Report of the Health Care Stabilization Fund Oversight Committee to the 2026 Kansas Legislature

CHAIRPERSON: Marvin Kleeb

OTHER 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 2026

Health Care Stabilization Fund Oversight Committee

Annual Report

Conclusions and Recommendations

The Health Care Stabilization Fund Oversight Committee (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:

- **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 investment policies and the ongoing climate affecting the investment yield of the Fund. The Committee recommends that a bill enabling the HCSF to use a variety of investment procedures be introduced and considered by the Legislature.

- **Advanced practice registered nurses as defined health care providers.** The Committee recommends legislation be introduced to add advanced 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 previously sought this protection and are now included in this definition.) 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 (Board) 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 18, 2025, 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, 2024, and serves as an addendum to the report provided to the HCSF Board of Governors on September 30, 2025. The actuary addressed forecasts of the HCSF's financial position at June 30, 2025, and June 30, 2026, along with the company's 2024 estimate for June 2025. In the 2024 review, the estimate of HCSF-held assets as of June 30, 2025, was $259.03 million, with liabilities of $235.63 million, and with $23.41 million in unassigned reserves.

The actuary presented the following estimates for the company's 2025 study:

- June 30, 2025: $259.61 million in assets, $234.30 million in liabilities, and $25.31 million in unassigned reserves; and

- June 30, 2026: $251.67 million in assets, $227.20 million in liabilities, and $24.47 million in unassigned reserves.

The actuary reviewed a material decrease 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 8.7 percent in calendar year (CY) 2026 in order to maintain its unassigned reserves at the expected year-end CY 2025 level (approximately $25 million).

Rate Level (Surcharge) Indications

The actuary also reviewed the HCSF's (premium surcharge) rate level indications for CY 2026, noting the indications assume a break-even

target between revenues and expenses. He detailed various CY 2026 items, including payments, with settlement and defense costs of $31.36 million; change in liabilities (due to referenced change in HCSF law) of $5.05 million (negative); administrative expenses of $2.58 million; and transfers of $1.0 million (assumes $800,000 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 2026 is an estimated $29.89 million. He further noted the HCSF has two sources of revenue: its investment income (assumed to be $6.53 million based on 2.60 percent yield) and surcharge payments from providers ($23.35 million needed to break even). With the projected surcharge revenue ($21.47 million), this translates to a positive rate level indication for CY 2026 (8.7 percent).

Historical review and comment. The actuary addressed surcharge revenue and claims costs from 1999 through projected 2026 (based on estimates as of December 31, 2024). 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 12 fiscal years, noting the highest level of yield during this time was in 2014 and, from FY 2022 through FY 2024, that yield had been less than 2.5 percent before increasing to 2.6 percent in 2025. He indicated the assumed yield rate for next year will be 2.60 percent, unchanged from the assumed future yield rate of 2.6 percent from the 2024 study. [*Note:* Testimony also indicated a 10-basis-point change in the assumed rate would cause a 1.3 percent decrease in the CY 2026 surcharge rate indication.]

Transfers to the Availability Plan

The actuary reported on transfers to the Availability Plan over the past seven years. The actuary noted the HCSF's revenue is deceasing due to changes in the law in 2021 and significant transfers made. The actuary noted that the transfer to the Availability Plan in 2025 was $3.87 million, representing 18.0 percent of the HCSF's revenue. The actuary indicated there will be another transfer to the Availability Plan in FY 2026 of approximately $600,000, resulting in eight consecutive years in which transfers have been made from the HCSF to the Availability Plan. This anticipated transfer will need to be built into the rate analysis for the HCSF, so the cost is being built into the rate indications. The report indicates an assumed $800,000 transfer to the Availability Plan in CY 2026, an increase from the $100,000 noted in the 2024 study.

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 2025 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 6 (surgery specialty, includes emergency room [ER] [no major] and ear, nose, throat [ENT]); Class 24 (nursing facilities); Class 13 (registered nurse anesthetists); Class 4 (family practitioners, including minor surgery and obstetrics); Class 16 (professional corporations, partnerships); Class 23 (assisted living and residential

health care facilities); and Class 7 (anesthesiology); and

- Increases greater than 10.0 percent (least to greatest increase): Class 22 (nurse midwives); Class 3 (physicians, minor surgery); Class 1 (physicians, no surgery, includes dermatology, pathology, and psychiatry); Class 5 (surgery specialty, includes urology, colon/rectal, general practitioner with major); and Class 17 (medical care facilities).

Class 17 comment. The actuary highlighted a concern with rate indications for Class 17. Looking to the analysis by relative loss experience, Class 17 providers paid 14.0 percent of the total surcharge for the period of 2017-2023 but represented 25.0 percent of the reported losses during that time.

CY 2025 surcharge rates. The actuary also provided a history of surcharge rate changes since 2013, 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 and CY 2024 surcharge rates. For CY 2025, the Board of Governors increased rates for 15 classes, decreased rates for 2 classes, and made no rate changes for 7 classes, with an overall impact of these selected changes of a 3.5 percent change in rate level. Addressing the CY 2026 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 overall rate increase and an increase to Class 17. The Board decided on the following rate changes for CY 2026:

- Rate increases on 10 classes, ranging from a positive 3.0 percent (Classes 8-11) to a positive 9.8 percent (Class 17);

- Rate decreases of approximately 2.0 percent for Classes 2 , 6, 13, and 24; and

- No change in rates for 10 classes.

[*Note:* The estimated net overall impact of these selected changes is a rate level increase of 3.1 percent.]

Discussion

CY 2024 observations. The actuary characterized the CY 2024 experience for the HCSF as mixed. 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 better than expected; investment results were better than in CY 2023; the transfer to the Availability Plan was very high; and the relative rate inadequacy for hospitals remained high (+31.0 percent), although it is down from the peak two years prior (+61.0 percent). The actuary concluded, given these indications, the HCSF's net financial position at June 30, 2025, is $1.9 million higher than the level previously forecast in the company's 2024 study. The actuary noted four areas of concern going into CY 2026: 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.

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 (New Mexico Patient's Compensation Fund). He provided updated numbers of the New Mexico fund, reporting the assets at year-end 2024 were $308.0 million, but liabilities were $342.0 million. The actuary reported, of the $308.0 million in assets, $98.0 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. Absent the $98.0 million in SGF, the Patient's Compensation Fund would have been underfunded by $132.0 million.

The actuary indicated other states with funds similar to the Kansas Fund have had to use taxpayer moneys to help address their financial shortfalls. However, the actuary noted the HCSF

has never been in that position since the actuary's involvement, and such need is not anticipated in the next one to two years.

Committee discussion. Committee members, the actuary, and Board of Governors' representatives discussed the disparities in surcharge rates for the different rate classes. The actuary has assisted the Board of Governors in analyzing different scenarios in an effort to gradually eliminate the disparities in class surcharges and avoid shocking one class with a substantial rate increase. The actuary noted the 3.1 percent increase in the CY 2026 surcharge rates would generate between $600,000 and $700,000 in additional revenue to the HCSF.

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 Committee's report to the 2025 Legislature that was submitted to the Legislative Coordinating Council and to the Legislature as required by statute, the budget summary of the Kansas Legislative Research Department regarding the approved budgets for the HCSF Board of Governors for FY 2025 and FY 2026, 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 2025 Session. An Assistant Revisor of Statutes with the Office of Revisor of Statutes highlighted five relevant bills:

- Sub. for SB 29, which became law after the Governor's veto was overridden, removes the authority of public health officers to prohibit public gatherings to control infectious or contagious diseases and prohibits a local health officer or the Secretary of Health and Environment from ordering law enforcement to assist in the execution of orders related to isolation, quarantine, or treatment for infectious or contagious diseases;

- SB 63, which became law after the Governor's veto was overridden, enacts the Help Not Harm Act with relevant provisions that prohibit health care providers from performing certain surgeries and prescribing certain drugs to children as treatment for a child's gender dysphoria. The bill provides for the revocation of a provider's license for violation of the act, holds a provider who provides the prohibited treatment strictly liable for harms to a child, and grants a cause of action to parents of a child who receives such prohibited treatment. The bill also prohibits professional liability insurance policies issued to health care providers from covering damages assessed against provider claims that result from prohibited treatments;

- Sub. for SB 67, which became law, authorized certified registered nurse anesthetist prescribing authority;

- SB 250, which became law without the Governor's signature, enacts the Right to Try for Individualized Treatments Act to allow a manufacturer to make an individualized treatment available to individuals with life-threatening or severely debilitating illnesses and does not create a private cause of action for harm caused by a covered drug, product, or device if the provider acted in good faith with reasonable care; and

- HB 2039, which became law, adds maternity centers to the definition of "healthcare provider" in HCSF statutes, allowing maternity centers to access the Availability Plan; excludes certain entities from the definition of "home health agency"; and amends emergency medical provider statutes to clarify the authorized activities of certain emergency medical services personnel and to address the operation and staffing of certain ambulance services).

