

As a result of the decision in Miller v. Johnson, there was renewed interest in the Availability Act. A number of organizations representing health care professionals or health care facilities inquired about the possibility of becoming defined health care providers under the Act. We provided information to those organizations, but our Board of Governors remained neutral regarding whether those new categories of professionals and facilities should be added to the Board of Governor's responsibilities. In the meantime, we drafted some technical amendments to update the Health Care Provider Insurance Availability Act. This included two significant tail coverage improvements.

Among other things, HB2516 repealed the five-year compliance requirement for HCSF tail coverage. In addition, when a health care provider becomes inactive, the amount of tail coverage is equal to the level of HCSF coverage on the date of the incident that resulted in a claim, plus the minimum coverage required for primary insurance (currently $200,000 per claim subject to not less than $600,000 annual aggregate coverage). This means that most health care providers will have $1.0 million per claim tail coverage immediately upon retiring or otherwise becoming inactive. This improvement benefits patients as well as physicians and other health care providers. We knew these changes would immediately increase our liabilities and reduce our unassigned reserves, but we also knew there has never been a better time to make these improvements.

Another bill enacted this year increased the limit on recovery of noneconomic damages in personal injury actions. You may recall that SB311 incrementally increases the cap on noneconomic damages as follows for causes of action accruing on or after the specified July 1 date:

- As of July 1, 2014 = $300,000
- As of July 1, 2018 = $325,000
- As of July 1, 2022 = $350,000

In other words, over a period of eight years, there will be a 40% increase in the amount that may be awarded by a court for pain and suffering or other noneconomic damages. Obviously this will increase our future liabilities.

Actuarial Analysis

Following enactment of SB311 and HB2516, we exercised a contingency clause in our contract with Towers Watson and asked Mr. Sutter to update our estimated liabilities based on passage of these two bills. That information is included in the next part of our report. Please note that the update does not estimate liabilities that will accrue as a result of adding five new categories of health care providers to our responsibilities. This includes two professions (nurse midwives and physician assistants) and also includes three categories of licensed adult care homes (assisted living facilities, nursing facilities, and residential health care facilities). Our next contract with Towers Watson in 2015 will include this expanded scope of analysis.

You may recall that one of your statutory duties is to decide whether to employ an independent actuary. Last year, during your discussion, one of your members indicated that he would like to know whether other states employ an independent actuary to offer second opinions. For that reason, we surveyed the six states other than Kansas that currently have some type of patient compensation fund. The result of our survey is described in the following table.

Fund State	Actuarial Services		Notes
Indiana	Contract,	Milliman	
Louisiana	Contract,	Towers Watson	
Nebraska	In-house		Insurance Department periodically contracts to evaluate actuarial analysis
New Mexico	Contract,	Pinnacle Actuarial	Also employs a staff actuary
South Carolina	Contract,	Merlinos & Associates	
Wisconsin	Contract,	Pinnacle Actuarial	Independent analysis is conducted every three years to evaluate assumptions and methodology

It should be noted that our approved budget for the current fiscal year does not include funding for a second independent actuarial analysis. If this Committee decides to recommend a second opinion, then it should also recommend that funding be authorized in our FY2016 budget. Another option would be an appropriation proviso that makes our expenditures for actuarial services not subject to our expenditure limitation.

The Medical Professional Liability Insurance Market

Following passage of HB2516 we received a number of inquiries from property and casualty insurance companies asking about the Kansas Health Care Provider Insurance Availability Act. This is because K.S.A. 40-3402 requires that Kansas resident health care providers purchase their basic coverage from an admitted carrier authorized by the Commissioner of Insurance to sell professional liability insurance to health care providers. We are led to believe that a number of companies are currently submitting the necessary documents to become admitted carriers in Kansas.

We also received a number of inquiries from insurance agents asking whether there is any way their clients (primarily adult care homes) can continue to purchase their basic coverage from non-admitted carriers. Our answer has been no, they cannot.

When the Legislature passed the original Health Care Provider Insurance Availability Act, the Legislature wanted to make certain that health care providers were insured by companies subject to regulatory oversight by the Commissioner of Insurance. In addition admitted carriers are required to pay assessments into a guaranty fund such that if an insurance company becomes insolvent, any remaining claims for which the company would have been liable can be paid by the guaranty fund. The Health Care Provider Insurance Availability Plan was created in order to assure that if a health care provider could not purchase liability insurance from an admitted carrier, the health care provider would always have access to coverage and thus be able to comply with the Act. This system has worked successfully for physicians, hospitals, and other health care providers for almost four decades

We believe the original legislative intent described above should be preserved for the protection of both the health care providers and their patients. Furthermore, at least seven insurance companies and risk retention groups have already obtained authorization to sell coverage to the three categories of adult care homes that will become defined health care providers on January 1, 2015. There is reason to believe that prior to January 1, 2015 there will be additional admitted carriers offering approved insurance coverage to adult care homes. And finally, if any Kansas adult care homes cannot obtain coverage from an admitted carrier, they will have reliable access to coverage via the Availability Plan.

Implementation Progress

You may recall that we requested a six-month transition period for implementation of House Bill 2516. Shortly after approval by the Governor, we initiated an education program for the benefit of the new health care providers and their insurers. We have provided educational programs for the two associations that represent adult care homes and we were invited to conduct a webinar for the Kansas Association of Insurance Agents. We have spent an extraordinary amount of time answering phone calls and responding to email messages. In the meantime, we have received exceptional support from the Board of Nursing and the Board of Healing Arts. They have contacted every licensed nurse midwife and every licensed physician assistant to make them aware of HB2516.

Thus far we have encountered some minor problems that were unforeseen. We discovered that although the Board of Nursing has statutory authority to grant inactive licenses to licensed nurses (RNs and LPNs), they do not have authority to grant inactive licenses to advanced practice nurses. There are a few APRNs who currently have active Kansas licenses, but they are no longer actually practicing in Kansas.

Fortunately, the Legislature delegated authority to our Board of Governors to grant temporary exemptions to health care providers when there are exceptional circumstances. When we do this, we require an affidavit that swears the health care provider will not provide patient care in the State of Kansas during the period of exemption.

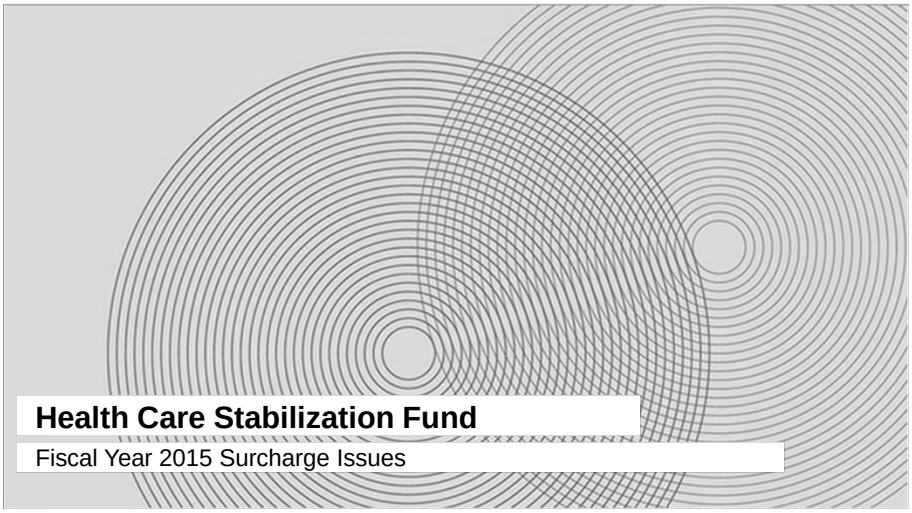
In addition, we discovered that there are some physician assistants who continue to maintain active licenses solely for the purpose of providing charity care at clinics for medically indigent patients. The Board of Healing Arts has agreed to request legislation to create an exempt license category for physician assistants that will allow these physician assistants to continue providing charity care in those limited settings and of course they will be exempt from the professional liability insurance requirements under the Health Care Provider Insurance Availability Act.

