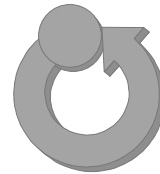


# The Kansas Health Care Stabilization Fund

## Guidelines for the optional Fund tail coverage -- July 1, 2008 to June 30, 2009



This brochure is intended to assist health care providers in understanding the cost of the optional tail coverage available from the Fund. Also included in this brochure are examples of how the additional tail coverage surcharge is calculated.

**NOTICE:** When requesting the optional Fund tail coverage, you must submit your request in writing, specifying the date on which you will cease rendering professional services as an active Kansas health care provider. If possible, we need to receive your request at least 15 days prior to your termination date. You should also advise your basic professional liability insurer to cancel your basic coverage policy on the same date. This will assist us in researching the necessary information to accurately calculate the amount of the additional tail coverage surcharge so you will have adequate time to pay the additional surcharge cost. Kansas law requires the additional tail coverage surcharge to be paid within 30 days of the date that you became an inactive health care provider. No extensions to the 30 day period for payment can be granted.

Estimates of tail coverage surcharge amounts may be requested by telephone. Please allow a reasonable period of time for us to respond. Even if you request a tail coverage estimate by phone, you will still need to submit a request in writing once you decide to cease practice as a Kansas active health care provider.

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 actual calculation of the additional optional tail coverage surcharge amount will be furnished by the Fund.***

### When should the optional tail coverage be considered by a health care provider?

Any health care provider who complies with the Health Care Stabilization Fund (Fund) for less than five years and becomes an inactive health care provider may wish to consider obtaining the optional tail coverage and pay the additional surcharge payment for the optional tail coverage from the Fund. This continuing Fund coverage (often referred to as the Fund's "tail" coverage) is for future claims or suits made against an inactive health care provider for professional services rendered while the health care provider was in compliance with the Fund. (Note: Fund compliance periods from a postgraduate program of residency training approved by the Kansas Board of Healing Arts are not included when computing the five year period.) Health care providers with five or more years of Fund compliance are eligible for the Fund's continuing coverage without an additional surcharge payment.

Revised optional tail coverage surcharge rate tables on page 2 of this brochure will become effective on July 1, 2008. The pre-calculated surcharge rates in these tables are derived from the FY 2009 Fund surcharge rates and the tail coverage surcharge percentage factors adopted by the Fund Board Governors in 2003. Health care providers with compliance periods of *less than the required five year period* may obtain the Fund's continuing tail coverage by paying an additional Fund surcharge amount *within thirty days of becoming an inactive health care provider*. The additional surcharge cost varies with the individual's prior Fund compliance records. This brochure provides general information and guidelines. The actual calculation of the additional optional tail coverage surcharge amount will be furnished by the Fund upon receipt of a written request submitted by the health care provider.

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



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The descriptions for Fund Class Groups can be found on the the Internet at  
[www.hcsf.org/FY2009rates/FY2009ClassGroups1-14.htm](http://www.hcsf.org/FY2009rates/FY2009ClassGroups1-14.htm)

\$100,000 / \$300,000 - Kansas Tail Surcharge

FUND CLASS GROUP	Number of Fund coverage years				
	One year	Two years	Three years	Four years	Less than five years
Following amounts are for full Fund coverage years. If you have partial Fund coverage years, amounts will vary from those shown in the table.					
1	\$617	\$948	\$1,109	\$1,223	\$1,295
2	1,082	1,656	1,935	2,130	2,263
3	1,391	2,121	2,485	2,735	2,900
4	1,561	2,376	2,779	3,054	3,242
5	1,817	2,786	3,263	3,593	3,808
6	2,309	3,518	4,118	4,535	4,806
7	1,830	2,794	3,277	3,605	3,824
8	4,205	6,420	7,534	8,286	8,783
9	4,238	6,447	7,563	8,309	8,816
10	6,068	9,269	10,875	11,954	12,681
11	9,184	13,990	16,404	18,041	19,127
12	328	507	602	657	696
13	643	979	1,140	1,257	1,344
14	1,509	2,303	2,699	2,968	3,144

