Report of the Health Care Stabilization Fund Oversight Committee to the 2025 Kansas Legislature

CHAIRPERSON: Marvin Kleeb

LEGISLATIVE MEMBERS: Senators Chase Blasi and Cindy Holscher; and Representatives Will Carpenter and Henry Helgerson

NON-LEGISLATIVE MEMBERS: Craig Concannon, M.D.; Darrell Conrade; Dennis George; Douglas Gleason, M.D.; James Rider, D.O.; and Jerry Slaughter

CHARGE

Review the Status of the Health Care Stabilization Fund

This Committee annually reviews the operation of the Health Care Stabilization Fund, reports, and makes recommendations regarding the financial status of the Fund.

January 2024

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Health Care Stabilization Fund Oversight Committee

Annual Report

Conclusions and Recommendations

The Health Care Stabilization Fund Oversight Committee considered two items central to its statutory charge: whether the Committee should continue its work and whether a second, independent analysis of the Health Care Stabilization Fund (HCSF or Fund) is necessary. The Committee continues in its belief that it serves a vital role as a link between the HCSF Board of Governors, health care providers, and the Legislature, and should be continued. Additionally, the Committee recognizes the important role and function of the HCSF in providing stability in the professional liability insurance marketplace, which allows for more affordable coverage to health care providers in Kansas. The Committee is satisfied with the actuarial analysis presented and does not request a second independent review.

The Committee considered information presented by the HCSF Board of Governors' representatives, including its statutorily required report, the Board's actuary, and health care provider and insurance company representatives and other interested parties. The Committee acknowledges its role to provide oversight and monitoring of the HCSF, including legislative actions and other contemporary issues affecting the soundness of the HCSF, and makes the following recommendations and comments:

- **Appreciation for Rita Noll, Chief Counsel and Deputy Director, HCSF, upon her retirement.** The Committee expresses its appreciation to Rita Noll for her 34 years of exemplary service to the HCSF and to the people of Kansas during her 40 years of service to the State of Kansas. Ms. Noll first served as Attorney for the HCSF at the Kansas Insurance Department from 1990 until the HCSF's separation from the Kansas Insurance Department in 1995. She continued her service to the HCSF in her role as Chief Counsel and Deputy Director until her retirement on June 7, 2024.

- **Fund revenue.** The Committee recognizes both the statutory requirements of the Health Care Provider Insurance Availability Act (HCPIAA) governing the investment and reinvestment of HCSF moneys in accordance with Pooled Money Investment Board (PMIB) investment policies and the ongoing climate affecting the investment yield of the Fund. The Committee recommends the Legislature give consideration to allowing the HCSF to invest pursuant to KSA 40-2a01 *et seq.*

- **Advanced practice registered nurses as defined health care providers.** The Committee recommends legislation be introduce to add advance practice registered nurses (APRNs) as defined health care providers for the HCSF and to provide protection to APRNs under the HCSF. (Some APRNs, such as registered nurse anesthetists and certified nurse midwives, have sought and been made part of this definition previously.) The Committee recognizes law enacted in 2022 (Senate Sub. for HB 2279) allowed an APRN to prescribe drugs without a written protocol as authorized by a responsible physician and required an APRN to maintain medical malpractice insurance. [*Note:* This requirement is part of the Kansas Nurse Practice Act, as amended, which does not specify the level of coverage that must be maintained.]

- **Fund to be held in trust.** The Committee recommends the following language to the Legislative Coordinating Council, Legislature, and the Governor regarding the HCSF:
  - The Health Care Stabilization Fund Oversight Committee continues to be concerned about and is opposed to any transfer of money from the HCSF to the State General Fund (SGF). The HCSF provides Kansas doctors, hospitals, and the defined health care providers with individual professional liability coverage. The HCSF is funded by payments made by or on behalf of each individual health care provider. Those payments made to the HCSF by health care providers are not a fee. The State shares no responsibility for the liabilities of the HCSF (excepting University of Kansas faculty and resident self-insurance programs reimbursement). Furthermore, as set forth in the HCPIAA, the HCSF is required to be "held in trust in the state treasury and accounted for separately from other state funds"; and
  - Further, this Committee believes the following to be true: all surcharge payments, reimbursements, and other receipts made payable to the HCSF shall be credited to the HCSF. At the end of any fiscal year, all unexpended and unencumbered moneys in such HCSF shall remain therein and not be credited to or transferred to the SGF or to any other fund.

Proposed Legislation: None.

Background

The Health Care Stabilization Fund Oversight Committee (Committee) was created by the 1989 Legislature and is described in KSA 40-3403b. The 11-member Committee consists of 4 legislators, 4 health care providers, 1 insurance industry representative, 1 person from the general public with no affiliation with health care providers or the insurance industry, and the Chairperson of the Health Care Stabilization Fund (HCSF or Fund) Board of Governors or another member of the Board designated by the Chairperson.

The law charges the Committee to report its activities to the Legislative Coordinating Council and to make recommendations to the Legislature regarding the HCSF.

The Committee met November 21, 2024, in the Statehouse.

Committee Activities

Report of Willis Towers Watson

Fund Position and Forecasts

The Willis Towers Watson actuarial report is based on the actuarial review of Fund experience as of December 31, 2023, and serves as an addendum to the report provided to the HCSF Board of Governors on July 18, 2024. The actuary addressed forecasts of the HCSF's financial position at June 30, 2024, and June 30, 2025, along with the company's 2023 estimate for June 2024. In the 2023 review, the estimate of HCSF-held assets as of June 30, 2024, was $276.93 million, with liabilities of $249.40 million, and with $27.53 million in unassigned reserves.

The actuary presented the following estimates for the company's 2024 study:

- June 30, 2024: $271.77 million in assets; $246.62 million in liabilities; and $25.15 million in unassigned reserves.

- June 30, 2025: $259.03 million in assets; $235.63 million in liabilities; and $23.41 million in unassigned reserves.

The actuary reviewed two material decreases in Fund revenue resulting from legislative changes. In 2014, a legislative change brought many new classes of providers into the Fund. In 2021, a legislative change that became effective in 2022 reduced the HCSF's coverage by changing the amount the primary carriers cover from $200,000 to $500,000, before the HCSF is responsible. Based on this analysis, the company determined the HCSF needed to raise its surcharge rates by 9.7 percent in calendar year (CY) 2025 in order to maintain its unassigned reserves at the expected year-end CY 2024 level (approximately $25 million).

Rate Level (Surcharge) Indications

The actuary also reviewed the HCSF's (premium surcharge) rate level indications for CY 2025, noting the indications assume a break-even target between revenues and expenses. He detailed various CY 2025 items, including payments, with settlement and defense costs of $35.41 million; change in liabilities (due to referenced change in HCSF law) of $9.13 million (negative); administrative expenses of $2.52 million; and transfers of $300,000 (assumes $100,000 to the Health Care Provider Availability Plan [Availability Plan] and $200,000 to the Kansas Department of Health and Environment.) The actuary indicated the net operating cost for the HCSF in CY 2025 is an estimated $29.11 million. He further noted the HCSF has two sources of revenue: its investment income (assumed to be $6.72 million based on 2.60 percent yield) and surcharge payments from providers ($22.38 million needed to break even). With the projected surcharge revenue ($20.41 million), this translates to a positive rate level indication for CY 2025 (9.7 percent).

Historical review and comment. The actuary addressed surcharge revenue and claims costs from 1999 through projected 2025 (based on estimates as of December 31, 2023). The actuary highlighted the significant decrease in revenue from 2021 to 2022, which reflects the change in 2021 to the Health Care Provider Insurance Availability Act (HCPIAA) reducing coverage requirements on the HCSF. In CY 2021, the HCSF was responsible for paying amounts for the layer of claims from $200,000 per claim for most providers up to $1.0 million per claim and $800,000 worth of coverage. Beginning in CY 2022, the coverage option changed to $500,000 of coverage, with the primary market responsible for $0 to $500,000, and the HCSF picking up from $500,000 to $1.0 million. The actuary noted the Fund will continue to see reductions over the next immediate years as the inventory of claims under the prior coverage limits wear off and the HCSF, under the limits as amended in 2021, will be responsible for paying only the excess of $500,000, instead of the excess of $200,000.

Investment Yield

The actuary reviewed the HCSF's investment income over the previous 11 fiscal years, noting the highest level of yield during this time was in 2014 and, in the past 3 years, that yield has been less than 2.5 percent. He indicated the assumed yield rate for next year will be 2.60 percent, a reduction from the assumed future yield rate of 2.7 percent from the 2023 study. [*Note:* Testimony also indicated a 10-basis-point change in the assumed rate would cause a 1.4 percent change in the CY 2025 surcharge rate indication.]

Indications by Provider Class; Loss Experience

The actuary provided an overview of rate indications by provider class, defining classes 1-30 and providing the number of providers and the CY 2024 rate for each class. The actuary noted, based on the company's analysis of experience by provider class, differences continue to be seen in relative loss experience among the classes. Classes with decreases greater than 15.0 percent or increases greater than 10.0 percent (meaning a rate decrease or increase is indicated by relative loss experience for the class) include:

- Decreases greater than 15.0 percent [greatest to least decrease]: Class 2 (physicians, no surgery); Class 24 (nursing facilities); Class 13 (registered nurse anesthetists); Class 6 (surgery specialty, includes emergency room [ER] [no major] and ear, nose, throat [ENT]); Class 7 (anesthesiology); Class 16 (professional corporations, partnerships); Class 18 (mental health centers); and Class 1 (physicians, no surgery, includes dermatology, pathology, and psychiatry); and

- Increases greater than 10.0 percent [least to greatest increase]: Class 11 (surgery specialty-neurosurgery); Class 15 (Availability Plan insureds); Class 5 (surgery specialty, includes urology, colon/rectal, general practitioner with major); Class 3 (physicians, minor surgery); and Class 17 (medical care facilities).