As you may know, there is a section of the Kansas Statutes (K.S.A. 39-937) that requires all licensed adult care homes to comply with all pertinent laws of the State of Kansas. Of course we consider the Health Care Provider Insurance Availability Act pertinent to assisted living facilities, nursing facilities, and residential health care facilities (on and after January 1, 2015), but it has been suggested that the Secretary for Aging and Disability Services lacks the authority to enforce compliance with the Availability Act. We respectfully disagree with that suggestion, but to be certain, we have corresponded with the General Counsel at the Department for Aging and Disability Services requesting his opinion on this matter. We anxiously await a response from Mr. Rein. Depending on his response, we may need to request legislation delegating necessary enforcement authority to the Secretary for Aging and Disability Services.

Conclusion

We do not believe there is any reason to amend the Health Care Provider Insurance Availability Act in the near future. We may need to request additional staff depending on the level of claims activity after January 1, 2015, but that will be a budgetary matter. We will continue to assist the new health care providers and their insurers to make the transition successful and assure that HB2516 is implemented in accordance with legislative intent.

Thank you.



Health Care Stabilization Fund

Fiscal Year 2015 Surcharge Issues

A presentation to the Health Care Stabilization Fund Oversight Committee
by Russel L. Sutter
October 15, 2014

This document was designed for discussion purposes only.
It is incomplete, and not intended to be used, without the accompanying oral presentation and discussion.

TOWERS WATSON

Table of Contents

- This presentation will address findings from our most recent annual study
  - Our projections of unassigned reserves at June 2014 and June 2015
  - Rate level indications for FY2015 (July 1, 2014 – June 30, 2015)
  - Observations regarding Fund loss experience
- The presentation will also discuss our analysis of anticipated changes in the Fund due to SB 311 and HB 2516
  - Higher caps on non-economic damages (SB 311)
  - Repeal of five-year compliance requirement for tail coverage eligibility (HB 2516)
  - $200,000 increase in coverage limits afforded to inactive providers (HB 2516)
- Questions are welcome throughout the presentation
- This presentation is an addendum to our report dated March 20, 2014 and our subsequent analysis of legislative changes dated September 8, 2014. As such, the **Distribution and Use** and **Reliances and Limitations** sections of those documents apply to this presentation

Conclusions – Annual Study

- Our forecasts of the Fund's position at June 30, 2014 and June 30, 2015 are as follows (in $millions)

Category	June 30, 2014	June 30, 2015
Assets	$261.88	$265.89
Liabilities	190.26	194.04
Unassigned Reserves	$ 71.62	$ 71.85

- In our 2013 study, we forecasted higher levels of assets ($265.4m) and liabilities ($197.5m) at June 2014, with a lower unassigned reserve ($67.8m). Payment activity in calendar year 2013 was higher than anticipated

Conclusions (continued)

- The forecasts assume
  - No change in surcharge rates for FY2015
  - $24.1 million in surcharge revenue in FY2015
  - A 3.85% yield on Fund assets
  - Full reimbursement for KU/WCGME claims, with continued payback of reimbursements from the state that were delayed until FY2014
  - No change in current Kansas tort law
  - Potential increase in claims due to Missouri's 2012 overturn of non-economic damage caps
- At its March 2014 meeting, the Board of Governors decided to make no change to the surcharge rates for FY2015

Liabilities at June 30, 2014

- The split of the Fund's liabilities at June 30, 2014 is as follows (in $millions)

Active Providers – Losses	$ 79.0
Active Providers – Expenses	15.9
Inactive Providers – Known at 6/30/14	7.1
Inactive Providers – Tail	75.2
Future Payments	14.9
Claims Handling	5.5
Other	0.9
Subtotal – Gross Liabilities	$198.4
Reimbursements	-8.2
Total Net Liabilities	$190.3