\$300,000 / \$900,000 - Kansas Tail Surcharge

FUND CLASS GROUP	Number of Fund coverage years				
	One year	Two years	Three years	Four years	Less than five years
Following amounts are for full Fund coverage years. If you have partial Fund coverage years, amounts will vary from those shown in the table.					
1	\$1,498	\$2,286	\$2,662	\$2,928	\$3,099
2	2,606	3,978	4,653	5,109	5,416
3	3,351	5,121	5,968	6,555	6,945
4	3,795	5,724	6,679	7,329	7,756
5	4,440	6,718	7,833	8,324	9,110
6	5,593	8,485	9,895	10,859	11,491
7	4,449	6,739	7,868	8,634	9,144
8	10,215	15,507	18,075	19,854	21,022
9	10,251	15,561	18,142	19,925	21,092
10	14,737	22,375	26,086	28,654	30,333
11	22,246	33,765	39,374	43,226	45,778
12	808	1,228	1,438	1,580	1,670
13	1,535	2,355	2,749	3,014	3,203
14	3,659	5,554	6,474	7,117	7,529

\$800,000 / \$2,400,000 - Kansas Tail Surcharge

FUND CLASS GROUP	Number of Fund coverage years				
	One year	Two years	Three years	Four years	Less than five years
Following amounts are for full Fund coverage years. If you have partial Fund coverage years, amounts will vary from those shown in the table.					
1	\$2,926	\$4,557	\$5,319	\$5,841	\$6,166
2	5,124	7,945	9,294	10,215	10,779
3	6,524	10,206	11,932	13,092	13,836
4	7,280	11,401	13,332	14,633	15,476
5	8,596	13,391	15,656	17,172	18,160
6	10,836	16,915	19,763	21,665	22,927
7	8,624	13,459	15,731	17,241	18,237
8	19,796	30,924	36,135	39,618	41,914
9	19,894	31,034	36,254	39,761	42,055
10	28,602	44,628	52,143	57,202	60,487
11	43,092	67,353	78,682	86,299	91,267
12	1,554	2,439	2,857	3,132	3,316
13	3,038	4,684	5,508	6,034	6,378
14	7,084	11,070	12,949	14,196	15,021

**Changes to the information, guidelines and optional Fund tail coverage surcharge rates may be made without advance notice to health care providers. In the event a change is made, information regarding such change, including the effective date of the change will be posted on the Internet web site of the Fund ([www.hcsf.org](http://www.hcsf.org)).**

**How to use these guidelines to obtain an *estimate* of the additional surcharge cost for the optional Fund tail coverage.**

**For Class Groups 1 to 14:** If you have less than five years of Fund coverage and become an inactive health care provider on the annual anniversary date of your basic professional liability coverage:

- Find the highest Fund Class Group applicable to your practice during your Fund coverage period(s).
- Based on all Fund coverage records, determine the length of time you have been in compliance with the Fund. (Note: 1. Fund compliance periods from a postgraduate program of residency training approved by the Kansas Board of Healing Arts are not included in this calculation; and 2. If you have partial years (for example, 2 years and 36 days), you will need to contact the Fund for assistance.)
- The intersect of the Fund Class Group line and the number of Fund coverage years column will be the optional surcharge rate amount that is due *within thirty days of the date you became an inactive Kansas health care provider.*

**Guideline Examples:**

1. You are an emergency medicine specialist (no major surgery), Fund Class Group 6, selected Fund coverage limits of \$300,000/\$900,000 and have 2 years of Fund coverage. Your optional tail surcharge rate would be \$8,485.
2. You are an OB/GYN specialist, Fund Class Group 10, selected the Fund coverage limits of \$800,000/\$2,400,000 and have four years of Fund coverage. Your optional tail surcharge rate would be \$57,202.
3. You first complied with the Fund as a family practice doctor, assisting in major surgery procedures, Fund Class Group 4, and you selected the Fund coverage limits of \$800,000/\$2,400,000. In the next coverage year, you changed to family practice, no surgery, which is included in Fund Class Group 2. At the end of that second year, you become inactive as a Kansas health care provider and wish to pay the additional Fund optional surcharge. The amount would be \$11,401 (from Fund Class Group 4 and the “Two years” column).
4. If you have less than one year of Fund coverage: Determine the Fund surcharge amount for the less than one year coverage period and note the highest Fund coverage level that was chosen during the coverage period. Locate the optional tail coverage percentage surcharge rate the table on page 3, multiplying the Fund surcharge amount by that percentage. Example: A general surgeon who complied with the Fund for 30 days at the \$800,000/\$2,400,000 Fund coverage limits paid a Fund surcharge of \$116. The percentage tail coverage surcharge rate for this doctor would be 1400% which results in an optional tail coverage surcharge payment of \$1,624 (\$116 x 14.00).
5. It will be necessary to contact the Fund for assistance if you have complied with the Fund for partial years (for example, 2 years and 36 days).