Class 17 comment. The actuary highlighted a concern with rate indications for Class 17; analysis suggests rates need to increase 46 percent in order for that revenue to cover the claims costs for hospitals. Looking to the analysis by relative loss experience, Class 17 providers paid 14.0 percent of the total surcharge for the period of 2016-2022 but represented 24.0 percent of the reported losses during that time.

CY 2025 surcharge rates. The actuary also provided a history of surcharge rate changes since 2012, noting the reduction in CY 2022, which corresponds to the 2021 amendments (providers receiving less coverage from the HCSF). In addition, there were no changes in the CY 2023 surcharge rates. For CY 2024, the Board of Governors increased rates for 5 classes, decreased rates for 6 classes, and made no rate changes for 13 classes, with an overall impact of these selected changes of a 0.0 percent change in rate level. Addressing the CY 2025 surcharge rates, the actuary noted the company provided several options to the Board of Governors to consider in establishing HCSF rates. It was noted that all of these options included an increase to Class 17. Given the current rate level indications, the company did not believe that no rate change, or an overall 0 percent change, was reasonable for CY 2025. The Board decided on the following rate changes for CY 2025:

- Rate increases on 15 classes, ranging from a positive 2.0 percent (Classes 1, 4, 12, and 23) to a positive 10.0 percent (Class 17);

- Rate decreases of 2.5 percent for classes 2 and 24; and

- No change in rates for seven classes.

[*Note:* The estimated net overall impact of these selected changes is a rate level increase of 3.5 percent.]

Discussion

CY 2022 observations. The actuary characterized the CY 2023 experience for the HCSF as worse than had been predicted for the Fund. He pointed to positive and negative indications for the year: payment activity was high; loss performance on active providers was worse than expected, particularly on defense costs; loss performance on inactive providers was closer to the level than expected; investment results were worse than anticipated; and surcharge revenue was close to the level predicted. The actuary concluded, given these indications, the HCSF's net financial position at June 30, 2024, is $2.4 million lower than the level previously forecasted in the company's 2023 study. The actuary noted four areas of concern going into CY 2025: the overall rate inadequacy is "creeping up"; the rate inadequacy for the hospitals remains very high (how much the hospitals are paying relative to the claims costs those facilities are experiencing); investment returns continue to be lackluster; and payments from the Fund to the Availability Plan have occurred for seven consecutive years and are consuming a larger portion of Fund revenue.

Stabilization mechanisms in other states. The actuary provided an update to his comments last year to the Committee on the state of New Mexico's program to address health care provider liability and patient compensation. He provided updated numbers of the New Mexico fund, reporting the assets at year-end 2023 were $219.0 million, but liabilities were $293.0 million. New Mexico's fund had a deficit at year-end 2023 of about $74.0 million versus the HCSF's surplus of $25.0 million. The actuary reported, of the $219 million in assets, $33.0 million was funds appropriated by the New Mexico Legislature from state general fund (SGF) taxpayer moneys to help address the shortfall in the Patient's Compensation Fund. The actuary indicated in CY 2024, another $36.0 million is being appropriated by the New Mexico Legislature from its SGF. He noted that over those two years, the New Mexico fund had to be bailed out by the taxpayers of New Mexico by nearly $70.0 million, and the fund is still deficient.

The actuary indicated the New Mexico fund was in the hole by about $74.0 million as of year-end 2023 and by year-end 2024, the fund deficit will continue despite it receiving $70.0 million of taxpayer money. He added, to provide for context with other states around the country, about eight states have funds like Kansas'. Not all of those funds operate exactly the same, but overall, despite his concerns about the HSCF compared with where it was a few years ago, the HCSF is still financially healthy and much healthier than similar funds in some other states.

Committee discussion. Committee members, the actuary, and Board of Governors' representatives discussed topics including the Board's investment policy (outlined in KSA 40-3406), the management of the investment process by the Pooled Money Investment Board, average duration of the investments and the longer-term liabilities of the Fund, and the relationship of investment income to overall Fund assets (*i.e.,* increased investment income reduces the needed income from health care provider surcharge revenues).

On the topic of rate level indications (surcharge), the actuary addressed costs and losses affecting hospitals and health care systems nationwide, Further discussion focused on the experiences of Class 17 participants and the Board action to address provider rate class relative experience. The rate discussion also included the applicability and present rate set for the Missouri Modification Factor. [*Note:* All Kansas resident health care providers who are also licensed to practice in Missouri must pay an additional 30.0 percent surcharge.]

Comments

In addition to the report from the Board of Governors' actuary, the Committee received information from Committee staff detailing resource materials provided for consideration, including the report of the Kansas Legislative Research Department (KLRD) regarding the approved budgets for the HCSF Board of Governors for FY 2024 and FY 2025, language from the KLRD 2025 Appropriations Report, a proviso enacted in 2023 that deals with the maternity center being viewed as a health care provider for purposes of the HCSF, and a comprehensive reference copy of the statutes that comprise the HCPIAA.

Committee staff also provided an update on relevant health care professional or facility legislation that was considered or passed during the 2024 Session. An Assistant Revisor of Statutes with the Office of Revisor of Statutes reviewed 2024 HB 2478 regarding maternity centers and abortion providers, which was recommended by the House Committee on Insurance but did not pass the House. She noted the language specific to maternity care centers was incorporated into proviso language in 2024 HB 2551 (section 19), which would deem a maternity center a "healthcare provider" for the purposes of the HCPIAA if that provider is accredited by a recognized national organization or falls within the definition of KSA 65-503. The proviso is in effect for FY 2025.

The Assistant Revisor highlighted three additional relevant bills:

- HB 2547 (emergency medication kits in schools), which became law;

- House Sub. for SB 287 (prohibits health care providers at a school facility from providing most health care to minors without receiving consent from such minor's parent, and the No Patient Left Alone Act, which prohibits patient care facilities providing end-of-life care to patients from denying such patients in-person visitation from any person designated by the patient), which became law; and

- House Sub. for SB 233 (Forbidding Abusive Child Transitions Act [FACT Act]; would have prohibited health care providers from providing gender identity care to children whose gender identity is inconsistent with their sex at birth). The bill passed both chambers but was vetoed by the governor. The motion to override the veto failed by two votes. The bill would have made several changes, including allowing civil causes of action against health care providers who provide gender identity care to children and prohibiting professional liability insurance

from covering those damages. The Assistant Revisor of Statutes indicated this may return as a bill during the 2025 Legislative Session.

Legal Counsel's Update

The Legal Counsel for the Board of Governors addressed the FY 2024 medical professional liability experience based on all claims resolved in FY 2024, including judgments and settlements. He characterized FY 2024 as a "busy year, but maybe not as busy as FY 2023."

Jury Verdicts and Settlements

Using HCSF data, the Legal Counsel stated 16 medical malpractice cases, involving a total of 20 Kansas health care providers, were tried to juries during FY 2024. The trials were held in the following jurisdictions: Johnson County (3); Sedgwick County (2); Butler County (1); Coffey County (1); Cowley County (1); Franklin County (1); Leavenworth County (1); Shawnee County (1); Wyandotte County (1); Jackson County, Missouri (3); and Clay County, Missouri (1). Fifteen of these cases resulted in defense verdicts, and one case ended in a hung jury. There were no cases where the jury found for the plaintiff.

The Legal Counsel highlighted the claims settled by the HCSF, noting in FY 2024, 82 claims in 66 cases were settled involving HCSF moneys. He reported the settlement amounts incurred by the HCSF for FY 2024 totaled $30,740,000. This amount does 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.

The Legal Counsel reported, for the 82 claims, primary insurance carriers tendered their policy limits to the HCSF in 73 claims and the HCSF provided primary coverage for inactive health care providers in 9 claims. He reported that for the claims involving HCSF moneys, the HCSF incurred $30,740,000 in settlement amounts; in addition, the primary insurance carriers contributed $24,638,167 and the excess insurance carriers contributed $7,625,000, for a total settlement amount of $63,003,167. The Legal Counsel also reported, in addition to the 82 settlements, 6 claims were settled by an excess insurance carrier when both the primary and HCSF coverage were exhausted.

The Legal Counsel reported that, in addition to the settlements involving HCSF contributions, the HCSF was notified primary insurance carriers settled an additional 154 claims in 81 cases. [*Note:* These are claims settled within the primary coverage limits and do not require excess coverage.] The total amount of these settlements was $9,523,167. The Legal Counsel also provided historical information on new cases by fiscal year, noting 285 new cases during FY 2024. There were 307 new cases in FY 2023.

Self-insurance Programs

The Legal Counsel also addressed the self-insurance programs and reimbursement for the University of Kansas (KU) Foundations and Faculty program and residents that provide basic liability coverage. (As directed by statute, the HCSF administers these programs and handles the claims for first-dollar coverage.) He reported the FY 2024 KU Foundations and Faculty program incurred $2,656,480 in attorney fees expenses and settlements; $500,000 came from the Private Practice Reserve Fund and $2,156,480 came from the SGF. The Legal Counsel noted the largest reason for the decrease from FY 2023 program costs was settlement amounts. He reported on the increase in claims, noting due to an increase in the number of pending claims, an uptick in claims was predicted and expected. However, there was a decrease in the number of settlements from 13 in FY 2023 to 6 in 2024. He further explained there was an uptick in the amount of attorney's fees and expenses, with some bigger cases being worked and still going through the appeals process that would cost more to defend.