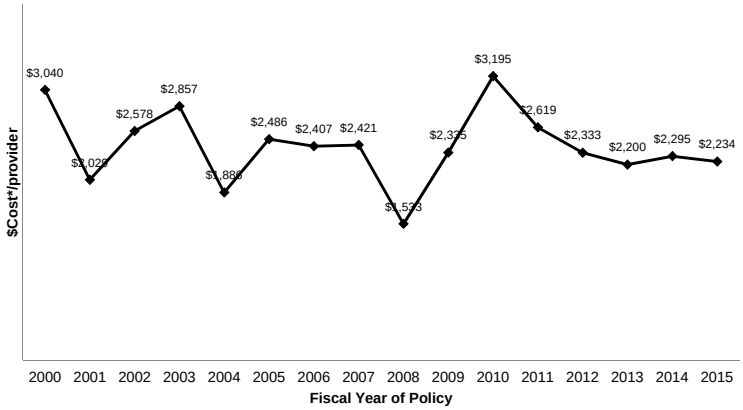
Rate Level Indications

- The Fund's rate level indications for FY2015 are shown below; assumes a break-even target

FY2015 Item	Amount ($000s)	Comments
1. Payments	$28,208	Net of Reimbursement
2. Change in Liabilities	3,785	From slide #3
3. Administrative Expenses	1,610	Based on FY13 and FY14
4. Plan and KDADS	200	Assumes no Plan transfer
5. Total FY2015 Costs (1) + (2) + (3) + (4)	$33,803	
6. Investment Income	9,898	3.85% on average assets
7. Surcharge Needed for Break-Even (5) – (6)	$23,905	
8. Projected Surcharge Revenue	24,129	At FY2014 rates
9. Rate Level Indications (7) / (8) – 1.00	-0.9%	

Observations on Fund Loss Experience

- The chart below shows the indicated cost per active provider since 2000. Indications for 2009-2014 include some conservatism in our selections due to the 2012 change in Missouri law



* Ultimate settlements and expenses, less reimbursed amounts, per provider. Excludes claims from inactive providers

Legislative Changes – Summary of Estimated Impacts

- The table below shows how our estimates of the Fund's financial position at June 30, 2015 changes due to SB 311 and HB 2516 (in $millions)

Category	Estimated June 30, 2015 Fund Financials	
	Annual Study	Reflecting SB 311 and HB 2516
Assets	$265.89	$265.89
Liabilities	194.04	221.83
Unassigned Reserves	$ 71.85	$ 44.06

- The estimate breakdown of the $27.8 million increase in Fund liabilities by law change is shown on the next slide

Legislative Changes – Impact by Specific Changes

- The table below shows our estimates of the changes in Fund liabilities by specific change, split by active providers versus inactive providers

Legislative Change	Impact on Liabilities at June 30, 2015 ($millions)			
	Active Providers	Inactive Providers	Other*	Total
1. Increase in caps	$ 0.3	$ 1.7	$ 0.1	$ 2.1
2. Waiver of 5-year Compliance for Tail Coverage	0.0	21.9	1.1	23.0
3. Higher limits for Inactive Providers	0.0	2.6	0.1	2.7
4. Total	$ 0.3	$26.2	$ 1.3	$27.8

* Claims-handling costs to be incurred by the Fund

Legislative Changes – Other Comments

- The increase in caps on non-economic damages has only a modest initial impact on the Fund's losses from active providers. That impact will grow over time. Ultimately, we estimate the higher caps will increase the Fund's indicated rate level by 10%
- The changes relative to inactive providers cause an immediate and material increase in the Fund's liabilities. However, that impact is virtually a one-time hit
- The changes cause additional uncertainty in estimates of the Fund's liabilities until the effects can be quantified with subsequent experience

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Medical Professional Liability Experience
Fiscal Year 2014

By Rita Noll
Deputy Director and Chief Attorney

This report for the Board of Governors of the Health Care Stabilization Fund summarizes medical professional liability experience in Kansas during fiscal year 2014. The report is based on statistical data gathered by the Fund in administering the Health Care Provider Insurance Availability Act.