Legal Counsel's Update

The Legal Counsel for the Board of Governors addressed the FY 2025 medical professional liability experience based on all claims resolved in FY 2025, including judgments and settlements. He indicated there were more claims than in FY 2024 but a lower HCSF obligation.

Jury Verdicts and Settlements

Using HCSF data, the Legal Counsel stated 17 medical malpractice cases, involving a total of 21 Kansas health care providers, were tried to juries during FY 2025. The trials were held in the following jurisdictions: Johnson County (5); Sedgwick County (5); Shawnee County (2); Wyandotte County (2); Dickinson County (1); and Clay County, Missouri (2). Of these cases, 14 resulted in defense verdicts, 2 cases resulted in plaintiff verdicts, and 1 case ended in a hung jury.

The Legal Counsel highlighted the claims settled by the HCSF, noting in FY 2025, 95 claims in 68 cases were settled involving HCSF moneys. He reported the settlement amounts incurred by the HCSF for FY 2025 totaled $27,743,947. 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. He stated the settlement average in FY 2025 was $292,041.55 per HCSF claim.

The Legal Counsel reported, for the 95 claims, primary insurance carriers tendered their policy limits to the HCSF in 74 claims and the HCSF provided primary coverage for inactive health care providers in 6 claims. He reported that for the claims involving HCSF moneys, the HCSF incurred $27,743,947 in settlement amounts; in addition, the primary insurance carriers contributed $37,010,314 and the excess insurance carriers contributed $15,200,000, for a total settlement amount of $79,954,261. The Legal Counsel also reported, in addition to the 95 settlements, 8 claims were settled by an excess insurance carrier when both the primary and HCSF coverage were exhausted. He indicated there were four or five cases involving birth injuries, which can be larger claims due to future care needs and involve excess insurance coverage.

The Legal Counsel also provided historical information on new cases by fiscal year, noting 236 new cases during FY 2025. There were 285 new cases in FY 2024.

Committee discussion. The Legal Counsel addressed questions regarding the plaintiffs' verdicts. One was a nursing home case in Clay County, Missouri, that did not reach the HCSF's level. The second case was in Johnson County involving a verdict of approximately $5.7 million, that is still with the court. He indicated there may be additional cases that go to trial in Johnson County and Wyandotte County. He noted Missouri has been more plaintiff-friendly. He confirmed this is the first year in which primary carrier payments exceeded HCSF payments, which he attributed to the legislation effective in 2022 that increased the claim amount primary carriers are required to cover before the HCSF is responsible. He agreed there is more motivation for primary carriers to defend cases due to the higher primary limits.

Self-insurance Programs

The Legal Counsel also addressed the self-insurance programs and reimbursement that provide basic liability coverage for the University of Kansas (KU) Foundations and Faculty program and residents. (As directed by statute, the HCSF administers these programs and handles the claims for first-dollar coverage.) He reported the FY 2025 KU Foundations and Faculty program incurred $3,372,801 in attorney fees expenses and settlements; $500,000 came from the Private Practice Reserve Fund and $2,872,801 came from the SGF. The Legal Counsel noted the largest reason for the increase from FY 2024 program costs was settlement amounts. He reported the increase in claims and settlements was predicted and expected. The number of settlements increased from six in FY 2024 to ten in FY 2025. He further explained that while the settlement amounts increased from FY 2024 to 2025, overall attorney fees and expenses decreased due to larger settlement amounts associated with those cases.

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 2025 was $2,490,530. The Legal Counsel commented that the program costs for the residents' self-insurance program increased

in FY 2025, with five settlements, some of which were larger cases. He predicted settlements for FY 2026 would be similar to those in FY 2025. He noted the number of faculty and residents at KU continues to grow each year, which may bring additional and potentially larger cases in the future. [*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 FY 2016. He reported the ten-year average cost for the KU Foundations and Faculty program is approximately $2.3 million a year. He noted the FY 2025 expenditures of $3,372,801, with $1.9 million in payment of claims and $1.3 million in expenses and attorney fees, were higher than for FY 2024 and above the ten-year average. He reported the ten-year average residents-in-training program cost is about $1.1 million a year. The expenditures for FY 2025 were $2,490,530, with $1,750,000 in claims payments and $740,530 in expenses. The Legal Counsel noted more claims involved multiple residents in bigger cases, which can be expensive to defend.

The Legal Counsel noted the increase in faculty meeting the criteria for participation in the self-insurance program (652 in FY 2016 and 1,191 in FY 2025). He noted that when the program was created, it was believed the intent was to cover full-time faculty who were employed by the KU Medical Center and who were actually supervising residents. He stated, most of the faculty do not supervise residents but have a voluntary faculty appointment and are not employed by the KU Medical Center; instead, they are employed by a private practice foundation and are rendering clinical services. He reminded the Committee that the Private Practice Reserve Fund reimburses the first $500,000 with SGF moneys.

The Legal Counsel also provided information about moneys paid by the HCSF as an excess carrier. He noted excess coverage claims involving residents in training in FY 2025 totaled $750,000. Moneys paid for claims involving full-time faculty members in FY 2025 totaled $525,000 from the HCSF excess coverage.

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' report, as required by KSA 40-3403(b)(1)(C), issued on October 1, 2025. The FY 2025 report indicated:

- Net premium surcharge revenue amounted to $21,464,460. The highest surcharge rate for a health care professional was $10,606 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 $13,788 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 (79 cases involving 95 claims were settled in FY 2025) was $333,357; these settlements resulted in a total HCSF obligation of $31,668,947 (These amounts are in addition to compensation paid by primary insurance carriers.); and

- The balance sheet, as of June 30, 2025, indicated total assets of $262,725,076 and total liabilities of $248,478,874.

Health Care Provider Insurance Availability Plan

The Executive Director's presentation also included an update on the Availability Plan. He reported 415 plan participants as of October 27, 2025. 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 2025) when the Plan's losses exceed income, the HCSF is required by law to transfer the net loss to the Availability Plan. For FY 2025, the HCSF will transfer $602,574.

HCSF Investments

The Executive Director discussed HCSF investments, noting a request from a Committee member for information regarding the Board of Governors' investments, policies, and statutes the Board of Governors is required to follow. He stated that information was provided to the Committee members and the Office of Revisor of Statutes, along with information from the President and Chief Executive Officer (CEO) of the Kansas Medical Mutual Insurance Company (KAMMCO). The information was to be used to prepare a bill to give the Board of Governors additional investment options without mandating additional types of investments. The goal is to try to increase the yield in a safe manner consistent with the mission of the Board of Governors. He noted the Executive Director and Chief Investment Officer of the Pooled Money Investment Board (PMIB) was also consulted.

Discussion

Committee members and the Executive Director discussed increasing the investment yield for the HCSF. A Committee member indicated he has requested a bill draft for the 2026 Legislative Session to provide investment options. Committee members discussed the introduction of the bill through an exempt legislative committee, such as the House Committee on Appropriations, and seeking referral to the House Committee on Health and Human Services for a hearing.

The Assistant Revisor noted the Committee's recommendation to the 2025 Legislature was to allow the HCSF to invest in a manner similar to an insurance company, for which requirements would be in *Kansas Statutes Annotated* Chapter 40, Article 2A, *et seq*.

The Executive Director indicated the PMIB has been involved in the bill drafting discussions and provided suggestions. He noted there are six investment opportunities the HCSF may invest in and described three of the categories: direct obligations insured by the United States, corporate bonds that do not exceed 11 years in maturity and are rated in one of the two highest credit rating categories, and commercial paper that does not exceed 270 days. The Executive Director did not believe the Board of Governors was opposed to expanding the investment list if it provides opportunities but does not mandate certain investments.

A Committee member indicated, in his discussions, committees have not been prone to changing the investment types because of risk to the SGF.

In a discussion regarding the laddering of investments, the Executive Director confirmed that the yield on investments, excluding bonds and Treasury notes, averaged 4.18 percent.

Medical Malpractice Insurance Marketplace; Availability Plan Update

The President and CEO of 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 CEO addressed several aspects of the Availability Plan and its current participants. He referenced the "Total Plan Insureds" in his written testimony, noting as of October 2025, 415 providers were in the Plan. He noted there were 430 participants in 2010, the number declined to a low of 277 defined health care providers in 2020, and the number climbed again in 2021. The KAMMCO CEO explained the trend over time is the direct result of what the industry calls a "soft market cycle" or a "hard

market cycle." He noted in the past four to six years, the market has been in a hardening cycle, when underwriting requirements tighten and prices increase. When the market hardens or becomes more restrictive, more health care providers turn to the Availability Plan.

The KAMMCO CEO noted 60 long-term-care facilities are generating a frequency of claims that is unacceptable to the regular market and have turned to the Plan. He noted the Plan is the insurer of last resort. The Plan does not have the option to select the risks, but it has to insure the health care providers the rest of the industry will not insure. He discussed the nature of the claims in the past couple of years that has created the losses. He noted much of the recent rise in health care providers insured by the Plan comes from the market conditions for adult long-term-care facilities, a likely result of conditions brought on by the COVID-19 pandemic.

Adult care homes. The KAMMCO CEO indicated, of the 415 health care providers in the Availability Plan, 60 are long-term-care facilities. 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;
- 2024: 59 insured facilities; and
- 2025: 60 insured facilities.

The KAMMCO CEO 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 nearly doubled again with 19 of the total 24 Availability Plan claims reported in CY 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. He noted, in CY 2025, the frequency of adult-care-facility claims has returned to normal level, with 10 of the total 15 Plan claims reported involving adult-care facilities. He indicated this is what is driving the losses to the Plan, which are accrued losses that have not yet been paid. He explained the Availability Plan has its own actuaries who help set up up reserves, just like the HCSF has, based on estimated amounts to be paid on filed claims over the course of the next few years.

In response to questions from Committee members, the KAMMCO CEO explained that all health care providers were under stress during the COVID-19 pandemic, particularly adult-care facilities. The adult-care facilities struggle financially and with staffing for direct care and management, which creates the potential for risk. This struggle has occurred nationally. He stated the issue is not a direct result of COVID-19 claims but is a result of the COVID-19 environment. He anticipates the effects of the COVID-19 environment will normalize in the next couple of years. He indicated that staffing has always been a problem in the adult-care-facility environment, but he hoped it would reset to a more normalized trend. He noted he was not aware of legislation to address the long-term-care facilities' exposure to risk.

Claims Environment; Firming Conditions

The KAMMCO CEO 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 that include, but are not limited to, increasing claim severity; an increase in the frequency of "mega verdicts" (verdicts exceeding $10.0 million); a steep increase in attorney advertising; 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.

Cap on non-economic damages. Speaking to Kansas-specific challenges, the KAMMCO CEO 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* (2012) remains the persuasive precedent for maintaining the cap in medical professional liability cases. He noted the need for a case to go

through the Kansas Supreme Court to clarify the *Hilburn* decision.

The KAMMCO CEO noted the June 2025 $5.7 million Johnson County jury award against a mental health counselor, an emergency medicine advanced practice registered nurse (APRN), and the hospital at which they worked, Advent Health. He noted the case and its potential appeal in the Kansas Court of Appeals and the Kansas Supreme Court raises timely topics that could affect the health care liability market in Kansas. The issues noted include whether the cap on non-economic damages in personal injury actions applies to medical malpractice actions, whether that cap applies to "survival actions" (actions filed by the estate of a deceased person), whether the cap on non-economic damages in wrongful death actions should be overruled, and how these issues are affected by certain categories of APRNs not being included as defined health care providers in the HCSF despite their expanded role in direct patient care.

APRN malpractice insurance coverage. The KAMMCO CEO noted the expansion of the APRN scope of practice enacted during the 2022 Legislative Session, which requires APRNs to maintain malpractice insurance coverage as a condition of practicing in Kansas and provide proof of such coverage at the time of licensure and renewal of a license. He stated the malpractice insurance requirement did not include APRNs as a defined health care provider eligible under the HCPIAA or allow for coverage in the HCSF.

The KAMMCO CEO 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 KAMMCO-insured physicians and surgeons. He noted the severity of those APRN claims (the amount professional liability insurance carriers must pay in judgments or settlements) is about the same as for physicians and surgeons. The KAMMCO CEO indicated those findings are also echoed in a national study by the Medical Professional Liability Association. He noted the goal of the HCSF is to protect patients and providers and create a reasonable environment for the delivery of care; however, APRNs are not benefiting from the same level of protection.

