Approved Feb. 21, 1984
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Rep. Rex Hoy at
Chairperson

3:30 ~~a.m.~~/p.m. on February 16, 1984 in room 521 S of the Capitol.

All members were present except:
Rep. Fuller and Rep. Peterson, who were excused

Committee staff present:
Wayne Morris, Legislative Research
Gordon Self, Revisor's Office
Mary Sorensen, Committee Secretary

Conferees appearing before the committee:
John Peterson
Others present:
See List (Attachment 1)

It was announced that HB 2885, by Rep. Spaniol, would not be discussed, but would be passed over until another date.

HB 2755, concerning the Health Care Provider Insurance Availability Act. Gordon Self, from the Revisor's Office, passed around Attachment 2, and explained briefly the sunset amendment, which had previously been approved by the committee; and explained the second amendment, which was suggested during the hearing on the bill. Dick Brock, from the Insurance Department, briefly explained the entire bill and its history. Rep. Sprague moved to adopt the new amendment. Rep. Littlejohn seconded. The motion carried. Rep. Spaniol moved to report HB 2755 favorably, as amended. Rep. Sutter seconded. The motion carried.

HB 2614, Proof of Motor Vehicle Liability Insurance or financial security, was next for final action. The balloon amendments were furnished to the committee on February 15th, and there had been previous discussion on the bill and amendments. Rep. Sutter moved to adopt the balloon amendments to HB 2614. Rep. Turnquist seconded. The motion carried. Rep. Sprague moved to pass out HB 2614 favorably as amended. Rep. Spaniol seconded. The motion carried.

HB 2251, Providing for the regulation of continuing care agreements and registration of providers. Rep. Sprague reported on the findings of the subcommittee. They have met with Security Commissioner's personnel and asked for strong disclosure requirements. The subcommittee will meet again and hope to have their recommendations ready for final action on Tuesday, February 21st.

Rep. DeBaun moved to approve the minutes of February 13, 1984. Rep. Sutter seconded. The motion carried.

John Peterson appeared with a request for a committee bill. He passed around suggested language for this bill (Attachment 3)which concerns health care policies. He briefly explained the proposed bill. Rep. Webb moved to introduce the bill, by request. Rep. Long seconded. The motion carried.

The meeting adjourned at 3:30 PM.

GUEST LIST

Attachment 1

COMMITTEE: House Insurance

DATE: Thurs. Feb. 16, 1984

NAME	ADDRESS	COMPANY/ORGANIZATION
Kathy Wade Apps	1334 S. Topeka	Ks. Chiropractic Assn
Bob Williams	5200 Huntoon	Ks Dental Assoc
[illegible]	Topeka	AIA
SGT William Jacobs	Topeka	Kansas Highway Patrol
Homer Cowan	Ft Scott. Ks	The Western Ins Co's
L.M. Cornish	Topeka	Ks Assoc of P/C
Dick Brock	"	Ins Dept
Larry Magill	"	IIAK

Att. 1

Session of 1984

HOUSE BILL No. 2755

By Committee on Insurance

(By request)

1-23

Attachment 2

AN ACT relating to insurance; concerning the health care provider insurance availability act; amending K.S.A. 1983 Supp. 40-3413 and repealing the existing ~~section~~ sections

Be it enacted by the Legislature of the State of Kansas:

~~Section 1.~~ K.S.A. 1983 Supp. 40-3413 is hereby amended to read as follows: 40-3413. (a) Every insurer and every rating organization shall cooperate in the preparation of a plan or plans for the equitable apportionment among such insurers of applicants for professional liability insurance and such other liability insurance as may be included in or added to the plan, who are in good faith entitled to such insurance but are unable to procure the same through ordinary methods. Such plan or plans shall be prepared and filed with the commissioner within a reasonable time but not exceeding 60 calendar days from the effective date of this act. Such plan or plans shall provide:

(1) Reasonable rules governing the equitable distribution of risks by direct insurance, reinsurance or otherwise including the authority to make assessments against the insurers participating in the plan or plans;

(2) rates and rate modifications applicable to such risks which shall be reasonable, adequate and not unfairly discriminatory;

(3) a method whereby annually the plan shall compare the premiums earned to the losses and expenses sustained by the plan for the preceding fiscal year. If there is any surplus of premiums over losses and expenses received for that year such surplus shall be transferred to the fund. If there is any excess of losses and expenses over premiums earned such losses shall be

Section 1. K.S.A. 1983 Supp. 40-3403 is hereby amended to read as follows: 40-3403.

