

## MINUTES

### HEALTH CARE STABILIZATION FUND OVERSIGHT COMMITTEE

November 21, 2024  
Room 112-N—Statehouse

#### **Committee Members Present**

Marvin Kleeb, Chairperson  
Senator Chase Blasi  
Senator Cindy Holscher (Virtual)  
Representative Will Carpenter  
Representative Henry Helgerson  
Craig Concannon, M.D.  
Darrell Conrade  
Dennis George  
Douglas Gleason, M.D.  
Jerry Slaughter

#### **Members Absent**

James Rider, D.O.

#### **Staff Present**

Iraida Orr, Kansas Legislative Research Department (KLRD)  
Amanda Prosser, KLRD  
Jenna Moyer, Office of Revisor of Statutes  
Randi Walters, Committee Assistant

#### **Conferees**

Russel L. Sutter, Actuary, Willis Towers Watson  
Steve Lehwald, Legal Counsel, Health Care Stabilization Fund Board of Governors  
Clark Shultz, Executive Director, Health Care Stabilization Fund Board of Governors  
Kurt Scott, President and Chief Executive Officer, Kansas Medical Mutual Insurance Company  
Tucker Poling, Vice President and General Counsel, Kansas Medical Mutual Insurance Company, on behalf of Rachelle Colombo, Executive Director, Kansas Medical Society

**Monday, November 21  
Morning Session**

**Welcome and Introductions; Approval of November 30, 2023, Minutes**

Chairperson Kleeb called the meeting to order at 8:30 a.m. The Chairperson welcomed Committee members and asked them to introduce themselves.

Chairperson Kleeb requested approval of the minutes. *Dennis George moved, and Dr. Craig Concannon seconded, the November 30, 2023, minutes be approved as presented. Motion carried.*

The Chairperson next recognized Iraida Orr, Principal Research Analyst, Kansas Legislative Research Department (KLRD). Ms. Orr announced the meeting is being broadcast on the Legislature's audio and video streams as well as its YouTube channel. Ms. Orr noted the agenda and meeting testimony are available on the Committee's page on the Legislature's website.

**Review of Committee Information and Recent Legislation and Law**

Ms. Orr presented an overview of resource materials provided to the Committee. She indicated among the items included in the resource folder is the Committee's report to the 2024 Legislature that was submitted to the Legislative Coordinating Council (LCC) and to the Legislature as required by statute. Ms. Orr referenced the report's conclusions and recommendations to the LCC and Legislature that were developed as part of the Committee's November 2023 meeting. Ms. Orr next referenced a report prepared by KLRD staff regarding the budget for the Health Care Stabilization Fund (HCSF or Fund) Board of Governors for FY 2024 and FY 2025 approved budgets; language from the KLRD 2025 Appropriations Report; a proviso passed 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 Health Care Provider Insurance Availability Act (HCPIAA) ([Attachment 1](#)).

Chairperson Kleeb recognized Jenna Moyer, Assistant Revisor, Office of Revisor of Statutes, to provide an update on relevant legislation considered or passed during the 2024 Legislative Session ([Attachment 2](#)).

Ms. Moyer provided an overview of 2024 HB 2478, regarding maternity centers and abortion providers. Ms. Moyer stated the bill passed out of the House Committee on Insurance but never passed the House floor. Ms. Moyer explained a proviso was added in the omnibus bill, 2024 HB 2551, section 19, that 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 fiscal year (FY) 2025.

Ms. Moyer next discussed 2024 HB 2547 that, among other provisions, amends law regarding emergency medication kits in schools. She explained the bill amends the following statutes: KSA 72-6283, regarding the stock, maintenance, and administration of emergency medication kits in schools, including epinephrine and albuterol; KSA 65-1680, allowing a pharmacist to distribute emergency medications to a school and not be held liable for civil

damages resulting from administration of such medication; and KSA 65-2872b, excluding persons administering epinephrine or albuterol in certain emergency situations from the practice of healing arts and expanding existing liability protections for individuals to administer emergency medications at school or school events to also include mid-level practitioners or physicians who write a prescription for emergency medications to a school. The bill became law on July 1, 2024.

Ms. Moyer provided an overview of 2024 House Sub. for SB 287, which prohibits health care providers at a school facility from providing most health care to minors without receiving consent from such minor's parent. Ms. Moyer indicated that also included in the bill is 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.

Ms. Moyer indicated another bill possibly relevant to this Committee is 2024 House Sub. for SB 233, the Forbidding Abusive Child Transitions Act (FACT Act). The bill would prohibit 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 in the House by a vote of 82-43, which was two votes short of overriding the veto. The bill would make 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. Ms. Moyer indicated this may return as a bill during the 2025 Legislative Session.

In answer to a question from a Committee member, Ms. Moyer explained the proviso for maternity centers is effective only for FY 2025.

## **Presentation of Health Care Stabilization Fund Board of Governors' Staff and Actuary Reports, 2023-2024**

### ***Actuary Report***

Chairperson Kleeb next recognized Russel Sutter, Actuary, Willis Towers Watson (firm), to provide an actuarial report. The presentation is an addendum to data contained in the Willis Towers Watson July 18, 2024, report to the Board of Governors (Board) ([Attachment 3](#)).

Mr. Sutter first addressed the history of surcharge revenue and claims costs by program year from 1999 through projected 2025 based on estimates as of December 31, 2023. He noted costs shown exclude investment income, and costs exclude HCSF operating expenses and any transfers to the Kansas Department of Health and Environment (KDHE) or the Availability Fund. Mr. Sutter reviewed two material decreases in HCSF revenue resulting from legislative changes. In 2014, a legislative change brought many new classes of providers into the HCSF. 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. Mr. Sutter noted beginning with calendar year (CY) 2022, the primary market covers from \$0 to \$500,000, and the HCSF covers from \$500,000 to \$1.0 million.

Mr. Sutter next addressed the report's overall conclusions, noting the findings were based on the analysis conducted in the first quarter of 2024 based on year-end 2023 data. Mr. Sutter indicated that, on average, CY 2023 was not a great year for the HCSF compared with what was anticipated. Mr. Sutter reported payment activity was high; loss performance on active

providers was worse than expected, particularly on defense costs; loss performance on inactive providers was close to the level expected; investment results were worse than anticipated; and surcharge revenue was close to the level predicted. Mr. Sutter noted the net effect was that the HCSF's position at June 30, 2024, was \$2.4 million lower than the level forecasted in the 2023 study.