In response to questions from Committee members, the KAMMCO CEO explained that the addition of APRNs would not have a detrimental effect on the HCSF because the HCSF collects an adequate surcharge from providers to match with claims experience. APRNs with which he has had a discussion have been opposed to joining the HCSF due to a lack of understanding of the construct and structure of the HCSF and the protections it provides. He indicated he believed APRNs would want to be included in the HCSF if they understood its benefit.

A Committee member noted some APRNs, such as nurse midwives and nurse anesthetists, are in the HCSF. The member stated APRNs were given the authority to prescribe drugs without a physician protocol in 2022, but the Legislature did not address adding APRNs to the HCSF. The member stated the issue should be addressed by the Legislature.

The KAMMCO CEO clarified that the APRNs who are not in the HCSF are mandated by statute to maintain malpractice insurance. However, there is no statutory requirement for the amount of coverage or where the policy is purchased. He noted any claim would be paid by the insurance company from whom the APRN purchased coverage and would be subject to the policy limit. He stated that the provider or the provider's employer will be responsible for the amounts over the coverage limit because of vicarious liability.

The KAMMCO CEO explained that, at KAMMCO, APRNs are insured through either hospitals or large physician clinic employers. KAMMCO issues an additional insured endorsement that covers these employers' non-defined health care providers, such as APRNs. These policies cover only the non-defined health care providers at the employer's place of business and does not follow these providers.

In response to a Committee member's comment regarding coverage for independent APRNs, many of whom are in rural parts of the state, the KAMMCO CEO indicated being part of the HCSF would benefit both the APRNs and their patients.

Primary malpractice insurance coverage increase. The KAMMCO CEO stated the increase in the basic coverage from $200,000 to $500,000 per claim appears to not be causing any major shocks to the insurance market or a loss of insurers offering coverage.

Effect on health care environment. The KAMMCO CEO noted these 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 KAMMCO CEO 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.

Case Addressing Damage Caps

The KAMMCO Vice President of Claims and General Counsel addressed the current status of the cap on non-economic damages, the wrongful death cap, and the issue of vicarious liability, highlighting the *Hilburn* and the *Yates v. AdventHealth* (2025 Johnson County case with a $5.7 million award) cases. In describing the *Yates* case, he indicated the court applied the wrongful death cap to reduce the non-economic damages but did not apply the general personal injury cap to the survival action. The KAMMCO General Counsel noted the plaintiffs and the defendants could appeal the decision, which could bring clarity on the application of the caps. He noted the decision also held the hospital, AdventHealth, vicariously liable for the actions of the APRN, who was not an employee of the hospital. He stated if APRNs were in the HCSF, the hospital would have been protected from that claim. He clarified that KAMMCO was not involved in the *Yates* case.

Comments from Health Care Providers and Other Interested Parties

Kansas Medical Society and Kansas Hospital Association. The Executive Director of the Kansas Medical Society (KMS) in conjunction with the Kansas Hospital Association (KHA) provided comment 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. The KMS conferee encouraged the Committee to consider recommending to the Legislature that participation in the HCSF be included when addressing changes related to licensure and scope of practice for health care providers.

Kansas Academy of Physician Associates. The Executive Director of the Kansas Academy of Physician Associates provided written comment in support of the HCSF and urged the Fund's continued protection and investment. He stressed the critical role the HCSF has played in supporting physician assistants in obtaining adequate malpractice protection at reasonable and stable premiums.

Kansas Trial Lawyers Association. The Executive Director of the Kansas Trial Lawyers Association provided written comment reiterating Association concern expressed at the 2024 Committee meeting related to the excess coverage options available under the HCSF and requesting the Committee recommend the 2026 Legislature amend statutes to clarify the Board's authority regarding the excess coverage options.

Kansas Affiliate of the American College of Nurse-Midwives. A Kansas APRN and certified nurse midwife (CNM) provided written testimony regarding actions that could be taken to decrease the barriers for CNMs to serve patients and improve access to care. The written testimony highlighted barriers for CNMs, including the lack of tiered categories of coverage in the HCSF like those available for physicians, the limited availability of insurance carriers that cover CNMs

and confusion with some available coverage that does not meet HCSF requirements, and the need for coverage for CNMs working within their scope of practice at state institutions, county health departments, and out-of-hospital locations.

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:

- Recommending legislation be introduced and considered to enable the HCSF to use a variety of investment options;

- 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.