(a) For the purpose of paying damages for personal injury or death arising out of the rendering of or the failure to render professional services by a health care provider, self-insurer or inactive health care provider subsequent to the time that such health care provider or self-insurer has qualified for coverage under the provisions of this act, there is hereby established the health care stabilization fund. The fund shall be held in trust in a segregated fund in the state treasury. The commissioner shall administer the fund or contract for the administration of the fund with an insurance company authorized to do business in this state.

(b) ~~Subject to subsection (c),~~ the fund shall be liable to pay: (1) Any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable resident health care providers or resident self-insurers for any such injury or death arising out of the rendering of or the failure to render professional services within or without this state; (2) any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable nonresident health care providers or nonresident self-insurers for any such injury or death arising out of the rendering or the failure to render professional services within this state. In no event shall the fund be obligated for claims against nonresident health care providers or nonresident self-insurers who have not complied with this act or for claims against nonresident health care providers or nonresident self-insurers that arose outside of this state; (3) any amount due from a judgment or settlement against a resident inactive health care provider for any such injury or death; (4) any amount due from a judgment or settlement against a nonresident inactive health care provider for any injury or death arising out of the rendering or failure to render professional services within this state. In no event shall the fund be obligated for claims against: (A) Nonresident inactive health care providers who have not complied with this act; or (B) nonresident inactive health care providers for claims that arose outside of this state, unless such health care provider was a resident health care provider or resident self-insurer at the time such act occurred; (5) reasonable and necessary expenses for attorney fees incurred in defending the fund against claims; (6) any amounts expended for reinsurance obtained to protect the best interests of the fund purchased by the committee on surety bonds and insurance pursuant to K.S.A. 75-4101 and amendments thereto; (7) reasonable and necessary actuarial expenses incurred in administering the act; (8) annually to the plan or plans, any amount ~~assessed or assessable from insurers under any plan or plans existing pursuant to K.S.A. 40-3413 and amendments thereto~~ due pursuant to subsection (a)(3) of K.S.A. 40-3413 and amendments thereto; and (9) reasonable and necessary expenses incurred by the insurance department in the administration of the fund.

(c) All amounts for which the fund is liable pursuant to paragraphs (1), (2), (3) or (4) of subsection (b) of this section shall be paid promptly and in full if less than $300,000, or if $300,000 or more, by installment payments of $300,000 or 10% of the amount of the judgment including interest thereon, whichever is greater, per fiscal year, the first installment to be paid within 60 days after the fund becomes liable and each subsequent installment to be paid annually on the same date of the year the first installment was paid, until the claim has been paid in full. Any attorney's fees payable from such installment shall be similarly prorated.

(d) A health care provider shall be deemed to have qualified for coverage under the fund: (1) On and after the effective date of this act if basic coverage is then in effect; (2) subsequent to the effective date of this act, at such time as basic coverage becomes effective; or (3) upon qualifying as a self-insurer pursuant to K.S.A. 40-3414 and amendments thereto.

Hb. 2

transferred from the fund;

(4) the limits of liability which the plan shall be required to provide, but in no event shall such limits be less than those limits provided for in subsection (a) of K.S.A. 40-3402 *and amendments thereto*;

(5) a method whereby applicants for insurance, insureds and insurers may have a hearing on grievances and the right of appeal to the commissioner.

(b) The commissioner shall review the plan as soon as reasonably possible after filing in order to determine whether it meets the requirements set forth in subsection (a) ~~of this section~~. As soon as reasonably possible after the plan has been filed the commissioner shall in writing approve or disapprove the ~~same~~ *plan*. Any plan shall be deemed approved unless disapproved within 30 days. Subsequent to the waiting period the commissioner may disapprove any plan on the ground that it does not meet the requirements set forth in subsection (a) ~~of this section~~, but only after a hearing held upon not less than 10 days' written notice to every insurer and rating organization affected specifying in what respect the commissioner finds that such plan fails to meet such requirements, and stating when within a reasonable period thereafter such plan shall be deemed no longer effective. Such order shall not affect any assignment made or policy issued or made prior to the expiration of the period set forth in the order. Amendments to such plan or plans shall be prepared, and filed and reviewed in the same manner as herein provided with respect to the original plan or plans.

(c) If no plan meeting the standards set forth in subsection (a) is submitted to the commissioner within 60 calendar days from the effective date of this act or within the period stated in any order disapproving an existing plan, the commissioner shall after *a* hearing, if necessary to carry out the purpose of this act, prepare and promulgate a plan meeting such requirements.

(d) If, after a hearing, the commissioner finds that any activity or practice of any insurer or rating organization in connection with the operation of such plan or plans is unfair or unreasonable or otherwise inconsistent with the provisions of this act, the

commissioner may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this act and requiring discontinuance of such activity or practice.

(e) For every such plan or plans, there shall be a governing board which shall meet at least annually to review and prescribe operating rules. Such board shall consist of nine members to be appointed by the commissioner as follows: Three members shall be representatives of foreign insurers, two members shall be representatives of domestic insurers, two members shall be representatives of the general public, one member shall be a licensed insurance agent actively engaged in the solicitation of casualty insurance and one member shall be a health care provider. The members shall be appointed for a term of two years.

(f) An insurer participating in the plan approved by the commissioner may pay a commission with respect to insurance written under the plan to an insurance agent licensed for any other insurer participating in the plan or to any insurer participating in the plan. Such commission shall be reasonably equivalent to the usual customary commission paid on similar types of policies issued in the voluntary market.

~~(g) The provisions of this section shall expire on July 1, 1984, but any plan created hereunder shall continue to exist for the purpose of allowing policies then in effect to expire, transferring surplus to the fund, completing the payment of claims and receiving reimbursement therefor.~~

(g) The provisions of this section shall expire on July 1, 1987, but any plan created hereunder shall continue to exist for the purpose of allowing policies then in effect to expire, transferring surplus to the fund, completing the payment of claims and receiving reimbursement therefor.

Sec. 3. K.S.A. 1983 Supp. 40-3413 is hereby repealed.

40-3403 and

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.

Attachment 3

House Bill _____

Section 1. 40-2,103 is hereby amended to read as follows: 40-2,103 The requirements of ~~this act~~ K.S.A. 40-2,100, 40-2,101, 40-2,102 and 40-2,104 and amendments thereto shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides or is employed in this state ~~more than one hundred twenty (120) days after the effective date of the act~~.

Section 2. This act shall take effect and be in force on publication in the statue book.

Atch. 3

40-2,100. Insurance coverage to include reimbursement or indemnity for services performed by optometrist, dentist or podiatrist. Notwithstanding any provision of any individual, group or blanket policy of accident and sickness, medical or surgical expense insurance coverage or any provision of a policy, contract, plan or agreement for medical service, issued on or after the effective date of this act, whenever such policy, contract, plan or agreement provides for reimbursement or indemnity for any service which is within the lawful scope of practice of any practitioner licensed under the healing arts act of this state, reimbursement or indemnification under such policy contract, plan or agreement shall not be denied when such services are performed by an optometrist, dentist or podiatrist acting within the lawful scope of their license.

History: L. 1973, ch. 194, § 1; July 1.

40-2,101. No policies, contracts or agreements for medical service shall deny reimbursement or indemnification for any service within scope of practice licensed under Kansas healing arts act. Notwithstanding any provision of any individual, group or blanket policy of accident and sickness, medical or surgical expense insurance coverage or any provision of a policy, contract, plan or agreement for medical service, issued on or after the effective date of this act, whenever such policy, contract, plan or agreement provides for reimbursement or indemnity for any service which is within the lawful scope of practice of any practitioner licensed under the Kansas healing arts act, reimbursement or indemnification under such policy contract, plan or agreement shall not be denied when such service is rendered by any such licensed practitioner within the lawful scope of his license.

History: L. 1973, ch. 195, § 1; July 1.

40-2,102. Insurance coverage for newly born children; notification of birth. All individual and group health insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a profit or nonprofit corporation which provides coverage for a family member of the insured or subscriber shall, as to such family members' coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one (31) days after the date of birth in order to have the coverage continue beyond such thirty-one day period.

History: L. 1974, ch. 190, § 4; July 1.

40-2,103. Same; time when provisions required in policies. The requirements of this act [*] shall apply to all insurance policies and subscriber contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after the effective date of the act [*].

History: L. 1974, ch. 190, § 5; July 1.

* "This act," see, 40-2,102, 40-1804, 40-1907, 40-19a10.

40-2,104. Insurance coverage to include reimbursement for services performed by certified psychologist. Notwithstanding any provision of an individual or group policy or contract of health and accident insurance, delivered within the state whenever such policy or contract shall provide for reimbursement for any service within the lawful scope of practice of a duly certified psychologist within the state of Kansas, the insured, or any other person covered by the policy or contract shall be allowed and entitled to reimbursement for such service irrespective of whether it was provided or performed by a duly licensed physician or a duly certified psychologist.

History: L. 1974, ch. 189, § 1; July 1.

40-2,105. Insurance coverage for reimbursement of services rendered in treatment of alcoholism, drug abuse and nervous or mental conditions. Unless refused in writing, every insurer, which issues any group policy of accident and sickness, medical or hospital expense insurance which provides for reimbursement or indemnity