KANSAS MEDICAL SOCIETY
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To: Senate Financial Institutions and Insurance Committee

From: Rachelle Colombo
Executive Director

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Subject: SB 290; Concerning the Health Care Stabilization Fund

The Kansas Medical Society appreciates the opportunity to submit the following comments in support of SB 290, which amends Health Care Provider Insurance Availability Act, found at KSA 40-3401 *et seq*. We would first like to provide some background and context to this bill.

Since 1976, Kansas has had a unique arrangement regarding professional liability (medical malpractice) insurance for physicians, hospitals and several other categories of health care providers. In response to a nearly complete collapse of the private insurance markets caused by a growing medical malpractice crisis in the 1970's, the legislature enacted the Health Care Provider Insurance Availability Act, which is a structure that combines insurance coverage from commercial markets with a state-operated but privately funded insurance facility called the Health Care Stabilization Fund (the Fund). Health care providers are required to purchase liability insurance from this structure in order to render professional services in Kansas. The insurance purchased by health care providers through this mechanism thus has two components: "basic insurance" which is purchased from the commercial market, and "excess insurance", which is purchased from the Fund. The Fund is financed almost entirely by insurance premiums paid by covered health care providers, except for faculty and resident physicians at the KU School of Medicine, whose insurance costs are paid by the state of Kansas.

The Fund serves two very important purposes – providing an assured source of liability insurance for health care providers, and ensuring that there is a source of recovery for patients who are injured as a result of medical malpractice. This system has worked exceedingly well for over four decades, and it has provided tremendous stability and benefit to patients, health care providers and the state of Kansas.

Most of the amendments contained in SB 290 are minor updates or technical in nature. We have worked closely with the affected stakeholder groups, as well as the Kansas Insurance Department and the Health Care Stabilization Fund on drafting this legislation. The principal thrust of the bill is intended to address two areas that need attention to reflect current needs as well as anticipated insurance market conditions in the coming years. Although the bill is somewhat lengthy, that really has more to do with the very

detailed and complicated statutory structure that is common throughout the insurance laws found in Chapter 40. The two main changes addressed in the bill do the following:

1. **Increases the minimum insurance coverage requirement for healthcare providers.** - (*amendments found on pages 1, 12 & 13 of the bill*) effective with all policies issued after January 1, 2022, the new minimum insurance limits required of healthcare providers would increase from the current $300,000 per claim to $1 million per claim. It would accomplish this by increasing both the so-called "basic coverage" (the insurance provided by private insurers) from the current $200,000 per claim to $500,000 per claim, and also increasing the Fund's "excess" coverage minimum from the current $100,000 per claim to $500,000 per claim. The last time the basic coverage and Fund coverage limits were addressed by the legislature was over thirty years ago (1984 SB 507 and 1989 HB 2501). In addition to this much-needed updating of the relationship between the basic and excess insurance coverage limits, the proposed change also addresses a concern that was noted by our Supreme Court in the *Miller v. Johnson* case (2012), that the minimum statutory coverage requirement had not been adjusted in over three decades.

2. **Updates the Fund coverage options available to healthcare providers** - (*amendments found on pages 12 & 13 of the bill*) these changes allow the Fund to offer a higher limit of excess coverage than that which it is able to do today. Again, much has changed in the insurance markets over the past three decades, and particularly in the "excess limits" or reinsurance markets. One of the driving forces for the establishment of the HCSF in the 1970's was the inability of physicians, hospitals and other health care providers to obtain adequate coverage limits from the excess or reinsurance markets. We are seeing a concerning trend developing again today, with reinsurance markets significantly contracting and severely limiting their underwriting of these higher insurance limit policies. Over the past year the two largest providers of excess limits reinsurance have announced their plans to exit the medical malpractice line of business, which is very troubling news for the health care community.

   By allowing the Fund to sell a higher layer of coverage to those providers who would like to purchase $2 million in coverage rather than $1 million in total insurance, we can help ensure the availability of such coverage. Today, about 95% of the health care providers covered by the Fund select the coverage option which gives them $1 million in coverage, making the two lower coverage options currently offered, for all practical purposes, obsolete. The amendments in this bill will eliminate the two lower and mostly unused coverage options, and make available just two new coverage options going forward, one for a total insurance package of $1 million, and a second option that provides a total package of $2 million for those providers who desire it. In addition, we have also included an

amendment in subsection (2) on page 13, lines 37 – 41, which will provide the Fund Board of Governors some flexibility to adjust the two optional coverage limits as market conditions may dictate from time to time, so long as the minimum total coverage for healthcare providers is not less than $1 million per claim, as noted above.