**For Class Group 15 (i.e., individual health care providers who could be in Fund Class Group 1 -14 but are insured by the Availability Plan and become an inactive health care provider on the annual anniversary date of their basic professional liability coverage):** Unless these individuals are being charged a higher basic coverage premium due to unusual risk rating characteristics (i.e., experienced rated), the optional Fund tail coverage surcharge will be based on the tail coverage surcharge rates shown in the tables on page 2. If the individual health care provider has been experience rated, then utilize the procedures for Class Groups 16 to 21.

**For Class Groups 16 to 21:** Select one of the following percentage surcharge rates based on your most recent Fund coverage documents and use the indicated percentage rate to multiply your current or most recent annual surcharge amount. It will be necessary to request assistance from our office to complete this calculation if you have short-term coverage periods or a mid-term cancellation of a coverage period.

Percentage Rates for Optional Fund Tail Coverage					
Fund Coverage Level	Number of HCSF coverage years				
	One year or less	Not more than two years	Not more than three years	Not more than four years	Less than five years
\$100,000/\$300,000	656%	387%	288%	287%	272%
\$300,000/\$900,000	908%	534%	395%	393%	372%
\$800,000/\$2,400,000	1400%	847%	628%	624%	590%

**For resident health care providers who practiced in Missouri:** Unless otherwise included in the optional Fund tail coverage surcharge amount calculations, add an additional 25% to the otherwise applicable optional Fund tail coverage surcharge. The additional Missouri surcharge rating factor can not be prorated.

**Part-time or partial practice coverage records (resident or non-resident health care providers):** Use the above procedures but the optional tail surcharge rate will be modified by using the highest part-time or prorated factor to compute the optional Fund tail coverage surcharge amount.

**Exceptions to the payment of the additional “tail” coverage surcharge:** The Board of Governors may approve exceptions to the five year compliance requirement for health care providers who die, retire from active practice, become disabled or cease their Kansas practice due to circumstances beyond their control. In addition, the Fund’s Board of Governors may grant temporary exemptions for health care providers who leave Kansas to obtain additional education or training or to participate in religious, humanitarian or governmental service programs. Health care providers who desire additional information regarding an exemption to the five-year compliance requirement should contact the Fund’s Compliance Section (telephone number: 785-291-3411). The applicable forms needed to support a health care provider’s request for an exception or temporary exemption from the payment of the additional surcharge are in the Appendix section of this brochure.

### **Other frequently asked questions about the Fund optional tail coverage**

**Will the Fund notify me that this option is available?** No. The Fund is under no obligation to notify individual health care providers regarding the availability of the optional tail coverage.

**Is it required that I purchase the optional tail coverage from the Fund?** No. This is an optional choice.

**Other than “going bare” or without tail coverage from the Fund, what are some other options which you may consider?**

- If you are a Kansas resident who is leaving to live and practice in another state, you may wish to ask if prior acts coverage is available on your next professional liability coverage program.
- If a locum tenens provider, the locum tenens placement group may have continuing professional coverage available already included in the group’s professional liability coverage. These professional liability coverage arrangements should be carefully studied, but may be an option to the health care provider.
- If you are a non-resident health care provider your professional liability insurance may provide its full coverage while you practice in Kansas. Some providers, after notifying and consulting with their existing insurance company regarding their practice in Kansas, comply with the Fund for its minimum coverage level while practicing in Kansas and do not acquire the Fund’s optional tail coverage.

**Does the Fund offer a tail coverage surcharge payment plan?** No. The optional tail coverage surcharge payment must be paid within thirty days of the health care provider becoming an inactive health care provider.

**Can the claims made retroactive rating date be advanced for a health care provider returning to active practice in Kansas?** No. As provided in the Fund law, all active health care providers must maintain basic coverage for any claim or suit made against them while actively rendering professional services as a Kansas health care provider.

**Will the Fund return an additional tail coverage surcharge payment if the health care provider returns to active practice in Kansas?** No. The previously paid optional Fund tail coverage surcharge will not be returned inasmuch as it is “earned” during the period the health care provider was inactive and the Fund was obligated to provide its “first dollar” tail coverage.