This report on medical malpractice litigation is based on all claims resolved in fiscal year 2014 including judgments and settlements. By far, the majority of medical malpractice cases are resolved by settlement rather than by jury trial.

Medical professional liability refers to a claim made against a health care provider for the rendering of or failure to render professional services (K.S.A. 40-3403). Health care provider is defined in K.S.A. 40-3401 to include physicians, chiropractors, podiatrists, registered nurse anesthetists, and certain medical care facilities. Fiscal year 2014 covers the period of time from July 1, 2013 through June 30, 2014.

It should be noted that dollar amounts will not necessarily correspond with the agency's accounting and budgeting documents because claims are not necessarily paid in the same fiscal year that the settlement was approved by the court, or the judgment was rendered by a jury. Data in this report reflects the status of cases at the end of the fiscal year. Data for prior years is for comparison purposes only, as case outcomes may have changed due to subsequent court proceedings.

MEDICAL PROFESSIONAL LIABILITY EXPERIENCE

A. Jury Verdicts

From HCSF data, 27 medical malpractice cases involving 35 Kansas health care providers were tried to juries during fiscal year 2014. Of these, 25 cases were tried to juries in Kansas courts, and two cases involving Kansas health care providers were tried to juries in Missouri. These jury trials were held in the following jurisdictions:

Sedgwick County	8
Johnson County	6
Wyandotte County	3
Jackson County, MO	2
Reno County	2
Douglas County	1
McPherson County	1
Montgomery County	1
Neosho County	1
Riley County	1
Shawnee County	1

Of the 27 cases tried, 23 resulted in defense verdicts, and one case ended in mistrial. Juries returned verdicts for plaintiffs in three cases as follows:

Case	Court	Verdict Amount	HCSF Amount
Plaintiff v. Doctor	Sedgwick Co.	$735,900	$535,900
Plaintiff v. Doctor	Reno Co.	$101,576	0
Plaintiff v. Doctor*	Johnson Co.	$1,252,785	$800,000
v. Corporation*		$417,595	$217,595

*Case on appeal

The following chart compares this year's experience to previous fiscal years:

Fiscal Year	Total Trials	Defense Verdict	Plaintiff Verdict	Split Verdict	Mistrials
2014	27	23	3		1
2013	18	14	4		
2012	21	19	1		1
2011	19	16	2	1	
2010	32	21	7	1	3
2009	27	20	5	1	1
2008	34	25	4	1	4
2007	36	31	5		
2006	29	23	6		
2005	34	22	7	3	2
2004	28	23	3	2	
2003	27	23	3		1

B. Settlements

Claims settled by the Fund. During FY 2014, 63 claims in 52 cases were settled involving HCSF monies. Settlement amounts incurred by the HCSF for the fiscal year totaled $24,005,914. These figures do not include settlement contributions by primary or excess insurance carriers. The settlement amounts are payments made, or to be made, by the HCSF in excess of primary coverage or on behalf of inactive health care providers.

Fiscal Year	Number of Claims/Cases	Fund Amount	Settlement Average
FY 2014	63/52	$24,005,914.00	$381,046
FY 2013	79/62	$27,610,000.00	$349,494
FY 2012	67/62	$21,431,000.00	$319,866
FY 2011	61/57	$17,518,727.54	$287,192
FY 2010	61/54	$19,745,200.00	$323,692
FY 2009	81/72	$23,867,283.72	$294,658
FY 2008	65/57	$17,352,500.00	$266,962
FY 2007	61/53	$20,929,250.00	$343,102
FY 2006	89/81	$24,917,984.00	$279,977
FY 2005	90/74	$23,544,658.00	$261,607
FY 2004	79/64	$18,905,505.00	$239,310
FY 2003	87/76	$17,483,778.00	$200,963
FY 2002	67/58	$16,173,742.00	$241,399
FY 2001	54/44	$15,592,748.80	$288,755
FY 2000	69/59	$20,071,607.50	$290,893
FY 1999	70/57	$18,344,368.15	$262,062
FY 1998	60/53	$11,461,345.13	$191,022
FY 1997	39/33	$12,448,978.83	$319,204
FY 1996	67/51	$21,808,406.14	$325,498
FY 1995	42/36	$15,344,749.98	$365,351
FY 1994	59/45	$19,526,821.53	$330,963
FY 1993	45/37	$18,239,093.06	$405,313
FY 1992	33/27	$ 7,890,119.83	$239,095
FY 1991	44/NA	$16,631,491.94	$377,988

Health Care Stabilization Fund individual claim settlement contributions during fiscal year 2014 range from a low of $15,000 to a high of $800,000. HCSF settlements fall within the following ranges and are compared to individual claim settlements in previous years:

	FY14	FY13	FY12	FY11	FY10	FY09	FY08	FY07	FY06
$000-$9,999	0	0	0	0	0	2	0	0	0
$10,000-$49,999	5	2	7	6	5	12	6	6	9
$50,000-$99,999	10	5	10	12	11	10	12	7	12
$100,000-$499,999	24	52	32	29	29	37	34	27	51
$500,000-$800,000	24	20	18	14	16	20	13	21	17
Total Claims	63	79	67	61	61	81	65	61	89

Of the 63 claims, the Fund provided primary coverage for inactive health care providers in nine claims. Also, the Fund "dropped down" to provide first-dollar coverage for six claims in which aggregate primary policy limits were reached. Primary insurance carriers tendered their policy limits to the Fund in 54 claims. Therefore, in addition to the $24,005,914 incurred by the Fund, primary insurers contributed $10,135,000 to these settlements. Further, four claims involved contribution from an insurer whose coverage was excess of Fund coverage. The total amount of these contributions was $3,875,000.

Total settlement amounts for claims involving Fund contribution are as follows:

Fiscal Year	Primary Carriers	HCSF	Excess Carriers
FY 14	$10,135,000.00	$24,005,914.00	$ 3,875,000.00
FY 13	$13,310,000.00	$27,610,000.00	$ 6,000,000.00
FY 12	$10,800,000.00	$21,431,000.00	$ 5,083,500.00
FY 11	$10,400,000.00	$17,518,727.54	$ 4,350,000.00
FY 10	$ 9,400,000.00	$19,745,200.00	$14,972,500.00
FY 09	$11,471,170.00	$23,867,283.72	$ 4,954,830.00
FY 08	$10,612,500.00	$17,352,500.00	$ 2,425,000.00
FY 07	$ 9,488,750.00	$20,929,250.00	$ 3,125,000.00
FY 06	$14,580,000.00	$24,917,984.00	$ 5,089,425.00
FY 05	$15,800,000.00	$23,544,658.00	$10,450,000.00
FY 04	$12,600,000.00	$18,905,505.00	$ 8,550,000.00
FY 03	$14,200,000.00	$17,483,778.00	$ 2,787,500.00
FY 02	$11,400,000.00	$16,173,742.00	$ 2,680,000.00
FY 01	$ 8,800,000.00	$15,592,748.80	$ 6,710,000.00
FY 00	$12,515,000.00	$20,071,607.50	$ 2,465,000.00
FY 99	$11,800,000.00	$18,344,368.15	$ 8,202,500.00
FY 98	$ 8,825,000.00	$11,461,345.13	$ 3,040,000.00
FY 97	$ 6,046,667.33	$12,448,978.83	$ 1,117,500.00
FY 96	$11,000,000.00	$21,808,406.14	$ 1,065,000.00

Claims settled by primary carriers. In addition to the settlements discussed above, the HCSF was notified that primary insurance carriers settled an additional 97 claims in 86 cases. The total amount of these reported settlements is $8,909,740. These figures compare to previous fiscal years as follows:

Fiscal Year	Settlement Reported Claims/Cases	Amount Paid by Primary Insurance Carriers
2014	97/86	$ 8,909,740.00
2013	88/76	$ 6,664,000.00
2012	98/81	$ 6,603,521.00
2011	99/83	$ 7,865,915.00
2010	110/92	$ 8,958,622.00
2009	90/80	$ 7,182,241.00
2008	104/88	$ 8,486,032.00
2007	167/146	$10,870,339.00
2006	110/98	$ 8,545,218.00
2005	103/88	$ 8,058,894.00
2004	99/85	$ 6,978,801.00
2003	122/99	$ 9,087,872.00
2002	141/124	$10,789,299.00
2001	109/88	$ 8,124,459.00
2000	116/102	$ 8,390,869.00

C. HCSF Total Settlements and Verdict Amounts

During fiscal year 2014 the HCSF incurred $24,005,914 in 63 claim settlements and became liable for $1,553,495 for three claims as a result of jury verdicts for a total 66 claims. The following figures show total Fund settlements and awards since the inception of the Health Care Stabilization Fund.

Fiscal Year	Total Claims	Settlements & Jury Awards	Average Per Claim
FY 2014	66	$25,559,409.00	$387,263.77
FY 2013	79	29,382,484.69	371,930.19
FY 2012	67	21,431,000.00	319,965.67
FY 2011	63	19,118,727.54	303,471.87
FY 2010	65	20,970,021.10	322,615.71
FY 2009	85	25,505,208.67	300,061.28
FY 2008	68	19,085,004.00	280,661.82
FY 2007	64	22,589,655.27	352,963.36
FY 2006	90	25,017,984.00	277,977.60
FY 2005	97	26,119,569.91	269,273.30
FY 2004	81	19,055,505.00	235,253.15
FY 2003	90	18,295,320.32	203,281.34
FY 2002	71	17,467,033.19	246,014.55
FY 2001	58	17,114,748.80	295,081.86
FY 2000	73	20,868,192.91	285,865.66
FY 1999	71	21,344,368.15	300,624.90
FY 1998	66	12,834,705.13	194,465.23
FY 1997	41	13,653,618.34	333,015.08
FY 1996	70	23,258,406.14	332,262.94
FY 1995	45	17,023,882.17	378,308.49
FY 1994	65	21,194,765.96	326,073.32
FY 1993	48	24,614,093.06	492,281.86
FY 1992	35	8,824,834.14	252,138.11
FY 1991	49	19,666,797.32	401,363.21
FY 1990	48	13,627,222.20	283,700.46
FY 1989	58	18,713,543.00	315,750.00
FY 1988	51	13,402,756.00	262,799.00
FY 1987	47	13,296,808.00	282,910.00
FY 1986	42	11,492,857.00	273,639.00
FY 1985	41	15,152,042.00	369,562.00
FY 1984	34	9,538,741.00	280,551.00
FY 1983	25	6,522,369.00	260,894.00
FY 1982	24	3,060,126.00	127,505.00
FY 1981	8	1,760,645.00	220,080.00
FY 1980	0	0.00	-
FY 1979	3	203,601.00	67,867.00
FY 1978	0	0.00	-
FY 1977	1	137,500.00	137,500.00

D. New Cases by Fiscal Year

The Health Care Stabilization Fund was notified of 268 new cases during fiscal year 2014. The following chart lists the number of new cases opened in each fiscal year since the Fund was created:

Fiscal Year	Number of Cases
2014	268
2013	229
2012	260
2011	267
2010	290
2009	310
2008	329
2007	304
2006	457
2005	336
2004	368
2003	392
2002	361
2001	341
2000	294
1999	319
1998	293
1997	318
1996	296
1995	326
1994	247
1993	263
1992	245
1991	230
1990	205
1989	251
1988	285
1987	320
1986	276
1985	245
1984	175
1983	153
1982	124
1981	98
1980	87
1979	50
1978	19
1977	2

University of Kansas Foundations and Faculty; Residents
Self-Insurance Programs/Primary Coverage
Reimbursement to the Health Care Stabilization Fund

I. KU Foundations and Faculty

Foundation Self-Insurance Program Costs

FY 2014	FY 2013	FY 2012	
$1,530,000.00	$ 975,000.00	$1,184,475.00	Settlement Amounts
$1,219,707.77	$ 562,668.29	$ 575,258.60	Attorney Fees and Expenses
$2,749,707.77	$1,537,668.29	$1,759,733.60	Totals

Reimbursable Amounts

FY 2014	FY 2013	FY 2012	
$ 500,000.00	$ 500,000.00	$ 500,000.00	Reimbursement Private Practice Reserve
$2,249,707.77	$1,037,668.29	$1,259,733.60	Reimbursement State General Fund
$2,749,707.77	$1,537,668.29	$1,759,733.60	Totals

II. KU and WCGME Residents

Residents Self-Insurance Program Costs

FY 2014	FY 2013	FY 2012	
0	0	0	Settlements, WCGME Residents
0	0	$ 351,025.00	Settlements, KU Residents
$539,702.75	$628,820.35	$ 474,606.44	Fees & Expenses, WCGME Residents
$259,661.06	$305,874.74	$ 375,477.55	Fees & Expenses, KU Residents
$799,363.81	$934,695.09	$1,201,108.99	Totals

Reimbursable Amounts

FY 2014	FY 2013	FY 2012	
$539,702.75	$628,820.35	$ 474,606.44	WCGME Reimbursement-General Fund
$259,661.06	$305,874.74	$ 726,502.55	KU Reimbursement-General Fund
$799,363.81	$934,695.09	$1,201,108.99	Totals - State General Fund

III. Expenditures by Fiscal Year

Fiscal Year	Foundations and Faculty*	KU and WCGME Residents**
2014	$2,749,707.77	$ 799,363.81
2013	1,537,668.29	934,695.09
2012	1,759,733.60	1,201,108.99
2011	1,184,218.79	455,621.25
2010	1,445,658.21	1,201,718.01
2009	2,693,099.94	812,492.66
2008	966,327.58	648,269.80
2007	2,037,227.63	1,194,968.11
2006	1,407,837.70	871,719.27
2005	1,706,763.57	1,749,032.25
2004	1,825,116.29	2,787,112.99
2003	1,113,326.84	1,418,927.85
2002	583,566.19	723,834.54
2001	1,540,133.41	953,304.62
2000	691,253.39	735,633.12
1999	1,371,640.73	645,997.65
1998	1,018,435.78	1,072,324.05
1997	1,111,787.72	999,388.16
1996	4,003,062.51	1,331,521.75
1995	255,117.85	534,124.84
1994	1,959,284.79	574,758.65
1993	1,453,444.21	650,033.67
1992	645,670.10	810,703.77
1991	435,540.69	458,561.65
1990	261,035.55	120,796.12

*Foundations and Faculty:
Amounts up to $500,000 are reimbursed from the Private Practice Reserve Fund.
Amounts over $500,000 are reimbursed from the State General Fund.
FY 10, FY 11, FY 12, FY 13, HCSF received reimbursement only from the Private Practice Reserve Fund.

**KU and WCGME Residents:
All amounts are reimbursed from the State General Fund.
FY 10, FY 11, FY 12, FY 13, HCSF received no reimbursement.

Amounts to be received from the State General Fund are carried forward as receiveables. The total accrued receiveables were $7,720,422.23. The HCSF received $1,544,084.43 reimbursement (20% of total) in July 2013 and $1,544,084.43 in July 2014. The remaining reimbursement receiveables are $4,632,253.37.

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

	FY 14	FY 13	FY 12	FY 11	FY 10
WCGME Residents	0	0	0	0	0
K.U. Residents	0	0	$150,000	0	0
Faculty, Foundations	$2,975,000	$1,267,500	$600,000	$195,000	$970,000
Total	$2,975,000	$1,267,500	$750,000	$195,000	$970,000