There are other amendments included in the bill that are largely technical, and which are necessary to implement the changes discussed above relating to the basic coverage required, and the new optional Fund coverage limits proposed. Those changes appear for the most part in Section 2, on page 12, lines 18 - 23; and in Section 3, pages 14 -15. Also in Section 2, on pages 13 -14, another technical amendment deletes language that expired in 2014. A further technical change, which is attached to this testimony, on page 21 of the bill, Section 6, moves the language regarding the maximum aggregate coverage (lines 30-33) to be a part of subsection (b) in order to clarify the aggregate limits allowed both before January 1, 2022, and on and after January 1, 2022. This change was also at the request of the HCSF.

Two other amendments that aren't technical in nature, but should not be controversial, appear also in Section 2. The first is found on pages 4 – 5, and it amends provisions related to the HCSF Board of Governors, the eleven-member governing body responsible for the operation of the HCSF, which is appointed by the Insurance Commissioner. The only substantive change included in this proposed amendment allows KMS the flexibility, if it chooses to do so, to nominate a non-physician representative for one of its three positions on the Board which is appointed by the Insurance Commissioner.

The other change is found on page 8, in subsection (d), lines 42 -43. This change was requested by the HCSF, and it affects the limitation on periodic or installment payments that the Fund makes in the case of judgments or settlements. This amendment would merely increase the current payment limitation from $300,000 to $500,000, which we believe is consistent with the changes made to the coverage requirements elsewhere in the bill.

Also, as noted earlier, another amendment allows certain healthcare facilities which qualify as self-insurers covered by a captive insurance company to opt out of selecting one of the new Fund coverage limits, so long as the facilities are in substantial compliance with the minimum coverage requirements of the act. The provisions of this amendment are found on page 12, lines 27 -33, and on page 17, lines 25 – 31. At the suggestion of the HCSF, we are proposing to further amend this provision by moving this language to a new subsection (3), which should help clarify its meaning, as a separate way to qualify as a self-insurer. The amendment is attached to this testimony.

Another amendment requested by the Health Care Stabilization Fund which is necessitated by the increase in the basic coverage insurance limits contained in the bill is found on page 17, line 5. It increases the minimum amount needed to be considered for qualifying self-insurers from $100,000 to $150,000, as recommended by the Fund's actuary. This amendment is also on the attached balloon.

Finally, an amendment suggested by the Kansas Trial Lawyers Association is found on page 16, lines 5 – 6. This is largely a technical change which extends from 10 days to 30 days the requirement for plaintiffs to provide notice to the Fund that a claim has been filed.

Over the past two years we have worked closely with all of the stakeholders in drafting this bill, and we are not aware of any opponents to it. We have included suggested changes from the Insurance Department, the Health Care Stabilization Fund, affected healthcare provider groups, and as noted above, even the Kansas Trial Lawyers Association. These amendments will help update the basic insurance coverage requirements in the law, and allow the Fund to offer a higher limit of excess insurance to providers who may desire it. We urge your support of SB 290. Thank you.

~~care~~ *healthcare* system organized and existing under the laws of this state ~~which~~ *that* owns and operates more than one medical care facility or more than one ~~health care~~ *healthcare* facility, as defined in K.S.A. 40-3401, and amendments thereto, licensed by the state of Kansas, whose aggregate annual insurance premium is or would be ~~$100,000~~ or more for basic coverage calculated in accordance with rating procedures approved by the commissioner pursuant to K.S.A. 40-3413, and amendments thereto, may qualify as a self-insurer by obtaining a certificate of self-insurance from the board of governors. Upon application of any such ~~health care~~ *healthcare* provider or ~~health care~~ *healthcare* system, on a form prescribed by the board of governors, the board of governors may issue a certificate of self-insurance if the board of governors is satisfied that the applicant ~~is possessed~~ *possesses* and will continue to ~~be possessed of~~ *possess the* ability to pay any judgment for which liability exists equal to the amount of basic coverage required of a ~~health care~~ *healthcare* provider obtained against such applicant arising from the applicant's rendering of professional services as a ~~health care~~ *healthcare* provider.