APPENDIX SECTION OF THE GUIDELINES FOR THE OPTIONAL FUND TAIL  
COVERAGE SURCHARGE RATES EFFECTIVE JULY 1, 2008

Table of required forms and other information for tail surcharge payment exemptions and temporary exceptions, with applicable forms or guidelines for making application for these situations.

1. General letter of request and transmittal of related documents (otherwise known as a cover letter).	If possible, please use your professional practice letterhead.
2. Application for Exemption	This form must be completed for any of the applicable exemptions or temporary exceptions. The form is on pages 6 and 7 of this brochure.
3. Death of a health care provider	The general letter advising our office will be sufficient. A completed application for exemption form and any supporting information (e.g., death certificate, obituary) would be appreciated.
4. Retirement of health care provider	Include a completed Affidavit of Retirement, page 8 of this brochure.
5. Disability of health care provider	Complete and return the Affidavit of Disability, page 9 of this brochure, along with a letter explaining the nature and extent of the disability.
6. Certain temporary absence periods	Include a completed Affidavit of Temporary Absence, page 10 of this brochure.
7. Request for extension of an existing period of temporary absence	Include a completed Affidavit of Extension on Temporary Exemption, page 11.
8. Requests due to being called to active military duty	Include a completed Affidavit of Temporary Absence Due to Military Duty, page 12. A copy of the military orders must be included with this request.
9. Ceasing Kansas practice due to circumstances beyond the Health care provider's control	Documentation for this type of exemption must be submitted with the Application for Exemption. Approval by the Board of Governors is required. Voluntary enlistment in military service, transfers of employment, leaving practice due to marriage, children or business considerations are not generally circumstances beyond the control of the provider and do not qualify for this exception.

**APPLICATION FOR EXEMPTION**  
**To Obtain Health Care Stabilization Fund Tail Coverage At No Additional Surcharge**

Health Care Providers who seek an exemption from the 5 year compliance requirement must obtain approval from the Board of Governors of the Health Care Stabilization Fund

**PLEASE TYPE OR PRINT**

1. Name of Health Care Provider: \_\_\_\_\_

2. Address: \_\_\_\_\_

3. Telephone #: (office) \_\_\_\_\_ (home) \_\_\_\_\_

4. Type of health care provider: \_\_\_\_\_ License #: \_\_\_\_\_

5. Reason for "exemption" (please check one in either Section A or B)

A.  Inactive provider exemptions and check one of the following:

Death  Retirement

Disability  Circumstance beyond control

B.  Temporary absence from the state exemptions, K.S.A. 40-3403(b)(1)(D) and check one of the following:

to obtain additional education or training

to participate in a religious service program

to participate in a humanitarian service program

to participate in a government service program

due to being called to active military service

6. Date of death, retirement, disability or date when you plan to leave the state: \_\_\_\_\_

7. Please provide a detailed narrative justifying your request.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Along with this Application for Exemption, one of the following documents verifying your reason for “exemption” must be submitted with a general (cover) letter:

- Death                    A general letter and if available a copy of death certificate or obituary would be appreciated. See items numbered 1, 2 and 3 on page 5.
- Retirement            The retirement affidavit must be completed and notarized. See form on page 8.
- Disability              The disability affidavit must be completed and notarized. See form on page 9.
- Circumstances beyond the control of the health care provider.      A written explanation is required. The general (cover) letter and/or the Application for Exemption form should include this explanation.
- Temporary absence      A written explanation is required. The general (cover) letter and/or the Application for Exemption form should include this explanation. Please include a copy of any letter of acceptance or other documentation for a particular training, religious, humanitarian or government service program. The temporary absence affidavit must be completed and notarized (see form on page 10).  
Also, please note that the form on page 11 of this brochure is to be used when requesting an extension of an existing approved temporary period of absence.
- Called to active military duty      The Affidavit of Temporary Absence Due to Military Duty must be completed and notarized. See form on page 12. A copy of the military orders must be included with this request.

I have read this application and understand that any omissions or false answers may result in denial of this application. I authorize the release to the Kansas Health Care Stabilization Fund of any information relative to verify this information. I swear that the information on this application and any supplementary pages attached is complete and to the best of my knowledge is true.

\_\_\_\_\_  
Signature of health care provider (If this form is being submitted by a person on behalf of the health care provider, please sign and include your relationship to the provider.)