Mr. Sutter reported four areas of concern going into CY 2025: the overall rate inadequacy is increasing slightly higher; rate inadequacy for the hospitals remains very high, with the amount paid by hospitals low relative to the claims cost experienced; investment returns continue to be lackluster relative to market interest rates; and payments from the HCSF to the Health Care Provider Insurance Availability Plan (Availability Plan) have occurred for seven consecutive years and are consuming a larger portion of HCSF surcharge revenue. He stated, in FY 2024, the HCSF sent the Availability Plan \$3.8 million; this is either the highest or second-highest fund transfer in the history of the HCSF.

Mr. Sutter next addressed forecasts of the HCSF's financial positions at June 30, 2024, and June 30, 2025, along with the prior estimate for June 2024. Last year, the estimate of the HCSF-held assets as of June 30, 2024, was \$276.93 million, with liabilities of \$249.40 million, and with \$27.53 million in reserve (2023 Study). As of June 30, 2024, the estimate was HCSF-held assets of \$271.77 million, liabilities of \$246.62 million, and \$25.15 million in reserve. The projection for June 30, 2025, is HCSF-held assets of \$259.03 million, liabilities of \$235.63 million, and \$23.41 million in reserve. Mr. Sutter stated that based on the firm's analysis, the HCSF needed to raise its surcharge rates by 9.7 percent in CY 2025 to maintain its unassigned reserves at the expected year-end CY 2024 level (estimated \$25 million).

Mr. Sutter explained the forecasts of unassigned reserves assume an average increase of 3.5 percent in surcharge rates for CY 2025, varying by class; surcharge revenue of \$20.7 million in FY 2025; a 2.60 percent discount rate for estimating the tail liabilities on a present value basis; a 2.60 percent yield on HCSF assets for estimating investment income; full reimbursement for University of Kansas (KU)/Wichita Center for Graduate Medical Education (WCGME) claims; and no change in current Kansas tort law or HCSF law. Based on these conclusions, the firm recommended to the Board of Governors that they implement an increase in rates for CY 2025, particularly for hospitals (Class 17). Given the current rate level indications, the firm did not believe that no rate change, or an overall zero percent change, was reasonable for CY 2025.

Mr. Sutter reviewed the HCSF's (premium surcharge) rate level indications for CY 2025, which assumes a break-even target. He first highlighted payments, with settlement and defense costs of \$35.411 million; because of the HCSF providing less coverage than in the past due to the referenced change in HCSF law, a change in liabilities of -\$9.125 million (negative); administrative expenses of \$2.522 million; and transfers to the Availability Plan assumed to be \$100,000 and to KDHE assumed to be \$200,000. The actuary drew attention to Line 4, which is bolded, indicating this was a series of estimates made eight months ago: \$200,000 to KDHE every year, and they had budgeted \$100,000 to transfer from the HCSF to the Availability Plan. Mr. Sutter stated that was woefully short because the HCSF transferred \$3.8 million to the Availability Plan in FY 2024. The actuary indicated the net operating cost for the HCSF in CY 2025 to be an estimated \$29.109 million. Mr. Sutter noted the HCSF has two sources of revenue to pay for those costs: its investment income (assumed to be \$6.724 million based on 2.60 percent yield on the HCSF's assets) and surcharge payments from providers (\$22.384 million needed to break even). Mr. Sutter indicated the HCSF's projected surcharge revenue will be \$20.406 million at CY 2024 rates. Mr. Sutter explained rate level indications stating 9.7 percent is the highest rate level indication for the HCSF in several years. The actuary indicated

the firm believes the HCSF will incur a net operating loss on its operations in CY 2025 of not quite 9.7 percent because the Board decided to raise rates.

Mr. Sutter next reported on the HCSF's average assets and investment yield over the past eleven fiscal years. Mr. Sutter noted FY 2014 had average assets of \$263.5 million and earned an investment income of \$9.3 million with an effective yield of 3.53 percent. The actuary explained that yield came down for several years in a row bottoming out in FY 2022 at 2.47 percent. He further explained the FY 2024 investment yield has not increased much, as it remains below 2.5 percent. Mr. Sutter noted last year the assumption was a 2.7 percent yield, but it had to be lowered. The report indicates the assumed future yield rate was lowered from 2.70 percent in their 2023 study to 2.60 percent. He noted a 10-basis point increase in the assumed rate would cause a 1.4 percent decrease in the CY 2025 surcharge rate indication.

In response to questions from Committee members:

- Mr. Sutter indicated in previous years there has been discussion about perhaps looking into the equities side for ways to increase the long-term yield of the HCSF investments;
- Mr. Sutter agreed that with interest rates on certificates of deposit being at 4.5 percent, there would be no need to raise rates if HCSF investments had such yields; and
- Mr. Sutter indicated the assets being reviewed are on an amortized cost or book value basis, so it would not take into account the market change on those assets.

A Committee member indicated the Board has met with the Executive Director and Chief Investment Officer of the Pooled Money Investment Board (PMIB). He explained the PMIB invests all monies that come into the HCSF. He noted that because of the nature of the HCSF's need for cash or long-term growth, a lot of its investments in the bond market were laddered out to a number of years, with a maximum of 11 years to be held. He noted the difficulty in improving the yield with so much of the money committed into the future because a substantial amount of the HCSF estimated liabilities are for future claims. He indicated the HCSF needs to invest somewhat conservatively against the expectation of those future claims. He noted the Board has encouraged its staff and the PMIB to look into opportunities to invest current income into higher-yielding vehicles while funds are available to do so. The Committee member noted the Board is well aware of the yield problem and is taking incremental steps to address it. He further noted the Board understands it has to be careful about the investments, particularly because the transition of shrinking the HCSF and its exposure long-term will affect the amount of money invested. In response to a question, the Committee member indicated the PMIB is statutorily required to manage the HCSF's investments.

Mr. Sutter provided an overview of rate indications by provider class and a brief description of the provider class system. Mr. Sutter explained class definitions, distributions, and the various rates. Mr. Sutter drew attention to the report that indicates the analysis of experience by HCSF class continues to show differences in relative loss experience among the 24 classes. To illustrate, Class 17 (medical care facilities) paid 14.0 percent of the total surcharge revenue for 2016-2022 but has incurred 24.0 percent of the reported claims cost for those years. Mr. Sutter indicated, when the firm makes recommendations to the Board for future rate changes, the firm talks not only about the overall rate need of 9.7 percent but how the rate need could be distributed. Mr. Sutter noted the firm's recommendations are to increase rates for those classes

paying less into the HCSF than their claims cost experience and reduce rates for those classes paying more than the claims cost experience. Mr. Sutter addressed the firm's concern with Class 17, which from his perspective is significantly underpriced. Mr. Sutter reported that for CY 2024, the Board chose to raise the rates for Class 17 by 10.0 percent due to the previous year's rate need on Class 17 of 60.0 percent. Mr. Sutter indicated the rate need has come down because of the rate actions implemented by the HCSF Board of Governors, but it is still a significant rate need.

