

# The Kansas Health Care Stabilization Fund

## Guidelines for the self-insurance provisions of the Fund

This brochure is intended to assist health care providers in understanding the basic professional liability self-insurance provisions of the Fund. Included in this brochure are the forms utilized in connection with the individual health care provider self-insurance authorizations by the Fund Board of Governors. Policies and procedures applicable to self-insured health care providers are published at the HCSF website <https://hcsf.kansas.gov/>.

**NOTICE:**

The information contained in this brochure is furnished as general guidelines and procedures to assist health care providers in understanding this important area of the Fund. ***The initial application for becoming an authorized basic professional liability self-insurer and the subsequent renewal request for the continuation of the basic professional liability self-insurer status is subject to the approval provisions by the Fund Board of Governors.***

### Which health care providers may make application for the basic professional liability self-insurer provisions of the Fund?

These self-insurance provisions of the Fund are applicable to individual health care providers. There are no provisions for “group” self-insurance for health care providers, although certain health care systems may combine their basic professional liability insurance premium costs to meet the \$150,000 premium eligibility requirement. Otherwise, the \$150,000 premium eligibility requirement is applicable to each individual health care provider. Applicants for self-insurance may qualify as a self-insurer by obtaining a certificate of self-insurance from the board of governors. The information furnished in this brochure is intended to be of assistance to health care providers who wish to submit their application for self-insurer status under the Fund law.

Individual health care provider certificates of self-insurance may be initiated for periods of up to one year; that is, the first authorized self-insurance certificate could be issued for less than one year, thereafter the certificate would customarily be continued for annual periods, subject to re-application to and re-approval by the Fund Board of Governors.

Surcharge payments for each health care provider are based on premium calculations utilizing the approved rules and rates of the Health Care Provider Insurance Availability Plan. Individual health care providers who are considering applying to the Fund Board of Governors to become an authorized basic professional liability coverage self-insurer should carefully review this Fund surcharge payment determination method with their insurance agent and risk management departments.

An initial letter of intent needs to be submitted to the Fund at least six months prior to the date an applicant wants to be authorized to be self-insured. The remaining portions of this brochure provides examples of the Fund forms, other required documents and a sample of the certificate of self-insurance that will be issued to applicants which are approved by the Fund Board of Governors.

**If You Have Questions or Need Additional Assistance:** Please contact the Fund office  
For any additional assistance you may feel is needed.



FACSIMILE  
785-291-3550

E-MAIL  
[hcsf@ks.gov](mailto:hcsf@ks.gov)



TELEPHONE  
785-291-3777



MAIL  
Health Care Stabilization Fund  
300 SW 8th Ave, 2nd Floor  
Topeka, KS 66603-3912



**Guide to letters, forms and other documentation used in connection with the health care provider application for basic professional liability self-insurance authorization from the Fund Board of Governors**

	<b>Description of item:</b>	<b>This should be:</b>	<b>To be submitted by:</b>	<b>Will be sent to:</b>
1.	Letter of request for consideration to become an authorized health care provider self-insurer	Letter of intent from new applicant 6 months prior to desired effective date	New applicants and applicants for the continuation of authorized self-insurance	Kansas HCSF Chief Financial Officer 300 SW 8 <sup>TH</sup> Avenue, 2 <sup>nd</sup> Fl. Topeka Kansas 66603-3912
2.	Health Care Provider Eligibility and Instructions for Basic Coverage Self-Insurance	Use to assist in the application or continuation process for the basic coverage self-insurance authorization of the Fund	N/A	N/A – Refer to page 3 of this brochure
3.	Application for Certificate of Self-Insurance from the Health Care Stabilization Fund Board of Governors	Completed and submitted with the initial application within 60 days of letter of intent	New applicant for Fund self-insurance	N/A – Refer to page 4 of this brochure
4.	Kansas Health Care Stabilization Fund Notice of Basic Coverage Instructions – Self-Insured Program	Complete sections I, II and III and submit with the completed application form, including the continuation of expiring self-insurance periods	Each applicant for Fund self-insurance	N/A – Refer to page 5 of this brochure
5.	Self-Insured Professional Liability Coverage Questionnaire For the Computation of the Annual Premium Based on the Rules and Rates of the Health Care Provider Insurance Availability Plan	Complete and submit with the application form, including applications for the continuation of expiring self-insurance periods	Each applicant for Fund self-insurance	N/A – Refer to page 6 of this brochure
6.	Declaration of Financial Compliance with the Kansas Health Care Provider Insurance Availability Act	Completed and submit with the application form, including applications for the continuation of expiring self-insurance periods	Each applicant for Fund self-insurance. Quarterly statements must be submitted	N/A – Refer to page 7 of this brochure
7.	Sample format of loss experience to be submitted	Completed and submit with the application form, including applications for the continuation of expiring self-insurance periods	Each applicant for Fund self-insurance	N/A – Refer to page 8 of this brochure
8.	Completed copy of the Kansas Health Care Stabilization Fund Notice of Basic Coverage Instructions – Self-Insured Program	N/A	N/A	To the Applicants who are approved by the Board of Governors. Section IV of this form completed by the Fund (this is the form that was initially submitted by the applicant).
9.	Checklist for the submission of a request for the issuance of a new or the continuation of a Certificate of Self-Insurance	Used as a guide by health care providers who are applying for basic coverage self-insurance authorization or continuation	N/A	N/A – Refer to page 9 of this brochure
10.	A copy of the liability policy or declarations page covering non-defined health care provider employees or an explanation as to how such employees are insured.	Submit with the application form, including applications for the continuation of expiring self-insurance periods	Each applicant for Fund self-insurance	N/A

## HEALTH CARE PROVIDER ELIGIBILITY AND INSTRUCTIONS FOR BASIC COVERAGE SELF-INSURANCE

The Kansas Health Care Provider Insurance Availability Act, K.S.A. 40-3414, provides that a health care provider, or health care system, whose annual insurance premium is or would be \$150,000 or more for basic coverage calculated in accordance with rating procedures approved by the Kansas Insurance Commissioner pursuant to K.S.A. 40-3413 may qualify as a self-insurer by obtaining a Certificate of Self-Insurance from the Kansas Health Care Stabilization Fund Board of Governors.

The issuance of the Certificate of Self-Insurance will be based upon the reports and information submitted by each applicant. In making the determination that the applicant has the ability, and will continue to have the ability, to pay any judgment for which liability exists equal to the amount of basic coverage (not less than \$500,000 per occurrence and not less than \$1,500,000 annual aggregate) required of each health care provider, the Board of Governors will consider the following:

- 1) The financial condition of the applicant and the amount of liquid assets reserved for the settlement of claims or potential claims. The most recent audited financial statement, reflecting the earnings and financial condition of the health care provider, must be submitted with the application. **Material changes that have occurred since the date of the audit must also be included.**
- 2) The procedures adopted and followed by the applicant to process and handle claims and potential claims.
  - a) The method of reporting claims to the Board of Governors. Notice of claims or actions for damages for injuries claimed to have been caused by the rendering of or failure to render professional services are to be submitted to the Board of Governors in accordance with K.S.A. 40-3421 (a).
  - b) Identification of individuals (by name and position) who are responsible for reporting claims to the Board of Governors as required by K.S.A. 40-3421(a).
  - c) The applicant should submit a narrative of any procedures adopted to handle and investigate grievances and complaints.
- 3) Any other relevant factors, including:
  - a) The applicant must provide an independent actuary's written report which provides recommendations for the applicant's self-insurance fund for the required basic \$500,000/\$1,500,000 professional liability insurance. The actuarial recommendations must also include the necessary funding for the prior acts liability that is assumed by the self-insured entity. Accompanying this actuarial report must be adequate information that the applicant has established or will establish a segregated professional liability self-insurance fund based on the actuary's recommendations.
  - b) A copy of the liability policy or declarations page covering non-defined health care provider employees or an explanation as to how such employees are insured and will not be considered part of the health care provider self-insurance program submitted for approval by the Board of Governors.
  - c) A method of notification to the Fund should the authorized self-insured health care provider become aware of any change in their financial, organization or operational structure and/or conditions that would adversely affect the basic coverage required by K.S.A. 40-3402 (a).
- 4) A five year claims history (not including the current or prior year) of all open and closed claims that includes the loss and loss expense reserves and paid loss and paid loss expense amounts associated with the claims. This experience report is to include only medical professional liability information for the applicant. Refer to page 8 for a sample of the experience report requested.

K.S.A. 40-3414 (b) requires any health care provider who holds a Certificate of Self-insurance to pay the applicable surcharge. In accordance with K.S.A. 40-3404 (a), the surcharge to be levied shall be an amount based upon a rating classification system established by the Board of Governors which is reasonable, adequate and not unfairly discriminating. The health care provider who holds a Certificate of Self-Insurance will be advised by the Board of Governors as to the dollar amount of the surcharge and will pay such amount to the Board of Governors within 30 days of notification of the amount. Such surcharge will be calculated on the basis of the rating information submitted on the completed questionnaire.

The Certificate of Self-Insurance form is continuous in nature until such certificate is suspended, revoked or terminated by the Health Care Stabilization Fund Board of Governors; however, on the subsequent annual renewal date, the items listed above must be resubmitted for reevaluation of continued eligibility.

**KANSAS HEALTH CARE STABILIZATION FUND BOARD OF GOVERNORS  
APPLICATION FOR CERTIFICATE OF SELF-INSURANCE**

\* \_\_\_\_\_ hereby makes application to the Kansas Health Care Stabilization Fund Board of Governors for a certificate of self-insurance pursuant to K. S. A. 40-3414 for the period of \_\_\_\_\_, 20\_\_\_\_ until such certificate is suspended, revoked or terminated by the Health Care Stabilization Fund Board of Governors and represents to said Board of Governors that \* \_\_\_\_\_ is a health care provider as defined in K.S.A. 40-3401 or is a system of health care providers as described in K.S.A. 40-3414.

Said health care provider or health care system understands that to be eligible for qualification as a self-insurer, the annual insurance premium for the basic coverage required by K.S.A. 40-3402(a) must equal or exceed \$150,000 when calculated in accordance with the rates and rating procedures (exclusive of any schedule rating modifications) approved by the Commissioner of Insurance pursuant to K.S.A. 40-3413 and that the completed rating information form attached hereto and made a part thereof, contains the information which will be used in determining compliance with such requirement.

Further, said health care provider or health care system hereby declares that in accordance with K.S.A. 40-3414(a), \* \_\_\_\_\_ is now and will continue to be possessed of the ability to pay any judgment equal to the amount of basic coverage required by K.S.A. 40-3402(a) and agrees that, in support of such declaration, the financial statement and claims handling procedural guide attached hereto and made a part thereof, may be used by the Health Care Stabilization Fund Board of Governors to satisfy that such declaration is a reasonable and valid evaluation.

It is agreed that, if a Certificate of Self-Insurance is issued pursuant to this application, the health care provider named herein will pay when assessed the applicable surcharge which is levied by the Board of Governors pursuant to K.S.A. 40-3404(a) and will cooperate in the preparation and submission of such reports and information as deemed necessary by the Board of Governors.

\_\_\_\_\_  
(Applicant Signature)

\_\_\_\_\_  
(By)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Date)

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
(Notary Public)

My commission expires \_\_\_\_\_

\*Name of health care provider or health care system desiring Certificate of Self-Insurance.

**Kansas Health Care Stabilization Fund Notice of Basic Coverage  
Instructions - Self-Insured Program**

1. This form is provided by the Health Care Stabilization Fund for those health care providers or health care systems which are authorized self-insurers.
2. The information in Sections I and II have been completed by the department and should be checked for any errors.
3. Section III must be completed and signed by the authorized officer of your medical care facility.

**SECTION I**

Health Care Provider's Name:			
Name of Medical Care Facility:			
Residence Address:			
City:			

**SECTION II**

Contact person for Self-Insured Program

Health Care Provider's Authorized Representative:			
Business Name:		Phone #	
Business Address:			
City :		State: KS	

**SECTION III**

The \_\_\_\_\_, hereby selects Health Care Stabilization Fund

Coverage Limits of :	\$500,000/\$1,500,000
Date Signed: _____	Signature of health care provider's Authorized Officer:  _____

PLEASE SIGN HERE

**SECTION IV**

**INSURANCE POLICY INFORMATION  
AND HEALTH CARE STABILIZATION FUND SURCHARGE PAYMENT**  
(To be completed by the Health Care Stabilization Fund)

I.S.O. Rate Classification No.	License, Registration or Certification Number of Provider	** Basic Coverage Premium Amount	HCSF Coverage Level And Surcharge Percent	** HCSF Surcharge Payment
80999	License Number	\$		\$

\*\* Information shown is based on the premium amount which would have been required if the self-insurer had obtained the required basic coverage from the Health Care Provider Insurance Availability Plan.

Inception Date:	Expiration Date:
-----------------	------------------

Policy Number

Claims Made (Self-Insured)

**SELF-INSURED PROFESSIONAL LIABILITY COVERAGE QUESTIONNAIRE FOR THE COMPUTATION OF THE ANNUAL PREMIUM BASED ON THE RULES AND RATES OF THE HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN**

**NAME OF HEALTH CARE PROVIDER:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP CODE** \_\_\_\_\_ - \_\_\_\_\_

**Rating information:**

- a. Number of licensed beds, including bassinets: \_\_\_\_\_
- b. Number of staffed (or set-up) beds including bassinets: \_\_\_\_\_
- c. Number of annual out-patient visits: \_\_\_\_\_
- d. Number of average occupied beds, including bassinets: \_\_\_\_\_

Is the hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)? If no, please explain.  Yes  No

Have any claims been made or suits filed due to any alleged malpractice error or mistakes?  Yes  No

List and explain the history of claims over the past 5 years. Please attach a separate listing if necessary.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title Of Authorized Representative

**AUTHORIZATION**

This is to authorize any person, business or legal firm to furnish the Kansas Health Care Stabilization Fund Board of Governors any and all information, opinions or records relating to the hospital's professional liability claims history.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**SELF-INSURED  
DECLARATION OF FINANCIAL COMPLIANCE  
WITH THE  
KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY ACT**

---

Pursuant to the provisions of K.S.A. 40-3414 and amendments thereto, the:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

hereby declares that it will provide financial statements annually showing the current balance in the dedicated professional liability reserve account and will immediately, upon learning of any financial event which will jeopardize the organizations ability to maintain the actuarial determined reserve fund amount, notify the Health Care Standardization Fund by registered mail, of the effective date and details of the change in financial condition.

Name of CEO \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of CFO \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Subscribed and sworn to before me, this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

\_\_\_\_\_  
Notary Public

My Commission expires \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

**Sample** format of the loss experience information needed in support of an application to be an authorized health care provider self-insurer submitted in May, 2023. All loss amounts should be limited to the basic coverage limit. It may be necessary to estimate loss expenses paid and reserved for amounts for just the basic portions of large losses. (As referred to in item 4 on page 3 and in the checklist on page 9.)

The experience being reported is only the medical professional liability of the applicant health care provider.

Experience years **do not** include the current year (2024) or the previous year (2023).

The experience being submitted is for calendar years.

The experience being submitted is annual period starting on \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.  
MONTH DATE YEAR

YEAR	Reference name or number for each claim listed	LOSS PAID AMOUNT	LOSS EXPENSE AMOUNT PAID	LOSS RESERVE AMOUNT	LOSS EXPENSE RESERVE AMOUNT
2022	BCA05-2			\$100,000	\$25,000
	BCA05-1			\$25,000	\$10,000
2021	BCA04-3 (closed 3-1-19)	\$0	\$12,500	\$0	\$0
2020	BCA04-2 (Settled 8-15-18)	\$90,000	\$20,000	\$0	\$0
	BCA04-1		\$5,000	\$10,000	\$2,000
2019	BCA03-1			\$45,000	\$7,000
2018	Nothing to report				
2017	BCA01-3 (closed 5-1-15)	\$0	\$0	\$0	\$0
	BCA01-2 (closed 1-1-16)	\$200,000	\$59,000	\$0	\$0
	BCA01-1 (closed 3-1-17)	\$0	\$3,000	\$0	\$0

The above loss experience information will be used in computing what the basic coverage premium would have been based on the approved rules, experience rating plan and premium rates of the Health Care Provider Insurance Availability Plan. A current copy of the Health Care Provider Insurance Availability Plan's hospital professional liability insurance rate filing will be provided upon written request.

A copy of the experience rating, premium calculations and final surcharge amount Excel worksheet will be provided to each applicant. Applicants are encouraged to review the worksheet, and may ask questions regarding any uncertain result shown therein.



**CHECKLIST OF WHAT NEEDS TO BE INCLUDED IN THE SUBMISSION OF A REQUEST FOR THE ISSUANCE OF A NEW OR CONTINUATION OF A CERTIFICATE OF SELF-INSURANCE:**

1. Items 1 through 6 on page 2 of this brochure. Item # 6 “Report of Reserves” must be submitted to the Fund annually. Report may be quarterly or annually as long as it includes a full year.
2. A copy of the health care provider’s most recent audited financial statement. New applicant must submit within 60 days of letter of intent to become self-insured.
3. A description of the health care provider’s financial condition including any material changes after the most recent audited financial statement. New applicant must submit within 60 days of letter of intent to become self-insured.
4. 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. New applicant must submit within 60 days of letter of intent to become self-insured.
5. A statement of the amount of liquid assets to be reserved for settlement of claims or payment of judgments against the health care provider. New applicant must submit within 60 days of letter of intent to become self-insured.
6. 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. New applicant must submit within 60 days of the letter of intent to become self-insured.
7. A history of claims for the previous five (5) years identifying paid losses for closed claims and loss reserves for open claims. New applicant must submit within 90 days of the letter of intent to become self-insured.
8. An independent actuary’s report indicating recommended reserves for self-insurance of the health care provider including reserves for prior acts. New applicant must submit within 90 days of the letter of intent to become self-insured.
9. A copy of the liability insurance policy or declarations page providing insurance coverage for employees who are not defined health care providers, or an explanation of separate self-insured coverage independent of the self-insurance of the health care providers. New applicant must submit within 90 days of the letter of intent to become self-insured.