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

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

My appointment expires:

*Please mail completed form to:  
Board of Governors  
Health Care Stabilization Fund  
300 S.W. 8th Street 2nd Floor  
Topeka, Kansas 66603-3912*

**AFFIDAVIT OF RETIREMENT**

I \_\_\_\_\_, hereby swear and affirm that I will retire from providing any and all professional services in Kansas or any other state or territory effective \_\_\_\_\_. I further understand and accept that, should I resume providing professional services, the tail coverage provided by the Health Care Stabilization Fund pursuant to the exception for retirement shall terminate (unless I am reinstated as an active Kansas health care provider) and I will be individually responsible and liable for all costs, fees, judgments and settlements for all prior occurrences.

\_\_\_\_\_  
Signature

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

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

My Appointment expires:

**AFFIDAVIT OF DISABILITY**

I, \_\_\_\_\_, being first duly sworn, on oath,  
state:

I am presently disabled and unable to provide professional services as covered by the Kansas Health Care Provider Insurance Availability Act. I have not provided any professional services since \_\_\_\_\_. I understand and agree that as of this date I will not provide any professional services in Kansas or elsewhere and will notify the Board of Governors of the Health Care Stabilization Fund should my status change, and should I provide professional services.

\_\_\_\_\_  
Signature

SUBSCRIBED AND SWORN TO before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

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

My Appointment expires:

**AFFIDAVIT OF TEMPORARY ABSENCE**

I, \_\_\_\_\_, being first duly sworn, on oath, state:

I am temporarily leaving the State of Kansas on \_\_\_\_\_, for the purpose of obtaining additional education or training or to participate in religious, humanitarian, or government service programs. I anticipate that I will return to Kansas on approximately \_\_\_\_\_. I will inform the Board of Governors of the Health Care Stabilization Fund of my out-of-state address and will notify the Board upon my completion of training or program participation and upon my return to the State. I understand that to take advantage of this exemption I must return to the State of Kansas upon completion of the training or program, as intended by K.S.A. 40-3403(b)(1)(D). Should I fail to return to Kansas, I further understand and agree that I must remit to the Board the surcharge for tail coverage within 30 days of the expiration of my temporary exemption or my coverage will be voided.

\_\_\_\_\_  
Signature

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

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

My Appointment expires:

**AFFIDAVIT OF EXTENSION ON TEMPORARY EXEMPTION**

I, \_\_\_\_\_, being first duly sworn, on oath, state:

I am requesting an "extension" on my "temporary exemption" effective \_\_\_\_\_, for the purpose of obtaining additional education or training or to participate in religious, humanitarian or government service programs. For this requested period of extension, I will be \_\_\_\_\_. I anticipate that I will return to Kansas on approximately \_\_\_\_\_.

(ENTER STARTING DATE OF TEMPORARY EXEMPTION PERIOD)

(ENTER A DESCRIPTION OF THE REASON)

(FOR THIS REQUESTED EXTENSION.)

(ENTER RETURNING DATE, ENDING THE TEMPORARY EXEMPTION)

I will inform the Board of Governors of the Health Care Stabilization Fund of my out-of-state address and will notify the Board of Governors upon completion of my program or training and upon my return to the State of Kansas. I understand that to take advantage of this "temporary exemption" I must return to Kansas upon completion of the program, as intended by K.S.A. 40-3403(b)(1)(D). Should I decide not to return to Kansas, I further understand I must remit to the Health Care Stabilization Board of Governors the additional tail coverage cost or my coverage will be voided.

\_\_\_\_\_  
Signature

SUBSCRIBED AND SWORN TO before me the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

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

My appointment expires:

**AFFIDAVIT OF TEMPORARY ABSENCE  
DUE TO MILITARY DUTY**

I, \_\_\_\_\_, being first duly sworn, on oath,  
state:

I am temporarily leaving the State of Kansas on \_\_\_\_\_,  
for the purpose of Active Military Duty. I anticipate that I will return to Kansas on  
approximately \_\_\_\_\_. I will inform the  
Board of Governors of the Health Care Stabilization Fund of my military address and will  
notify the Board upon completion of my military assignment and upon my return to the  
State. I understand that to take advantage of this exemption I must return to the State of  
Kansas upon completion of active military duty, as intended by K.S.A. 40-3403(b)(1)(D).  
Should I fail to return to Kansas, I further understand I must remit to the Board the  
surcharge for tail coverage within 30 days of the expiration of my temporary exemption  
or my coverage will be voided.

\_\_\_\_\_  
Signature

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

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

My Appointment expires: