Approved 2-3-86
Date

MINUTES OF THE House COMMITTEE ON Insurance.

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

3:30 XX.m./p.m. on January 28, 1986 in room 521-S of the Capitol.

All members were present except:

Rep. Graeber, excused

Committee staff present:
Emalene Correll, Research Department
Melinda Hanson, Research Department
Gordon Self, Revisor of Statutes Office
Deanna Willard, Secretary

Conferees appearing before the committee:
Dr. Robert Harder, Secretary, Department of Social and Rehabilitation Services
Mr. Dick Brock, Insurance Department

Dr. Robert Harder requested legislation relating to insuring handicapped children. Coverage would not necessarily have to be in a medical setting. His second request would require HMOs to pay for court-ordered (involuntary) commitments.

Mr. Dick Brock presented requests for 13 pieces of legislation, six of which would be in this committee; the others are for the Senate Committee on Financial Institutions and Insurance. (Attachment 1.)

1. Senate - limits insurer's right to cancel commercial and casualty policies.

2. Senate - defines federal product liability risk retention act and sets forth state requirements for risk retention groups.

3. House - provides that the legislature does not intend that premium tax differential paid in accordance with procedures set forth in Kansas statutes be refunded.

4. House - suggests that evaluation of HMOs be made the responsibility of individual HMOs through services of an independent organization acceptable to the Commissioner.

5. House - provides that subscribers terminated from an HMO would be given the same six-month continuation privileges granted persons insured by more traditional means.

6. House - would require all insurers to participate in the IRIS (early-warning system.) Same kind of provision as HB 2499.

7. Senate - amount would be increased to $500 before which State Committee on Surety Bonds would be required to use competitive bidding process.

8. Senate - brings the numbers and descriptions of minimum education requirements for life, accident, and health insurance agents into conformity with current nomenclature.

9. Senate - defines as an unfair trade practice an insurer's refusal to insure based solely on the condition of blindness.

10. House - makes the unfair trade practices act applicable to HMOs.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

Minutes of the House Committee on Insurance, January 28, 1986

11. House - amends statutes covering agents' licenses: removes stated amount charged, provides that amount submitted not be refunded for any reason.

12. Senate - provides that premium for any renewal policy be the same as previously paid until the insured has been notified of any difference.

13. Senate - prohibits individual underwriting of persons to be covered by a group contract.

Rep. Blumenthal moved that all requested legislation by Dr. Harder and Mr. Brock be introduced as committee bills. Rep. Neufeld seconded the motion. The motion carried.

The minutes of the January 23, 1986, committee meeting were approved as amended.

The meeting was adjourned at 4:10 p.m.

GUEST LIST

COMMITTEE: Insurance DATE: 1-28-86

| NAME | ADDRESS | COMPANY/ORGANIZATION |
| --- | --- | --- |
| Dick Brock | Topeka | Ins Dept. |
| Chuck Blankenship | Topeka | Victory Life |
| Richard Harmon | Topeka | KS Assn. of Prop./Casualty Cos. |
| Lee WRIGHT | MISSION | FARMERS INS. GROUP |
| Steve Ortmeyer | Shawnee | State Farm Ins. |
| Dick Scott | O.P. | State Farm Ins. |
| Paul M. Klotz | Topeka | Assn. of CMHCs KS |
| LARRY MAGILL | " | INDEP INS. AGENTS OF KS |
| JACK ROBERTS | " | BC-BS |
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Explanatory Memorandum For
Legislative Proposal No. 1

This proposal applies only to commercial property and casualty insurance and is designed to address some of the problems that have arisen as a result of the current insurance market situation.

Specifically, the proposal recommends that limitations be placed on an insurer's right to cancel any policy of commercial property and casualty insurance. Further, the proposal requires insurers to provide 90 days notice to the insured of any intent not to renew a commercial property or casualty insurance policy.

The limitations on mid-term cancellations and the advance notice of intent not to renew should be of assistance to those persons, firms and organizations who experience difficulty in obtaining property or casualty insurance because of a sudden unexpected cancellation during the term of an existing contract or a sudden and unexpected advice from their agent or company that their current coverage would not be renewed. In such situations the risk is left with inadequate time to search the market for replacement coverage often with no knowledge of the factors that contributed to the problem.

Revised

# LEGISLATIVE PROPOSAL NO. 1

AN ACT relating to insurance; property and casualty; cancellation; nonrenewal; limitations; requirements.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:

1 Section 1. No policy of property or casualty insurance, other than
2 accident and sickness, used primarily for business or professional needs
3 that has been in effect for 90 days or more may be cancelled except for one
4 of the following reasons:
5 (a) Non-payment of premium;
6 (b) the policy was issued because of a material misrepresentation;
7 (c) any insured violated any of the material terms and conditions of
8 the policy;
9 (d) unfavorable underwriting factors exist that were not present at the
10 inception of the policy; or
11 (e) a determination by the commissioner that continuation of coverage
12 could place the insurer in a hazardous financial condition or in
13 violation of the laws of this state.

14 Sec. 2. Any insurance company that denies renewal or substitution of
15 similar coverage for the same exposures under any property or casualty
16 insurance policy, other than a policy covering accident and sickness, which
17 is used primarily for business or professional needs shall give at least 90
18 days written notice to the named insured at his or her last known address of
19 its intention not to renew such policy. The company may satisfy this
20 obligation by causing such notice to be given by a licensed agent.

21 Sec. 3. This act shall take effect and be in force from and after its
22 publication in the statute book.

Explanatory Memorandum for
Legislative Proposal No. 2

This proposal consists of the model product liability risk retention act adopted by the National Association of Insurance Commissioners to complement the federal product liability risk retention act of 1981. In brief, the federal law was enacted during the period when product liability insurance was virtually impossible to obtain and was extremely high in cost if such coverage was available. It permits groups of corporations, associations, organizations or other entities to be organized for the purpose of pooling their resources and self-insuring their product liability or completed operations risks. Risk retention groups may include members whose principle activity consists of the manufacture, design, importation, distribution, packaging, labeling, lease or sale of a product or products. The federal act preempts to a large degree the ability of state insurance departments to regulate the activities of a risk retention group. However, the federal law does permit the states to tax such groups and does permit states to license agents and brokers for risk retention groups. In addition, the risk retention group must, of course, comply with the provisions of the federal law because failure to do so would result in transaction of the insurance business without being authorized to do so under the laws of either the federal government or the individual states.

Legislative Proposal No. 2 therefore defines risk retention groups; identifies the state or territory having jurisdiction over a risk retention group depending on where it is domiciled; sets forth the requirements regarding the licensing of agents and brokers for a risk retention group; and establishes the taxes that risk retention groups would be subject to in this state.

LEGISLATIVE PROPOSAL NO. 2

AN ACT relating to insurance; risk retention groups; formation; operation; requirements.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:

Section 1. Definitions.

(A) As used in this Act --

(1) "Commissioner" means the state insurance commissioner of this state; and "commissioner" means the commissioner, director or superintendent of insurance in any other state;

(2) "completed operations liability" means liability arising out of the installation, maintenance, or repair of any product at a site which is not owned or controlled by --

(a) any person who performs that work; or

(b) any person who hires an independent contractor to perform that work; but shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability;

(3) "insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this state;

(4) "product liability" means the liability for personal injury and property damages arising from the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product as defined and construed by the laws of this state.

(5) "risk retention group" means any corporation or other limited liability association taxable as a corporation or as an insurance company formed pursuant to this act:

(a) which is organized for the primary purpose of assuming and spreading the product liability or completed operations liability risk exposure of its members;

(b) whose primary activity consists of assuming and spreading all, or any portion, of the product liability or completed operations liability risk exposure of its groups members; and

(c) which is composed of members each of whose principal activity consists of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product or products.

(6) "Service providers" means any person providing insurance related services or management services to, or for, a risk retention group, including but not limited to agents, brokers, claims appraisers and adjusters, insurers, actuaries and financial management consultants.

(7) "State" means this state of Kansas and "state" means any state of the U.S. and the District of Columbia.

Sec. 2. Risk Retention Groups Chartered in This State. A risk retention group seeking to be chartered in this state must be chartered and licensed as an insurance company authorized by the insurance laws of this state and, except as provided elsewhere in this act, must comply with all of the laws, rules, regulations and requirements applicable to such insurers chartered and licensed in this state.

Sec. 3. Risk Retention Groups Not Chartered in This State.

(A) Risk retention groups chartered in states other than this state, or Bermuda, or the Cayman Islands and seeking to do business as a risk retention group in this state must:

(1) register with the commissioner in this state;

(2) designate the commissioner as its agent for service of process and receipt of legal documents;

(3) no later than March 1 of each year, file with the commissioner of this state its annual statement as filed with the commissioner in the chartering state or the public official having supervision of insurance in the chartering jurisdiction;

(4) file a copy of the last examination, if any, made of the risk retention group, certified by the commissioner of the chartering state or the public official having supervision of insurance in the chartering jurisdiction; and

63 (5) file with the commissioner, no later than January 15 of each
64 year or within 60 days thereafter, the product liability loss
65 experience data report required by K.S.A. 1984 Supp. 40-1132.
66 (B) Risk retention groups chartered in Bermuda or the Cayman Islands,
67 in addition to the requirements of subsection (A) above, must:
68 (1) be chartered or licensed and authorized to do business under
69 the laws of Bermuda or the Cayman Islands before January 1, 1985;
70 (2) file with the commissioner of this state a copy of the
71 certification filed with the commissioner of at least one state
72 that satisfies the capitalization requirements of that state,
73 together with evidence that such certification has been accepted by
74 the commissioner of that state as meeting the requirements of that
75 state; and
76 (3) file, with the commissioner of the state in which it certifies
77 its capitalization, a waiver of any secrecy laws of the
78 jurisdiction in which it is chartered.

79 Sec. 4. Agents and Brokers.
80 (A) (1) Any person who is a resident of this state, acting or offering
81 to act as an agent or broker for a risk retention group, whose
82 activities include, but are not limited to the solicitation,
83 negotiation and placement of insurance on behalf of a risk
84 retention group operating in this state, or any of its members in
85 this state, must obtain a license as an agent or broker in
86 accordance with the applicable provisions of articles 2 and 37 of
87 chapter 40 Kansas statutes annotated.
88 (2) An agent or broker duly licensed by another state and residing
89 outside of this state may act as an agent or broker for a risk
90 retention group operating in this state or any of its members in
91 this state in the same manner as a resident agent or broker, upon
92 obtaining a license in accordance with K.S.A. 1984 Supp. 40-246.
93 (3) Any agent or broker licensed in accordance with subsections
94 (1) or (2) above, in addition must report to the commissioner the
95 activities and scope of services they are providing to the risk
96 retention group.
97 (B) Before placing business with a risk retention group, each agent or
98 broker shall secure from the appropriate insurance regulatory authority a
99 certified copy of the certificate of authority verifying that such insurer
100 is authorized in its domiciliary jurisdiction to write the product liability
101 or completed operations insurance policy proposed to be procured from it by
102 said agent or broker.
103 (C) Every policy or contract of insurance placed by an agent or broker
104 with a risk retention group chartered or licensed in this state shall bear
105 across its face in not less than ten point bold red type the following
106 legend: "The insurance hereby evidenced is written by a risk retention
107 group licensed by the state of Kansas but in the event of insolvency of this
108 risk retention group, is not protected by the Guaranty Fund of this state."
109 (D) Every policy or contract of insurance placed by an agent or broker
110 with a risk retention group not chartered or licensed in this state shall
111 bear across its face in not less than ten point bold red type the following
112 legend: "The insurance hereby evidenced is written by a risk retention
113 group not licensed by the state of Kansas, not subject to its supervision
114 and not protected, in the event of the insolvency of this risk retention
115 group by the Guaranty Fund of this state."

116 Sec. 5. Other Service Providers.
117 (A) Service providers who are not licensed agents or brokers must:
118 (1) register with the commissioner; and
119 (2) report the activities and scope of services which they are
120 providing to the risk retention group.
121 (B) This section shall not be interpreted to allow service providers
122 whose activities otherwise require licensing in this state to act on behalf
123 of risk retention groups without such a license.

124 Sec. 6. Taxes.
125 (A) All risk retention groups shall be subject to taxation and shall be
126 deemed to be insurers for the purpose of assessing and collecting taxes in
127 accordance with the provisions of K.S.A. 1984 Supp. 40-252 and subject to
128 the same interest, fines and penalties for nonpayment.
129 (B) Agents and brokers shall report and pay the taxes upon the premiums
130 for risks which they have placed with or on behalf of a risk retention group
131 not chartered in this state.

132 Sec. 7. Restrictions. A risk retention group may not:
133 (A) insure any risks other than those of its member companies;
134 (B) provide any insurance or insurance related service other than for
135 product liability or completed operations unless it obtains a license in
136 this state and becomes subject to all the laws and regulations of this state
137 with respect to those additional lines of insurance and related services; or
138 (C) exclude any person from membership in the group solely to provide
139 for members of such a group a competitive advantage over such a person.

140 Sec. 8. Exemption From Compulsory Associations. No risk retention
141 group, with respect to its product liability or completed operations
142 insurance shall be permitted to join or contribute financially to any
143 insurance insolvency guaranty fund, or similar mechanism, in this state, nor
144 shall any risk retention group, or its insured, receive any benefit from any
145 such fund for claims arising out of the operations of such risk retention
146 group for product liability or completed operations insurance.

147 Sec. 9. Countersignature Not Required. A policy of insurance issued to
148 a risk retention group or any member of that group shall not be required to
149 be countersigned as otherwise provided in K.S.A. 1984 Supp. 40-246.

150 Sec. 10. Unfair Claims Settlement Practices. A risk retention group
151 doing business in this state shall be subject to all applicable unfair
152 claims settlement practices laws and regulations as provided in K.S.A. 1984
153 Supp. 40-2401 et seq.

154 Sec. 11. Examination for Financial Impairment.
155 (A) A risk retention group chartered in this state must submit to
156 examinations to determine its financial condition as deemed necessary by the
157 commissioner.
158 (B) A risk retention group not chartered in this state, and doing
159 business in this state, must submit to an examination if:
160 (1) the commissioner has reason to believe the risk retention
161 group is in a financially impaired condition; and
162 (2) the commissioner of the state or the public official having
163 supervision over insurance in the jurisdiction in which the group
164 is chartered has not begun or has refused to initiate an
165 examination of the group.
166 (C) Such examination shall be conducted in accordance with the laws,
167 regulations and procedures applicable to insurers licensed in this state
168 (K.S.A. 1984 Supp. 40-222).

169 Sec. 12. Delinquency Proceedings.
170 (A) A risk retention group chartered and licensed in this state must
171 comply with all lawful orders issued in a delinquency proceeding commenced
172 by the commissioner.
173 (B) A risk retention group not chartered in this state and doing
174 business in this state must comply with a lawful order issued in a
175 delinquency proceeding commenced by the commissioner if the commissioner of
176 the state or the public official having supervision over insurance in the
177 jurisdiction in which the group is chartered has failed to initiate such a
178 proceeding after notice of a finding of financial impairment under section
179 11 of this act.

180 Sec. 13. Penalties.
181 (A) A risk retention group which is chartered and licensed under
182 sections 2 or 3 of this act and which violates any provision of this act
183 will be subject to fines and penalties applicable to licensed insurers
184 generally, including revocation of its license and/or the right to do
185 business in this state.
186 (B) A risk retention group doing business in this state and which is
187 not chartered or licensed in accordance with either sections 2 or 3 of this
188 act, will be deemed an unauthorized insurer and subject to the fines and
189 penalties of chapter 40 Kansas statutes annotated.