In response to questions from Committee members:

- Mr. Sutter discussed Class 15 (Availability Plan insureds). Mr. Sutter indicated that from an HCSF coverage level, while the Availability Plan's rate is inadequate from the firm's perspective, it is not a big driver of the HCSF's overall results compared with Class 17. Mr. Sutter further indicated he would like the rates for the Availability Plan insureds to increase a little more, but he believed the bigger issue is addressing the underlying economics of the Availability Plan so the HCSF does not have to send a seven-figure check to the Availability Plan in the future;
- Mr. Sutter indicated he has not seen the COVID-19 pandemic having much of a residual effect on medical professional liability costs other than for nursing homes. He noted the pandemic has not been a big driver on the underlying challenges that the medical professional liability community is currently facing. He indicated the bigger issue is a general increase in the cost of claims. He stated claims that used to cost \$100,000 to \$200,000 to settle are settling for three or four times that amount on occasions; and
- Mr. Sutter indicated he believed the Board concluded a few years ago that the increased claims for Class 17 were more across-the-board rather than a few repeat offenders.

Mr. Sutter provided a history of HCSF surcharge rate changes since 2012. Mr. Sutter noted rates were fairly stable, with the overall rate change in total never increasing by more than 6.0 percent, although some class rates increased more than that. Mr. Sutter pointed out a reduction in the surcharge rates in CY 2022 as a result of the law change that reduced the HCSF's coverage from \$800,000 to \$500,000.

Mr. Sutter addressed the CY 2025 surcharge rates. The report noted the Board was offered several options to consider in establishing HCSF rates for CY 2025. All recommendations involved a rate increase to Class 17. The Board decided on the following rate changes for CY 2025, resulting in an overall increase in fund revenue of 3.5 percent:

- Rate increases to 15 classes, ranging from 2.0 percent (Classes 1, 4, 12, and 23) to 10.0 percent (Class 17);
- Rate decreases of 2.5 percent for Classes 2 and 24; and
- No changes in rates for seven classes.

Mr. Sutter provided an update to comments he made last year to the Committee on the equivalent funds in the state of New Mexico. The actuary provided updated numbers for 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. Mr. Sutter reported, of the \$219.0 million in assets, \$33.0 million was transferred from New Mexico's state general fund (SGF) into New Mexico's fund. Mr. Sutter indicated in CY 2024 year, another \$36.0 million is being transferred from New Mexico's SGF. Mr. Sutter noted that over those two years, the New Mexico fund has had to be bailed out by the taxpayers of New Mexico by nearly \$70.0 million, and the fund is still deficient. Mr. Sutter indicated the New Mexico fund will still have a deficit despite receiving \$70.0 million of taxpayer money. Mr. Sutter added for context with other states around the country, there are about eight states that have funds like Kansas. Not all of those funds operate exactly the same, but overall, despite his concerns about the HCSF compared with where it was a few years ago, the HCSF is still financially healthy and much healthier than in some other states.

In response to questions from Committee members:

- As to how the New Mexico fund got into its financial situation, Mr. Sutter indicated he would have to read between the lines because he only started paying attention the last few years to the situation in New Mexico. Mr. Sutter reported that New Mexico's actuary is well-qualified and comes from a very reputable firm. For several years, New Mexico only looked at its program every two years, and there is no indication that there is an organization like this Committee paying attention to New Mexico's fund. Mr. Sutter noted that, again reading between the lines, New Mexico's fund apparently has some significant data issues with the information provided to its actuary. Mr. Sutter, again trying to interpret based on what the actuary is seeing in the reports, noted it seemed like the New Mexico fund did not pay as much attention to having annual reviews by its actuary or an organization like this Committee paying attention. Mr. Sutter stated that once a fund like this gets behind, it is hard to catch up;
- A Committee member commented that he believes two things that do not exist in other states have made the HCSF successful and financially secure. First, there was an understanding in the beginning that the HCSF was going to be entirely funded by the health care provider community. There has been no state money in the HCSF, except to the extent that the State reimburses the Fund for losses associated with faculty at the University of Kansas School of Medicine and medical students due to being employees of the State. Beyond that, the HCSF is entirely privately funded by the hospitals, doctors, and other health care providers that participate or are compelled to participate by state law. There was an understanding that, since the health care provider community was responsible, a longer view of the losses was necessary. That is why the actuarial reports look at liabilities that go out many years into the future, because these are long-tail claims. The Committee member noted it was important that the health care community understand that the Board was going to try to avoid an intergenerational transfer of liabilities to the future. Money was then set aside to not only pay current claims but any future claims that may arise from care provided during that year. That is a fundamentally important reason the HCSF is one of the few funds of the seven or eight other states' funds that has remained actuarially sound and has not relied on state taxpayer funds. The other reason is that the HCSF is governed by a group of health care providers that actually pay the premiums. The persons who run the HCSF or the health care providers who are insured by the HCSF understand they are paying the bill, and they cannot rely on the State. This imposes a discipline to ensure adequate pricing or adequate premiums. The Committee member also discussed the rate inadequacy in Class 17, indicating the Board has said it will correct that problem,

but it cannot be done overnight because that would be too much of a rate shock to those facilities in Class 17 that are already struggling financially;

- Mr. Sutter stated he had two theories for claims settling for several times more than previously. First, he believed the plaintiffs' bar was beating the defendants' bar in terms of presenting cases to juries and, once verdicts increase, settlements increase as a consequence. Second, he believes there is a general anger among the public and, as a result, they take it out in many cases on someone that is nameless and faceless as opposed to an obviously injured plaintiff;
- Mr. Sutter addressed the material difference in the types of claims between hospitals and nursing homes. Mr. Sutter noted the severity of the claims between those two groups tends to be radically different because of the economic damages impact. Mr. Sutter indicated nursing home facilities have many claims, but the claims usually settle for low five- or six-figure amounts, while the hospitals are seeing seven-to-eight-figure claims. Mr. Sutter noted the cost of an individual claim is much different, and now claims under \$500,000 do not touch the HCSF;
- The Committee member clarified that he was inquiring about the differences in claims between assisted living and nursing facilities, Classes 23 and 24. Mr. Sutter indicated, because those facilities have only been in the HCSF for eight or nine years with data, there is not much data available to determine the differences; and
- Mr. Sutter addressed claims for assisted living facilities as those beds are increasing across the state. Mr. Sutter believes there will be many claims against assisted living facilities, but the risk of a claim over \$500,000 is much lower than for most other HCSF providers.

### ***Legal Counsel's Update***

Chairperson Kleeb next recognized Steve Lehwald, Legal Counsel, HCSF Board of Governors, to address the FY 2024 medical professional liability experience (based on all claims resolved in FY 2024, including judgments and settlements) ([Attachment 4](#)). Mr. Lehwald noted FY 2024 was busy but had a promising overall trend. Mr. Lehwald addressed FY 2024 jury verdicts, noting 16 medical malpractice cases involving a total of 20 Kansas health care providers were tried to juries during FY 2024. Of the 16 cases, 15 cases resulted in defense verdicts, one case ended in a mistrial, and there were no plaintiff verdicts. The trials were held in the following jurisdictions: Johnson County (3), Sedgwick County (2), Shawnee County (1), Wyandotte County (1), Franklin County (1), Butler County (1), Coffey County (1), Leavenworth County (1), Cowley County (1), Jackson County, Missouri (3), and Clay County, Missouri (1).

Mr. Lehwald highlighted the claims settled by the HCSF, noting in FY 2024, 82 claims in 66 cases were settled involving the HCSF moneys. Settlement amounts incurred by the HCSF totaled \$30,740,000. [Note: This amount does not include settlement contributions by primary or excess insurance carriers.] This was 13 fewer claims than in FY 2023. Mr. Lehwald noted the settlement amount was slightly above average over the past 10 or 11 years. Mr. Lehwald indicated there seemed to be bigger cases, but the settlements overall were still within a reasonable range.

Mr. Lehwald reported on the severity of claims in FY 2024, noting there were five more claims in the top category of the \$600,001-\$1,000,000 range compared with FY 2023. Of the 82 claims settlements in FY 2024, primary insurance carriers tendered their policy limits to the HCSF in 73 claims; the HCSF provided primary coverage for inactive health care providers in 9 claims; and 9 claims involved contribution from an insurer whose coverage was excess of HCSF coverage. Of the 82 claims involving HCSF moneys, the HCSF incurred \$30,740,000 in settlement amounts; in addition, the primary insurance carriers contributed \$24,638,167 to these claims, and the excess insurance carriers contributed \$7,625,000. For the 82 claims involving the HCSF, the total settlement amount was \$63,003,167, which is an increase of about \$6.0 million from FY 2023. In addition to the 82 settlements, six claims were settled by an excess insurance carrier when both primary and HCSF coverage were exhausted.

Mr. Lehwald reported in addition to the settlements involving HCSF contributions, the HCSF was notified primary insurance carriers settled an additional 154 claims in 81 cases. The total amount of these reported settlements was \$9,523,167. Mr. Lehwald included a historical report of HCSF total settlements and verdicts for FY 2014 to FY 2024.

Mr. Lehwald reported on the numbers of new cases by fiscal year, noting there were 285 new cases during FY 2024. Mr. Lehwald provided historical context for the past ten fiscal years. He noted FY 2023 had 307 new cases, but FY 2024 dropped closer to the historical average since 2014.

Mr. Lehwald next addressed the self-insurance programs and reimbursement for the KU Foundations and Faculty and the Residents in Training programs, noting these programs provide the basic professional liability coverage. By statute, the HCSF administers these programs and handles the claims for first-dollar coverage. Mr. Lehwald reported the FY 2024 KU Foundations and Faculty Self-Insurance Program incurred \$2,656,479.98 in attorney fees expenses and settlements; \$500,000 came from the Private Practice Reserve Fund, and \$2,156,479.98 came from the SGF. Mr. Lehwald reported on the increase in claims, noting that due to an increase in the number of pending claims, an uptick in claims was predicted and rang true. However, there was a decrease in the number of settlements from 13 in FY 2023 to 6 in FY 2024. There was an uptick in the amount of attorney 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 KU/WCGME resident self-insurance programs, including the Smoky Hill residents in Salina, total amount of reimbursements to the HCSF for FY 2024 was \$248,083.80. Mr. Lehwald noted that by statute, all reimbursements for the residency program are from the SGF. Mr. Lehwald indicated the program costs 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. Mr. Lehwald indicated his prediction for FY 2025 is a possible slight increase in settlements based on some cases he knows will involve residents, but he did not believe settlements would reach the FY 2023 level.

Mr. Lehwald provided a list of historical expenditures by fiscal year for the KU Foundations and Faculty and the Residents in Training programs since the inception of the two self-insurance programs. He reported the Faculty and Foundations program's average over the past ten years is slightly over \$2.6 million. Mr. Lehwald noted FY 2024 expenditures were lower than FY 2023 but were above the average, mostly due to fees and expenses. Mr. Lehwald 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.

Mr. Lehwald noted the increase of faculty meeting the criteria for participation in the self-insurance program paid for by the State of Kansas. He indicated the requirements to be eligible for a State of Kansas self-insurance program for faculty are: 1) being a member of the Foundation; and 2) having a full-time faculty appointment. Mr. Lehwald explained that in 1989 when the program was created, the intent was for to be for full-time faculty who are employed by the University of Kansas Medical Center and who are actually supervising residents. However, now most of the over 1,000 faculty do not supervise residents but have a voluntary faculty appointment and are not employed by the Kansas University Medical Center; instead they are only employed by the Foundation and are rendering clinical services. Mr. Lehwald advised the Committee that all program costs over \$500,000 are reimbursed by the SGF (paid for by the taxpayers), and that amount has not changed since 1989. Mr. Lehwald reported that in 1989, there were 277 faculty, and in FY 2024, there were 1,089 faculty. Mr. Lehwald noted the primary coverage increase in 2022 from \$200,000 to \$500,000.

Mr. Lehwald next reported on moneys paid by the HCSF for excess coverage claims for KU Foundations and Faculty and Residents in Training in excess of \$200,000 prior to 2022 and \$500,000 thereafter. Mr. Lehwald noted there were no settlements regarding Residents in Training involving excess coverage in FY 2024. He indicated there were six claim settlements involving full-time faculty members in FY 2024, with total settlements of \$1,595,000 from the HCSF excess coverage. Mr. Lehwald stated the excess coverage amount is not reimbursed but is paid by the HCSF as part of the health care provider's excess coverage.

In response to questions from Committee members:

- Mr. Lehwald 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 doctor, and managing everything about the claim. The HCSF keeps apprised of everything because if at any point that primary carrier decides the case is going to be outside of their value and want to tender it to the HCSF, then 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 or 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; and
- Mr. Lehwald indicated the HCSF has experienced attorneys throughout the state who work with newer attorneys to develop experience and expertise to defend these cases and take them to trial or settle, as needed.

A Committee member requested the Committee enter into the record its appreciation for Rita Noll's exemplary role as Chief Counsel for the HCSF for 34 years and the contributions she made not only to the HCSF and the health care provider community, but also to the State of Kansas more broadly.

### **Board of Governors Overview**

Chairperson Kleeb recognized Clark Shultz, Executive Director, HCSF Board of Governors ([Attachment 5](#)). Mr. Shultz commented on Rita Noll's retirement as Deputy Director and Chief Counsel for the Board. He also thanked the Committee for suggesting that Ms. Noll be recognized in the Committee's report for her work with the Committee. He also expressed

appreciation for Mr. Lehwald as Legal Counsel replacing Ms. Noll, indicating he has a breadth of experience and is fitting in well.

Mr. Shultz provided a brief history of the HCPIAA. He explained that when the law was passed 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 Health Care Provider Insurance Availability Plan (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. Mr. Shultz explained the Surcharge Subcommittee compared other states' programs to address professional liability insurance coverage, and Kansas appears to have a good program. He reported two states have contacted the HCSF considering joining states with a program similar to Kansas. He considers this interest an acknowledgment of the good job Kansas has done thanks to the Legislature, the Kansas Department of Insurance, this Committee, and the Board.

Mr. Shultz provided the Board's statutory annual report, as required by KSA Supp. 40-3403(b)(1)(C), issued October 1, 2024. Mr. Shultz reported the FY 2024 annual report indicated the net premium surcharge revenue was \$20,215,254. The highest surcharge rate was \$10,006 for coverage of \$500,000 per claim with a \$1.5 million annual aggregate limit. Application of the 30.0 percent Missouri modification factor for a Kansas resident neurosurgeon (if licensed 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). Mr. Shultz detailed the medical professional liability case settlements resulting in a total HCSF obligation of \$36,740,000. The average compensation per settlement (66 cases involving 82 claims were settled) was \$374,878. These amounts are in addition to compensation paid by primary insurance carriers (typically \$200,000 per claim). Mr. Shultz noted the balance sheet, as of June 30, 2024, indicates total assets of \$276,898,210 and total liabilities of \$271,180,336.

Mr. Shultz presented an overview of the Availability Plan. Mr. Shultz reported that as of October 28, 2024, there were 410 plan participants. Mr. Shultz noted these participants are health care providers that would not be able to provide patient care in Kansas if it were not for the Availability Plan. Mr. Shultz reported the individual providers pay about 33.0 percent more premium for basic coverage than if insured by a commercial insurance company and also pay a higher HCSF surcharge rate. As a result, a health care provider insured by the Availability Plan pays about 36.0 percent more than their peers pay for professional liability coverage. Mr. Shultz noted the HCSF acts as a reinsurer for the Availability Plan and provided a brief explanation. When the Availability Plan experiences a surplus, the net income is transferred to the HCSF. When the Availability Plan's losses exceed income, the HCSF is required by law to transfer the net loss to the Availability Plan. Mr. Shultz indicated for FY 2024, the HCSF will make a payment of \$3,871,247 to the Availability Plan.

Mr. Shultz briefly discussed the legislation effective January 1, 2022, that increased the required basic coverage defined health care providers must obtain from an insurer from \$200,000 to \$500,000 per claim. Mr. Shultz noted there are many cases at the \$200,000 level, but there will be more cases at the \$500,000 policy limit as the old cases are settled. Mr. Shultz noted a historical overview of the HCPIAA is included in his written report.

Mr. Shultz stated he believes the HCSF is helping Kansans by providing compensation when ordered or settled by the court and trying to protect the providers and citizens of the state.

Mr. Shultz noted, from the HCSF's perspective, it has no legislation to introduce for the 2025 Session, but the HCSF will act as directed by the Board.

Mr. Shultz discussed the proviso regarding birth centers, indicating the proviso in place for the past few years was primarily for the New Birth Center that has now closed. Mr. Shultz explained that current statute allows a licensed midwife to open a clinic and have individual coverage and coverage for the clinic. The proviso allowed a clinic (a birth center that was not owned by a licensed midwife) to obtain coverage under the HCSF. New Birth Center was different as it was owned by an entrepreneur, not by a licensed midwife. Mr. Shultz noted there is no mechanism in statute to allow for HCSF coverage for such ownership.

Mr. Shultz next discussed the HCSF investments, noting the Board has twice met with Joel Oliver, Executive Director and Chief Investment Officer of the PMIB, and all parties are aware of the low investment income. Mr. Shultz 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 the overnight investments, which have paid well. Mr. Shultz explained the problem is that is also the pool of money used to pay settlements. Mr. Shultz indicated the Board talked about increasing the current cap on overnight investments set at 15.0 percent of the HCSF assets. Mr. Shultz noted, at this time, the overnight investments are under 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. Mr. Shultz indicated cashing out and selling stocks and bonds and trying to reinvest would not be prudent, as the losses would be excessive. Mr. Shultz 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.

A Committee member commented on the rate of return of the investment income. Mr. Shultz agreed that there is an estimated \$275.0 million in the PMIB, and approximately 10.0 percent renews every year. The Committee member mentioned that three years ago there was discussion that claims could come up at any time, so investment funds needed to be kept liquidified to ensure availability. The Committee member stated a structured amount should be available every year, but the majority of funds should be in longer-term investments to protect the HCSF from possible future lawsuits. He stated he believed that even if the investments were at a stair-step approach, 10.0 percent should be credited back into the PMIB and that cash could be in overnight rates. The Committee member indicated that if the investments are not more aggressive, health care providers end up paying higher rates. The Committee member stated he believes the Committee should encourage the Board to look at a stronger, aggressive 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 any such restrictions should be changed.

A Committee member commented on the conversation three years ago and the laddering and rollover of investments. The Committee member indicated he was surprised when looking at the current rates that a group of ladders that renewed or came available to be renewed over the past two years were not picked up given the 3 to 7 percent bond reach. The Committee member noted there was an uptick from 2023 to 2024 from 2.41 percent to 2.47 percent. He stated that looking at the investments, there was a great movement up into the five- and ten-year bonds. The Committee member asked about the laddering process as the new batches roll over and the amount of those returns, which should have been higher.

Mr. Shultz explained he did not want to oversimplify, but as that money has matured, much of it has had to be used for cases and settlements. Mr. Shultz indicated there is about \$17.0 million in repurchase agreements at close to 5 percent, but as money rolls out of the lower rate, much has to be spent. Currently, less money is being invested overall. Mr. Shultz indicated the Board will continue to discuss with the PMIB if a shorter ladder is needed. Mr. Shultz stated there is no available option at this time, but the cases and settlements should normalize and, in turn, the investments would also normalize.

In answer to questions from Committee members:

- Mr. Shultz explained he did not know the total dollar amount for a physician to purchase insurance from the Availability Plan. However, on average, it would cost a physician about 33.0 percent more to buy insurance from the Availability Plan than from a commercial carrier;
- Mr. Shultz indicated he was not aware of a statute that would allow or prohibit a line of credit using the financial assets as collateral for the necessary settlements in order to invest longer term for a better rate of return; and
- Mr. Shultz explained the difference between the HCSF and the Availability Plan and the \$3.8 million the HCSF transferred to the Availability Plan. He indicated the HCSF acts as a reinsurer for the Availability Plan. The Availability Plan was responsible for the first \$200,000 under previous law or \$500,000 under the new law for any cases settled or for which there was a judgment. He noted the Availability Plan had a \$3.8 million loss. The HCSF acts as a reinsurer and makes the Availability Plan whole by sending it \$3.8 million. Mr. Shultz explained that when the Availability Plan has a gain, it would send the HCSF a check in the amount of such gain. Mr. Shultz suggested thinking of the Availability Plan as a separate insurance company, and a health care provider who purchases from the Availability Plan will obtain the base coverage. The HCSF will provide the second coverage, the second \$500,000 under current law. Mr. Shultz noted when the Availability Fund has excessive losses, the HCSF also makes good on that by transferring funds to cover the loss.

A Committee member also commented on the Availability Plan, stating it should be viewed as a small insurance company. The Committee member indicated that in the current year, the Availability Plan has 410 plan participants, and it is almost impossible to charge an adequate premium on a group that small to make it actuarially sound at any given time. He noted the Availability Plan is not necessarily for bad providers or providers with adverse claim experience, but it also insures providers where an adequate market for a particular provider class is not available. The Committee member pointed out that if health care providers are compelled to carry a liability insurance, there must be market availability to purchase it. He indicated that, overall, the Availability Plan has primarily paid its own way since 1976. He further noted, without the Availability plan, there would be no insurance to cover losses for individual patients, and there would be providers or facilities unable to practice.

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. He explained he wanted to see the cash flow now and for the next several years. The Committee member commented, with the investments, there is a good idea of the amount coming out in the

next several years. He further commented that fees and revenue come in roughly about the same amount as what goes out, and a large reserve is still kept there.

## **Update on the Status of the Medical Malpractice Insurance Market; Update on the Health Care Provider Insurance Availability Plan; and Comments from Health Care Providers and Other Interested Parties**

### ***Kansas Medical Mutual Insurance Company***

Chairperson Kleeb recognized Kurt Scott, President and Chief Executive Officer, Kansas Medical Mutual Insurance Company (KAMMCO), to address the current status of the medical malpractice marketplace in Kansas and the Availability Plan ([Attachment 6](#)). Mr. Scott provided the history of KAMMCO and noted it is the servicing carrier for the Kansas Availability Plan. Mr. Scott explained it offers coverage to those who are required by state law to have medical malpractice insurance but are, for whatever reason, unable to acquire coverage in the regular market. He noted the reasons participants may be in the Availability Plan could include claims experience, regulatory restrictions on their license, or moonlighting residents.

Mr. Scott explained the basic coverage insurance that medical malpractice insurance companies and the Availability Plan are required to offer and physicians and other defined health care providers are required to have is \$500,000 per claim and \$1.5 million in the annual aggregate. On top of that, the HCSF comes in and covers \$500,000 in excess of that base \$500,000. Mr. Scott noted, if someone buys excess insurance above the HCSF, excess carriers offer a policy of excess insurance. He indicated KAMMCO offers excess insurance as well, but the Availability Plan does not. Mr. Scott explained Availability Plan insureds are entitled to the \$500,000 basic coverage and \$500,000 from the HCSF, but they cannot access excess insurance above that.

Mr. Scott explained the Availability Plan collects premiums just like an insurance company, manages the plan, pays claims, and pays all of the overhead expenses of running an insurance enterprise. At the end of the state fiscal year, each June 30th, KAMMCO produces a financial statement audited by an outside independent audit firm that reviews the profit or loss for that particular year of the Availability Plan. If the Availability Plan operated financially at a loss, the HCSF provides funding in the amount of the loss, which is the \$3.8 million loss previously discussed. Mr. Scott explained that if at the end of the year there is a profit in the Availability Plan, the Availability Plan sends that profit to the HCSF. Mr. Scott explained the Availability Plan is unable to underwrite to spread risk, so over time, the Availability Plan is almost designed to have a loss. He noted that over all the years the Availability Plan has existed, there is probably a typical average loss of about \$500,000 per year.

Mr. Scott noted the Availability Plan also has a small surcharge plan. Those providers insured in the Availability Plan that have an extreme amount of loss experience may be charged more than 33.0 percent; in fact, it can go up to a 100.0 percent claim surcharge. Mr. Scott noted the Availability Plan has a loss prevention program that gives a 2.0 percent credit off the cost of insurance for taking classes and attending qualified seminars. However, providers who do not attend offered loss prevention classes and seminars receive a 12.0 percent debit. Mr. Scott provided an example of the cost for a health care facility that has extreme claim experience. Mr. Scott noted the Availability Plan collects an extra \$569,000 per year in extra surcharges from those providers with significantly adverse loss experience or restrictions on their licenses. Mr. Scott noted KAMMCO will be reviewing the Availability Plan claims experience and making

recommendations for the Availability Plan Board of Governors to consider to help modify the claims experience. Mr. Scott noted the recommendations may include surcharge plan rates higher than 100.0 percent.

Mr. Scott referenced the “Total Plan Insureds” chart showing the covered insureds population of the Availability Plan over time. He noted that in 2020 there were 277 defined health care providers, and there are now 410 defined health care providers. Mr. Scott noted the all-time high was in 2004 with 661 providers. Mr. Scott stated more providers insured by the Availability Plan that cannot purchase coverage in the regular market is likely to produce more claims and losses. Mr. Scott 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. Mr. Scott noted the 59 adult long-term care facilities represent about 28.0 percent of the long-term skilled nursing facilities in Kansas. Mr. Scott discussed the nature of the claims in the past couple of years that have created the losses. He indicated the Availability Plan has not paid all of the claims yet, but he assumes they will be paid. Mr. Scott 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. Mr. Scott noted that a significant number of new claims over the last year or so that have doubled the number of claims in the Availability Plan have come from adult care facilities.

Mr. Scott indicated the COVID-19 pandemic had a significant impact on adult care facilities. Mr. Scott explained the adult care facilities were already under pressure with low reimbursement, a growing population, and workforce issues. Mr. Scott noted many of the long-term care facilities in Kansas have more beds licensed than they can staff. Mr. Scott also noted that over the past few sessions, the Legislature passed legislation that provided some immunity for health care providers as a result of the COVID-19 pandemic. Mr. Scott indicated KAMMCO is not seeing much in the way of COVID-19 claims; instead, it is seeing the impact and effect on health care of some trends that were already underway. Mr. Scott noted these were not new issues, but they were exacerbated and accelerated as a result of the pandemic.

In answer to a questions from Committee members:

- Mr. Scott stated he would provide the number of adult long-term care facilities that are for-profit and not-for-profit within the Availability Plan that represent 28.0 percent of the long-term care facilities in the state. Mr. Scott explained KAMMCO began insuring adult care facilities when the law was changed and effective on January 1, 2015, when those facilities came into the HCSF. Mr. Scott stated KAMMCO, not the HCSF, insures about 115 adult care facilities in Kansas. He explained KAMMCO had an initial tendency to think that, from a risk standpoint, not-for-profit was good and for-profit was bad. He noted KAMMCO discovered the risk depends more directly on structure, management, and workforce. He explained more staffing, better staffing, more experienced staff, and trained staff ensure better risk management, whether in for-profit facilities or not-for-profit facilities;
- Mr. Scott indicated there is a national trend of private equity firms buying up adult care facilities. Mr. Scott also noted the wide range of appearance of adult care facilities. Some are like a resort, and some in small Kansas communities are not-for-profits with residents mostly on Medicaid; and

- Mr. Scott explained he provided aggregated information and examples. Mr. Scott stated KAAMCO is prohibited by both state and federal law from providing information on who it insures or individual claims experiences.

Mr. Scott next addressed national trends in professional liability insurance, indicating the medical professional liability insurance industry in the nation has had underwriting losses since 2014. Mr. Scott explained the HCSF exists to stabilize health care in the State of Kansas. He further explained it was established to ensure providers had a ready source of malpractice insurance so they could practice medicine and to insure a right of recovery for injured patients. Mr. Scott noted the HCSF is a perfect public-private partnership between the State of Kansas, the state's patients, and health care providers in Kansas. Mr. Scott indicated when there have been vast malpractice crises in the country, Kansas has avoided the crises because of the HCSF structure and the review provided by the Committee.

Mr. Scott addressed tort reform in Kansas, providing background on the state of the cap on non-economic damages as a result of the 2019 *Hilburn v. Enerpipe Ltd.* case and the 2012 *Miller v. Johnson* medical malpractice case. Mr. Scott indicated the decisions in the two cases seem in conflict, leaving the issue unresolved. Mr. Scott noted this creates uncertainty about whether there is a cap on non-economic damages. Mr. Scott 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. Mr. Scott 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.

Mr. Scott next addressed advanced practice registered nurses (APRNs). Mr. Scott explained that when the Legislature broadened the scope of practice of APRNs in 2022, a requirement that they maintain malpractice insurance was added, but APRNs were not placed into the HCSF as defined health care providers and do not qualify for the liability coverage provided by the HCSF available to other advanced practice professionals. Further, neither APRNs nor their employers enjoy the same legal protections limiting vicarious liability claims. Mr. Scott noted APRNs do not have the tail coverage provided by the HCSF. Mr. Scott explained the industry issues policies that cover APRNs for care provided at the place where the policy is issued. If APRNs go somewhere else as a contract person who moonlights, that policy or coverage does not follow them; they have to purchase another policy.

Mr. Scott stated the results of a KAMMCO ten-year study on claims against APRNs prior to the 2022 legislation indicated there were very few claims against APRNs. Mr. Scott reported that today, the frequency of claims filed against APRNs per population of those providers is about the same as physicians. He noted the severity of those claims (the amount professional liability insurance carriers have to pay in judgments or settlements) is about the same as physicians. Mr. Scott 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. Mr. Scott indicated, in KAMMCO's view, it is a policy question the Legislature needs to address because, 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. Mr. Scott 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.

In answer to questions from Committee members:

- Mr. Scott explained gaps in APRN coverage versus defined health care providers under the HCSF law. Mr. Scott described blanket policies that cover those who are not defined health care providers, including APRNs, where there is a policy with a shared limit. APRNs think they have insurance, have been told they have insurance, and have a certificate of insurance, but the certificate does not indicate they are not covered if they go out and cover an emergency room. Mr. Scott noted APRNs do not know of the coverage gap, so that is a problem. Mr. Scott mentioned another issue is as APRNs come and go from a facility, KAMMCO does not know who they are because it has not underwritten them. KAMMCO is not pricing them as to whether they are working in a family practice clinic or covering an emergency room; there is a big difference between those two risk settings. Mr. Scott indicated the solution would be for APRNs to become defined health care providers in the HCSF. Mr. Scott indicated the KAMMCO Board believes this issue should be addressed;
- Mr. Scott indicated the one possible downside to adding the APRN's as defined health care providers is such changes created angst and confusion for those providers, and the transition is not easy; and
- Mr. Scott addressed providing coverage for health care in alternate settings, such as in the home, a recreational vehicle park, or doing hospital-at-home. Mr. Scott indicated the HCSF law requires the policy issued to those defined health care providers must cover them for health care services rendered or failed to be rendered. Mr. Scott explained the care as part of a professional license is covered. Mr. Scott noted there are very few things that can be excluded from coverage, and those are stated in the policy. Mr. Scott indicated the lack of clarity and the shared coverage is not necessarily following the health care provider. Mr. Scott provided an example of a physician whose coverage was not renewed. The physician had two APRNs working for him. The provider physician can go to the Availability Plan as a defined health care provider. The APRNs in the physician's clinic cannot go to the Availability Plan. Mr. Scott indicated nobody will insure an APRN when the physician who supervises the APRN's activities is not also insured by them. Mr. Scott indicated he does not know where the APRNs will be able to obtain coverage. He noted APRNs are not entitled to prior acts coverage; if APRNs want tail coverage, they have to buy tail coverage at two times their last annual premium. Mr. Scott indicated APRNs are not aware of these issues.

A Committee member concurred with Mr. Scott's remarks about the long-term care facilities' opposition to becoming defined health care providers. The Committee member indicated that a couple of years after the long-term care facilities became defined health care providers, there was no opposition to it. He explained once the long-term care facilities fully understood what they were able to obtain — the broader coverage and the assurance of coverage — they speak highly of the HCSF and its benefits.