(2) In making such determination the board of governors shall consider:

~~(1)~~*(A)* The financial condition of the applicant;

~~(2)~~*(B)* the procedures adopted and followed by the applicant to process and handle claims and potential claims;

~~(3)~~*(C)* the amount and liquidity of assets reserved for the settlement of claims or potential claims; and

~~(4)~~*(D)* any other ~~relevant~~ factors *the board deems relevant.* ~~*Any applicant for self-insurance that owns and operates more than one medical care facility or more than one healthcare facility shall be deemed qualified by the board of governors if such applicant is insured by a captive insurance company, as defined in K.S.A. 40-4301, and amendments thereto, or under the laws of the state of domicile of any such captive insurance company.*~~ The certificate of self-insurance may contain reasonable conditions prescribed by the board of governors. Upon notice and a hearing in accordance with the provisions of the Kansas administrative procedure act, the board of governors may cancel a certificate of self-insurance upon reasonable grounds therefor. Failure to pay any judgment for which the self-insurer is liable arising from the self-insurer's rendering of professional services as a ~~health care~~ *healthcare* provider, the failure to comply with any provision of this act or the failure to comply with any conditions contained in the certificate of self-insurance shall be reasonable grounds for the cancellation of such certificate of self-insurance. The provisions of this subsection shall not apply to the Kansas soldiers' home, the Kansas veterans' home or to any ~~person~~ *individual* who is a self-insurer pursuant to subsection (d) or (e).

$150,000

(3) Any applicant for self-insurance that owns and operates more than one medical care facility or more than one healthcare facility shall be deemed qualified by the board of governors if such applicant is insured by a captive insurance company, as defined in K.S.A. 40-4301, and amendments thereto, or under the laws of the state of domicile of any such captive insurance company.

~~health care~~ *healthcare* provider insurance availability act, each nonprofit corporation organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated with the university of Kansas school of medicine shall be deemed to have been a self-insurer within the meaning of subsection (h), and amendments thereto, from and after July 1, 1997.

(3) Subject to the provisions of paragraph (4), for the purposes of the ~~health care~~ *healthcare* provider insurance availability act, the election of fund coverage limits for each nonprofit corporation organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated with the university of Kansas school of medicine shall be deemed to have been effective at the highest option, as provided in K.S.A. 40-3403(l), and amendments thereto, from and after July 1, 1997.

(4) No nonprofit corporation organized to administer the graduate medical education programs of community hospitals or medical care facilities affiliated with the university of Kansas school of medicine shall be required to pay to the fund any annual premium surcharge for any period prior to the effective date of this act. Any annual premium surcharge for the period commencing on the effective date of this act and ending on June 30, 2001, shall be prorated.

Sec. 6. K.S.A. 2020 Supp. 40-3424 is hereby amended to read as follows: 40-3424. (a) For all claims made on and after July 1, 2014, the amount of fund liability for a judgment or settlement against a resident or nonresident inactive healthcare provider shall be equal to the minimum professional liability insurance policy limits required pursuant to K.S.A. 40-3402, and amendments thereto, *and in effect on the date of the incident giving rise to a claim,* plus the level of coverage selected by the healthcare provider pursuant to K.S.A. 40-3403(l), and amendments thereto, at the time of the incident giving rise to a claim. ~~The aggregate fund liability for all judgments and settlements arising from all claims made in any fiscal year against a resident or nonresident inactive healthcare provider shall not exceed $3,000,000 in any fiscal year.~~

(b) ~~This section shall be part of and supplemental to the healthcare provider insurance availability act.~~ *For all claims made for incidents occurring on or after January 1, 2022, the aggregate fund liability for all judgments and settlements made in any fiscal year against a resident or nonresident inactive healthcare provider shall not exceed three times the coverage amount in subsection (a).*

Sec. 7. K.S.A. 40-3409 and K.S.A. 2020 Supp. 40-3402, 40-3403, 40-3408, 40-3414 and 40-3424 are hereby repealed.

Sec. 8. This act shall take effect and be in force from and after its publication in the statute book.

The aggregate fund liability for all judgments and settlements arising from all claims made in any fiscal year against a resident or nonresident inactive healthcare provider shall not exceed $3,000,000 in any fiscal year.