190 Sec. 14. Rules and Regulations. The commissioner may establish such
191 rules and regulations relating to risk retention groups as are necessary to
192 carry out the provisions of this act.

193 Sec. 15. This act shall take effect and be in force from and after its
194 publication in the statute book.

Explanatory Memorandum For
Legislative Proposal No. 3

Legislative Proposal No. 3 is in response to the legal uncertainty of retaining a premium tax differential between foreign and domestic insurance companies. The U.S. Supreme Court and at least one State Supreme Court have both issued rulings on this subject and such legal actions or ruling are always accompanied by the possibility that the premium tax differential may be declared unconstitutional on a retroactive basis thereby subjecting states to a requirement that "unconstitutional" taxes be refunded to the companies that paid them. Legislative Proposal No. 3 would simply add a provision to the Kansas premium tax law which would prohibit the refund of taxes and fees paid in accordance with the laws of Kansas.

## LEGISLATIVE PROPOSAL NO. 3

AN ACT relating to insurance; taxes and fees; refunds; limitations, prohibitions; amending K.S.A. 40-252a and repealing the existing section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:

Section 1. K.S.A. 40-252a is hereby amended to read as follows: 40-252a. A revolving fund, designated "insurance company tax and fee refund," in an amount not to exceed three thousand dollars ($3,000) shall be set apart and maintained for the insurance commissioner from insurance company tax and fee collections which shall be held by the state treasurer for the payment of all such refunds due an insurance company or companies. If the commissioner of insurance finds that the tax and/or fee paid by such company or companies is in excess of the amount ~~legally-due-the-state,~~ prescribed by K.S.A. 1984 Supp. 40-252, the commissioner shall certify the amount of the overpayment on a voucher to the director of accounts and reports for refund of such tax and/or fee. Upon receipt of such voucher, properly executed, the director of accounts and reports shall issue his warrant to the state treasurer for the payment out of the revolving fund provided for in this section. In the event such fund as established by this section is, at any time, insufficient to provide the amount of tax and fee refunds due the insurance company or companies, then the commissioner shall certify the amount of additional funds required to the director of accounts and reports who shall promptly transfer the said required amount from the state general revenue fund to the insurance company tax and fee revolving fund, and notify the state treasurer, who shall make proper entry on his records. The commissioner shall maintain in his files for a period of five (5) years from its date a duplicate of said voucher and a statement which shall set forth the reasons such refunds have been made. No refunds of taxes and fees paid pursuant to K.S.A. 40-252 shall be permitted except as provided herein.

Sec. 2. K.S.A. 40-252a is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

Explanatory Memorandum For
Legislative Proposal No. 4

Current statutes relating to health maintenance organizations require the Commissioner to at least once every three years make an examination concerning the quality of health care services provided by HMO's and providers with whom such organizations have contracts. The statute provides that the Commissioner may request assistance of the Secretary of Health and Environment to assist in carrying out this function because the Commissioner of Insurance obviously is not in a position to evaluate the quality of health care delivered by any institution or provider. In response to requests, however, the Secretary of Health and Environment has advised that they do not have the funds or personnel necessary to assist with this task. Therefore, because we do have indications that some quality of care evaluation is needed, Legislative Proposal No. 4 suggests that such evaluation be made a responsibility of the individual HMO's through a certification process and the services of an independent peer review organization acceptable to the Commissioner.

LEGISLATIVE PROPOSAL NO. 4

AN ACT relating to insurance; health maintenance organizations; quality of care; certification; amending K.S.A. 40-3211 and repealing the existing section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:

Section 1. K.S.A. 40-3211 is hereby amended to read as follows: 40-3211. (a) The commissioner may make an examination of the affairs of any health maintenance organization and providers with whom such organizations has contracts, agreements or other arrangements as often as the commissioner deems it necessary for the protection of the interests of the people of this state but not less frequently than once every three (3) years.