Mr. Scott spoke to the questions about the investment situation at the HCSF. Mr. Scott noted the HCSF does not have the benefits of an insurance company when making investments because of the structure within which it has to invest. Insurance companies are regulated by Chapter 40, Article 2A (KSA 40-2a01 *et seq.*), and KSA 40-2b01 *et seq.* is for life and annuity companies. Mr. Scott explained the statutes lay out the restrictions on investments. KAMMCO

can invest in common stocks, preferred stocks, exchange-traded funds, government bonds, corporate bonds, mortgage back securities, and a wide variety of things. Mr. Scott indicated KAMMCO has learned over time that diversification is good because it lowers risk and provides the ability to move from one asset class to another asset class without necessarily suffering the consequences that Mr. Shultz identified. Mr. Scott explained if the HCSF only invests in bonds, it would realize a loss if it had to sell them to invest differently. Mr. Scott explained what KAMMCO has done over the past several years and indicated it has the management tools needed to manage through the changing times. The HCSF does not enjoy that flexibility because its statutory investment authority is much narrower. Mr. Scott also explained KAMMCO, as an insurance company, can belong to the Federal Home Loan Bank. Mr. Scott indicated KAMMCO can borrow money from the Federal Home Loan Bank at about 20-basis points, so it could borrow money from the Federal Home Loan Bank and invest the funds at higher yields or use the funds to help deal with issues related to liquidity. Mr. Scott indicated passing law to expand the investment authority of the HCSF to be that of an insurance company pursuant to KSA 40-2a01 *et seq.* would provide the HCSF the tools to invest and the mechanisms with which to better manage investments.

A Committee member inquired if the Committee could make a recommendation to the HCSF Board of Governors to add APRNs as defined health care providers so they could participate in the HCSF for the protection of Kansas constituents. Another Committee member mentioned that topic was discussed at the 2023 Committee meeting and, at the time, the Committee felt unsure if it should move forward with that recommendation. The Committee member indicated that it would require legislative action to make the change. The Committee member believed 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.

Mr. Scott agreed with a previous comment regarding long-term care facilities being reluctant to join the HCSF and how they may be the biggest advocate for joining the HCSF. Mr. Scott believed the APRNs' reluctance to participate in the HCSF is because they do not understand it. He indicated if the HCSF was clearly explained and APRNs saw the benefits, especially regarding instances where APRNs think they have coverage but do not, participating in the HCSF would be more palatable.

### ***Kansas Medical Society and Kansas Hospital Association***

Chairperson Kleeb recognized Tucker Poling, Vice President and General Counsel, KAMMCO. Mr. Poling provided testimony on behalf of Rachelle Colombo, Executive Director, Kansas Medical Society (KMS), who was unable to attend but submitted written testimony in conjunction with the Kansas Hospital Association (KHA) ([Attachment 7](#)).

Mr. Poling stated the HCSF was established at the height of the medical malpractice liability crisis in Kansas as part of an overall effort to stabilize the health care delivery environment in Kansas. Mr. Poling indicated insurance premiums came down or stabilized, and a barrier to practice in Kansas was reduced. Mr. Poling indicated the intent was twofold: 1) to ensure health care providers had reasonable access to adequate liability coverage so patients had access to care; and 2) to provide a guaranteed source of monetary recovery for patients who are injured by substandard care. Mr. Poling noted this package of policies has succeeded in performing as intended for Kansas for over four decades. Mr. Poling noted the HCSF is a rare public-private partnership that achieves a balance in the market that both protects patients and reduces a barrier to providing health care in Kansas for health care providers. Mr. Poling stated

the KMS and KHA believe the Committee serves a vital role in ensuring that the HCSF remains both solvent and independent and encouraged the continued oversight and reporting to the Legislature. The KMS and KHA affirm the HCSF actuarial soundness and do not believe that an additional actuarial analysis is required at this time.

Written-only testimony was provided by:

- Doug Smith, Executive Director, Kansas Academy of Physician Associates ([Attachment 8](#)); and
- Callie Denton, Executive Director, Kansas Trial Lawyers Association ([Attachment 9](#)).

### **Consideration of Proposed Amendments to the Health Care Provider Insurance Availability Act**

Chairperson Kleeb asked for any proposed amendments to the HCPIAA. No amendments were brought before the Committee.

### **Committee Discussion for the Purpose of Determining Conclusions and Recommendations to the 2025 Legislature and Direction to Staff for the Committee Report to the Legislative Coordinating Council**

Chairperson Kleeb invited Committee discussion for the purpose of reaching conclusions and making recommendations to the 2025 Legislature.

*Mr. Slaughter moved, seconded by Representative Helgerson, that the Committee recognize Rita Noll in the Committee record expressing its appreciation to Ms. Noll for her 34 years of exemplary service to the HCSF in her role as Chief Counsel, and to the people of the State of Kansas during her 40 years of service to the State of Kansas. With no further discussion, the motion carried.*

*Mr. Slaughter moved, seconded by Representative Helgerson, that the Committee recommend the Legislature give consideration to allowing the HCSF to invest pursuant to K.S.A. 40-2a01 et seq. With no further discussion, the motion carried.*

*Mr. George moved, seconded by Dr. Concannon, that the possibility of adding APRNs to the HCSF as a defined health care provider be studied to protect the interest of constituents in the State of Kansas and to provide APRNs with protection as they move from place to place and to have their own protection.*

*After discussion, Mr. George, with permission from the second, amended the motion to state that the Committee recommend legislation be introduced to add APRNs as defined health care providers for the HCSF and to provide protection to APRNs under the HCSF. With no further discussion, the motion carried.*

At the Chairperson's request, Ms. Orr outlined the following language included in the Committee's Report to the 2024 Legislature for the Committee's consideration for inclusion in the Committee's Report to the 2025 Legislature:

- Funds to be held in trust. The Committee recommends the following language to the Legislative Coordinating Council, Legislature, and the Governor regarding the Health Care Stabilization Fund.
  - 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 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 KU 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.

*Mr. Slaughter moved, seconded by Representative Helgerson, to incorporate the above-referenced language in the report. With no further discussion, the motion carried.*

*Mr. Slaughter moved, seconded by Dr. Gleason, that consistent with the recommendation made by the Kansas Medical Society and others, the Committee is of the opinion there is no need for an additional actuarial study, as the present actuary is adequate and is doing a good job. Secondly, the conferees have expressed support for the continuation of this oversight Committee and the role it plays in continuing the viability of the HCSF. With no further discussion, the motion carried.*

## **Adjournment**

Chairperson Kleeb thanked the Committee members, staff, and attendees for their participation in the annual review.

*Chairperson Kleeb made a motion to adjourn, seconded by Representative Helgerson. Without further discussion, the motion carried.*

The meeting was adjourned at 11:32 a.m.

Prepared by Randi Walters

Edited by Iraida Orr and Amanda Prosser

Approved by the Committee on:

April 11, 2025

(Date)