In regard to the self-insurance programs for the KU/Wichita Center for Graduate Medical Education (WCGME) residents programs, including the Smoky Hill residents in Salina, the total amount for FY 2024 was $248,084. The Legal Counsel commented that the program costs for the residents' self-insurance program decreased in FY 2024, with no settlements, no large cases involving residents, and the number of pending claims being about the same as FY 2023. He predicted a possible slight increase in settlements for FY 2025 based on some cases that involve

residents, but he did not believe settlements would reach the FY 2023 level. [*Note:* All expenses—settlement amounts and attorney fees and expenses—are reimbursed from the SGF.]

The Legal Counsel provided a list of historical expenditures by fiscal year for the KU Foundations and Faculty program and the residents in training since the inception of the two self-insurance programs. He reported the ten-year average for the KU Foundations and Faculty program cost is just over $2.6 million a year. He noted the FY 2024 expenditures were lower than those for FY 2023 but were above the average, mostly due to fees and expenses. He indicated this made sense with the increase in faculty each year. The residents-in-training program expenditures for FY 2024 were about the same as the ten-year average, about $1.0 million. The Legal Counsel noted the increase in faculty meeting the criteria for participation in the self-insurance program (557 in FY 2013, 1,089 in FY 2024). He advised the Committee that the Private Practice Reserve Fund reimbursement amount (which reimburses the first $500,000 of this program's expenses) has not changed since 1989, in contrast to the substantial growth of full-time faculty (277 in FY 1990) and the primary insurance coverage limit change in CY 2022 from $200,000 to $500,000 for new claims.

The Legal Counsel also provided information about moneys paid by the HCSF as an excess carrier. He noted there were no settlements that involved residents in training in FY 2024. There were 6 settlements involving full-time faculty members in FY 2024, with a total amount of $1,595,000 from the HCSF excess coverage. He stated the excess coverage amount is not reimbursed but is paid by the HCSF as part of the health care provider's excess coverage.

Discussion

The Committee and Legal Counsel discussed the HCSF's role in the litigation process as outlined below.

Role of HCSF in Litigation Process

The Legal Counsel further discussed the HCSF's involvement in cases filed. He explained that, in general, the primary carrier is responsible for the $500,000 primary coverage at the inception of the claim. The primary carrier is responsible for hiring defense counsel, working with the health care provider, and managing all aspects of the claim. The HCSF keeps apprised of everything because if, at any point, the primary carrier decides the case is going to be outside of its value and wants to tender it to the HCSF, the HCSF is ready to talk to defense counsel and make decisions regarding the need to hire certain experts, whether the HCSF approves of the experts, case strategy in general, and ultimately whether the HCSF wants to settle the claim, take it to trial, or tender onto the excess carrier above the HCSF level. He indicted the HCSF has experienced attorneys throughout the state who work with newer attorneys to develop experience and expertise to defend the cases and take them to trial or settle, as needed.

Appreciation for Retired HCSF Chief Counsel

A Committee member requested the Committee's appreciation for Rita Noll, who provided exemplary service as Chief Counsel for the HCSF for 34 years prior to her retirement in June 2024, be recorded. Ms. Noll was commended for the contributions she made not only to the HCSF and the health care provider community, but also the State of Kansas more broadly.

Medical Malpractice Insurance Marketplace; Availability Plan Update

The President and Chief Executive Officer, Kansas Medical Mutual Insurance Company (KAMMCO), reviewed the current status of the medical malpractice marketplace in Kansas and the Availability Plan.

Health Care Provider Insurance Availability Plan; Market Conditions

The KAMMCO conferee addressed several aspects of the Availability Plan and its current participants, noting as of October 1, 2024, 410 providers were in the Plan. He noted in 2020 there were 277 defined health care providers, and the all-time high was in 2004 with 661 providers. The conferee stated having more providers insured by the Availability Plan that cannot purchase coverage in the regular market is likely to produce more claims and losses. He discussed the nature of the claims in the past couple of years that has created the losses. He indicated the Availability

Plan has not paid all of the claims yet but assumes they will be paid. The conferee explained the Availability Plan puts up reserves, just like the HCSF, based on estimated amounts to be paid on filed claims over the course of the next few years. He noted a significant number of new claims over the last year or so, which have doubled the number of claims in the Availability Plan, have come from adult care facilities.

The conferee also noted legislation was enacted over the past few sessions that provided some immunity for health care providers as a result of the COVID-19 pandemic. The conferee indicated KAMMCO is not seeing many COVID-19 claims; instead, it is seeing the impact and effect on health care of some trends there were already underway. The conferee noted these were not new issues, but they were exacerbated and accelerated as a result of the pandemic.

Adult care homes. The KAMMCO conferee indicated, of the 410 health care providers in the Availability Plan, 59 are long-term care facilities, with the vast majority being skilled nursing facilities. He noted the 59 adult long-term care facilities represent about 28.0 percent of the long-term skilled nursing facilities in Kansas. The KAMMCO conferee indicated the COVID-19 pandemic had a significant impact on hospitals and especially on adult care facilities. He explained the adult care facilities were already under pressure with low reimbursement, a growing population, and workforce issues. He noted many of the long-term care facilities in Kansas have more beds licensed than they can staff. Recent plan participation data shows:

- Plan Year 2019: 8 insured facilities;
- 2020: 20 insured facilities;
- 2021: 49 insured facilities;
- 2022: 58 insured facilities;
- 2023: 54 insured facilities; and
- 2024: 59 insured facilities.

The KAMMCO conferee noted the Availability Plan has experienced a significant increase in adult care facility claims in the past few years. For example, in CYs 2018 and 2019, the Plan had one reported adult care facility claim each year. The number of reported Availability Plan adult care facility claims increased to 11 in CY 2020 (Plan year 2020-21) and has since nearly doubled again, with 19 of the total 24 Availability Plan claims reported in calendar year 2023 involving adult care facilities. This increase in claims has resulted in financial losses to the Availability Plan, which are funded by the Fund and all health care providers in the state.

Claims Environment; Firming Conditions

The KAMMCO conferee addressed the current environment for the insurance industry, noting underwriting loses since 2014 after more than a decade of profitable underwriting results. He noted various factors contributing to the underwriting losses experienced by the insurance industry include, but are not limited to, increasing claim severity; an increase in the frequency of "mega verdicts" (verdicts exceeding $10.0 million); erosion of tort reform; tightening terms and increasing rates for reinsurance programs; and inadequacy of primary insurer rates due to a consolidating health care market creating greater competition for the remaining business opportunities.

Speaking to Kansas-specific challenges, the KAMMCO conferee noted the continued uncertainty surrounding the cap on non-economic damages resulting from the Kansas Supreme Court opinion in *Hilburn v. Enerpipe Ltd.* (2019), and whether *Miller v. Johnson* remains the precedent for maintaining the cap in medical professional liability cases. He indicated the biggest problem is not necessarily what the non-economic damage amount might be, but that the health care costs and attorneys' fees are increasing. The conferee discussed how the amount paid out in terms of settlements or judgments is a direct result of acceleration in the cost of health care, jury attitudes, and mega verdicts. He stated Kansas has avoided but is not immune to mega verdicts. He indicated this creates significant uncertainty for insurance companies.

The KAMMCO conferee stated many headwinds affect the medical professional liability insurance environment in Kansas and nationwide. He noted the many challenges in the health care environment, along with macro-economic conditions of inflation and rising interest rates, are resulting in rate increases being felt by Kansas health care providers across all lines of insurance. He indicated, with rising costs and lower

reimbursements, health care providers across the country are under significant stress, especially considering their experiences during the COVID-19 pandemic. The conferee noted conditions including workforce issues, provider burnout, and financial viability appear likely to create additional risks and liabilities, which will be felt by the medical professional liability insurance industry and the HCSF into the future.

Addition of Advanced Practice Registered Nurses to HCSF

The KAMMCO conferee next addressed the topic of advanced practice registered nurses (APRNs). He explained when the Legislature broadened the scope of practice of APRNs in 2022, a requirement that APRNs maintain malpractice insurance was added, but APRNs were not placed into the HCSF as defined health care providers and do not quality for the liability coverage provided by the HCSF available to other advanced practice professionals. He further noted neither APRNs nor their employers enjoy the same legal protections limiting vicarious liability claims. He noted APRNs do not have the tail coverage provided by the HCSF. He explained the industry issues policies that cover APRNs for care provided at the place where the policy is issued. An APRN who goes somewhere else as a contract person or who moonlights is not covered by the employer's policy or coverage; the APRN must purchase another policy.

The KAMMCO conferee stated the results of a KAMMCO ten-year study on claims against APRNs prior to the 2022 legislation found very few claims against APRNs. He reported that today, the frequency of claims filed against APRNs per population of those providers is about the same as for physicians. He noted the severity of those claims (the amount professional liability insurance carriers must pay in judgments or settlements) is about the same as for physicians. The conferee indicated those findings are also echoed in a national study by the Medical Professional Liability Association, so the increase in APRN claims is not unique to Kansas. The conferee indicated, in KAMMCO's view, it is a policy question the Legislature needs to address. If trends continue, situations will occur involving significant claims that may not be adequately insured and will not have the same benefits and protections for patients or providers offered by the HCSF to defined health care providers. He also noted, if an APRN cannot purchase professional liability coverage in the private market for whatever reason, the Availability Plan is not available to them. He indicated the solution would be for APRNs to become defined health care providers in the HCSF. The conferee indicated the KAMMCO Board believes this issue should be addressed.

HCSF Investment Options

The KAMMCO conferee spoke to the questions about the investment situation at the HCSF. He noted the HCSF does not have the benefits of an insurance company when making investments because of the structure within which it must invest. Insurance companies are regulated by Chapter 40, Article 2A (KSA 40-2a01 *et seq.*), with KSA 40-2b01 *et seq.* applying to life and annuity companies. He explained the statutes lay out the restrictions on investments. He noted KAMMCO can invest in common stocks, preferred stocks, exchange-traded funds, government bonds, corporate bonds, mortgage-backed securities, and a wide variety of things. The conferee indicated KAMMCO has learned over time that diversification is good; diversification lowers risk and provides the ability to move from one asset class to another asset class without necessarily suffering the consequences the HCSF Executive Director identified.

The conferee explained if the HCSF invests only in bonds, it would realize a loss if it had to sell them to invest differently. He explained what KAMMCO has done over the past several years indicated it has the management tools needed to manage through the changing times. The HCSF does not have that flexibility because its statutory authority is much narrower. He provided the example of KAMMCO, as an insurance company, being able to belong to the Federal Home Loan Bank and borrow money from the Federal Home Loan Bank at about 20 basis points. That allows KAMMCO to borrow money at the Federal Home Loan Bank and invest the funds at higher yields or help deal with issues related to liquidity.

The KAMMCO conferee indicated expanding the investment authority of the HCSF to be that of an insurance company by enacting a law that allows the HCSF to invest pursuant to KSA 40-2a01 *et seq.* would provide the tools and the

mechanisms with which to better manage investments.

Discussion

The Committee members and KAMMCO conferee discussed the HCSF investment limitations as follows:

- A Committee member mentioned that topic was discussed at the 2023 Committee meeting and, at the time, the Committee was unsure whether it should move forward with that recommendation. The Committee member indicated that it would require legislative action to make the change. The Committee member expressed belief it was time to address the issue as APRNs are now prescribing with unlimited restrictions, which creates risk not only for APRNs but for the patients to whom they provide care; and

- Committee members discussed the past reluctance of long-term care facilities to join the HCSF, but which may now be the biggest advocates for joining the HCSF. The KAMMCO conferee stated he believed the APRNs' reluctance to participate in the HCSF is due to a lack of understanding of the Fund and the coverage and liability protection benefits provided.

Comments from Health Care Providers and Other Interested Parties

Kansas Medical Society and Kansas Hospital Association. The KAMMCO Vice President and General Counsel provided comment on behalf of the Executive Director of the Kansas Medical Society (KMS) in conjunction with the Kansas Hospital Association (KHA) on both the continuation of the Committee's oversight and the report provided by the Board of Governors' actuary, stating the HCSF has done exactly what was intended for more than four decades: ensuring providers had reasonable access to adequate liability coverage so patients had access to care and providing patients access to a right to recovery in the event of an adverse outcome. The conferee stated KMS and KHA believe the Committee plays a vital role in protecting the public by ensuring that the Fund remains solvent and independent and encouraged the continued oversight and reporting to the Legislature. The conferee indicated KMS and KHA do not believe an additional outside actuarial analysis is necessary.

Kansas Academy of Physician Associates. The Executive Director of the Kansas Academy of Physician Associates provided written comment in support of the HCSF and the responsiveness and dedication of the HCSF staff.

Kansas Trial Lawyers Association. The Executive Director of the Kansas Trial Lawyers Association provided written comment reiterating Association concern expressed at the 2023 Committee meeting related to the excess coverage options available under the HCSF and requesting the Committee recommend the 2025 Legislature amend statutes to clarify the Board's authority regarding the excess coverage options.

Board of Governors' Statutory Report

The Executive Director of the HCSF Board provided a brief history of the HCPIAA, noting that when this law was enacted in 1976, it had three main functions: a requirement that all health care providers, as defined in KSA 40-3401, maintain professional liability insurance coverage; creation of a joint underwriting association, the Availability Plan, to provide professional liability coverage for those health care providers who cannot purchase coverage in the commercial insurance market; and creation of the HCSF to provide excess coverage above the primary coverage purchased by the health care providers and to serve as reinsurer of the Availability Plan.

The Executive Director provided the Board of Governors' statutory report [as required by KSA 40-3403(b)(1)(C)] issued on October 1, 2024. The FY 2024 report indicated:

- Net premium surcharge revenue amounted to $20,215,254. The highest surcharge rate for a health care professional was $10,006 for coverage of $500,000 per claim/ $1.5 million annual aggregate limit. Application of the 30.0 percent Missouri modification factor for a Kansas resident neurosurgeon licensed to practice in

Missouri would result in a total premium surcharge of $13,008 for this health care practitioner; the lowest surcharge rate for a health care provider was $200 (primarily used by a non-resident provider providing minimum health care services in Kansas);

- The average HCSF compensation per settlement (66 cases involving 82 claims were settled in FY 2024) was $374,878; these settlements resulted in a total HCSF obligation of $36,740,000 (These amounts are in addition to compensation paid by primary insurance carriers.); and

- The balance sheet, as of June 30, 2024, indicated total assets of $276,898,210 and total liabilities of $271,180,336.

Health Care Provider Insurance Availability Plan

The Executive Director's presentation also included an update on the Availability Plan. He reported 410 plan participants as of October 28, 2024. The Executive Director noted the Plan's purpose and reported that individual providers pay about 33.0 percent more in premiums for basic coverage than if insured by a commercial insurance company and also must pay a higher HCSF surcharge. He also discussed the HCSF's role as the reinsurer to the Plan, noting in years (including FY 2024) when the Plan's losses exceed income, the HCSF is required by law to transfer the net loss to the Availability Plan. For FY 2024, the HCSF will transfer $3,871,247.

HCSF Investments

The Executive Director discussed the HCSF investments, noting the Board has met twice with the Executive Director and Chief Investment Officer of the Pooled Money Investment Board (PMIB), and all parties are aware of the low investment income. He explained part of the reason the investment income is lower than preferred is because 85.0 percent of investments are in bonds and securities that have not matured; they are in a long-term, laddered approach of 10 and 11 years. As those long-term investments mature, the money is going into overnight investments, which have paid well. He explained that is also the pool of money used to pay settlements, which creates the problem. The Executive Director indicated the Board talked about increasing the current cap on overnight investments set at 15.0 percent of the HCSF assets. He noted, at this time, the overnight investments are less than 7.0 percent. Since the overnight investments are unlikely to reach the 15.0 percent cap in the near future, the Board did not need to increase the cap. The Executive Director indicated cashing out and selling stocks and bonds and trying to reinvest would not be prudent, as the losses would be excessive. He assured the Committee that the Executive Director of the PMIB has been directed by the Board to look for any opportunities to increase the yield on investment income.

Discussion

Committee members expressed concern over the low rate of return on investment income. A Committee member stated a structured amount should be available every year to pay claims, but the majority of the funds should be in longer-term investments to protect the HCSF over possible future lawsuits. The Committee member indicated if investments are not more aggressive, health care providers end up paying higher rates. The Committee member stated he believed the Committee should encourage the Board to look at a stronger, aggressive investment strategy. The Committee member indicated the Committee or the Board needs to have a more in-depth conversation about any statutory restrictions on investments and, if so, whether those restrictions should be changed.

Another member expressed surprise that a group of laddered investments that renewed or came available for renewal over the past two years were not picked up given the 3.0 to 7.0 percent bond reach. The Committee member asked about the laddering as new batches roll over and the amount of those returns, which the member stated should have been higher.

The Executive Director explained, as that money has matured, much of it has had to be used for cases and settlements. He indicated there is about $17.0 million in repurchase agreements at close to 5.0 percent, but as money rolls out of the lower rate, much must be spent. He noted less money is being invested overall. He indicated the Board will continue to discuss with the PMIB

whether the laddering needs to be shorter. He stated there is no available option at this time, but the cases and settlements should normalize and, in turn, the investments would also normalize.

A Committee member requested a profit and loss statement showing the amount of money taken in, the amount going to the PMIB, and the distribution of the pooled money investments, particularly the rate of return and the dates the investments will be redeemed. The Committee member explained he wanted to see the current cash flow and the cash flow for the next several years.

Conclusions and Recommendations

The Committee considered two items central to its statutory charge: whether the Committee should continue its work and whether a second, independent analysis of the HCSF is necessary. It concluded this Committee continues in its belief that it serves a vital role as a link between the HCSF Board of Governors, health care providers, and the Legislature, and it should be continued. Additionally, the Committee recognizes the important role and function of the HCSF in providing stability in the professional liability insurance marketplace, which allows for more affordable coverage to health care providers in Kansas. The Committee is satisfied with the actuarial analysis presented and does not request an independent review.

The Committee considered information presented by the Board of Governors' representatives, including its required statutory report; the Board's actuary; and health care provider and insurance company representatives and other interested parties.

The Committee acknowledges its role to provide oversight and monitoring of the HCSF, including legislative actions and other contemporary issues affecting the soundness of the HCSF, and agreed on recommendations and comments on the following topics:

- Expressing appreciation for the years of service by Rita Noll, HCSF Chief Counsel and Deputy Director, upon her retirement;

- Considering allowing the HCSF investment options available to insurance companies under KSA 40-2a01 *et seq.*;

- Recommending legislation be introduced to add APRNs as defined health care providers for purposes of the HCSF; and

- Affirming that the Fund is to be held in trust.