(b) ~~The commissioner may make an examination concerning the quality of health care services of any health maintenance organization and providers with whom such organization has contracts, agreements or other arrangements as often as the commissioner deems it necessary but not less frequently than once every three (3) years. Upon the request of the commissioner, the secretary of health and environment or other state agency shall assist the commissioner in carrying out the examination authorized by this subsection.~~ At least once every three years and at such other times as the commissioner may require, a health maintenance organization shall obtain a certification from an independent peer review organization acceptable to the commissioner setting forth its opinion relating to the quality of care provided by such organization and the providers with whom such organization has contracts, agreements or other arrangements for providing health care. Failure to obtain such certification or an unfavorable opinion rendered by the peer review organization shall give the commissioner cause to institute action in accordance with K.S.A. 40-3205 or 40-3206 and 40-3207.

(c) Every health maintenance organization and provider shall submit its books and records relating its operation to such examinations. Medical records of individuals and records of providers under a contract to the health maintenance organization shall be subject to such examination, but the identity of patients shall not be disclosed in any report to the commissioner or the commissioner's agents or representatives. For the purpose of examinations, the commissioner may administer oaths to, and examine the officers and agents of the health maintenance organization and the principals of such providers.

(d) The fees and expenses of examinations under this section shall be assessed against the organization being examined and remitted to the commissioner. The fees and expenses of the commissioner shall be in accordance with K.S.A. 40-223, or any amendments thereto.

(e) In lieu of such examination, the commissioner may accept the report of an examination made by the appropriate examining agency or official of another state.

Sec. 2. K.S.A. 40-3211 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

Explanatory Memorandum For
Legislative Proposal No. 5

This proposal would require health maintenance organizations to include a provision in their contracts which would permit persons covered by an HMO but terminated from the group because of loss of employment or some other reason to be able to continue their coverage with the HMO for a period of six months. This is the same type of continuation provision which applies to Blue Cross and Blue Shield and commercial accident and sickness insurance policies written on a group basis. Subscribers to an HMO obviously are faced with the same difficulties when they are terminated from the group for any reason and should be afforded the same opportunity for continuation as persons insured or whose health care financing protection is provided by more traditional means.

# LEGISLATIVE PROPOSAL NO. 5

AN ACT relating to insurance; health maintenance organizations; continuation of coverage; amending K.S.A. 40-3209 and repealing the existing section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:

Section 1. K.S.A. 40-3209 is hereby amended to read as follows: 40-3209. (a) All forms of contracts issued by the organization to enrollees or other marketing documents purporting to describe the organization's health care services shall contain as a minimum:

(1) A complete description of the health care services and other benefits to which the enrollee is entitled;

(2) The location of all facilities, the hours of operation and the services which are provided in each facility;

(3) The predetermined periodic rate of payment which the enrollee is obliged to pay;

(4) All exclusions and limitations on services or any other benefits to be provided including any deductible or copayment feature and all restrictions relating to pre-existing conditions;

(5) All criteria by which an enrollee may be disenrolled or denied re-enrollment; ~~and~~

(6) Service priorities in case of epidemic, or other emergency conditions affecting demand for medical services~~.~~ ; and

(7) A provision that an enrollee or a covered dependent of an enrollee whose coverage under the health maintenance organization contract has been terminated for any reason and who has been continuously covered by the health maintenance organization for at least three months shall be entitled to have such coverage nonetheless continued for six months. The terminated enrollee or dependent shall pay to the insurer the premium for the six-month continuation of coverage and such premium shall be the same as that applicable to enrollees remaining in the group. Failure to pay such premium after receiving reasonable notice of the required payment shall terminate coverage under the health maintenance organization contract at the end of the period for which the premium was paid. The frequency of premium payment shall be the frequency customarily required but shall not require payments less frequently than quarterly.

(b) No health maintenance organization authorized under this act shall contract with any provider under provisions which require enrollees to guarantee payment, other than copayments and deductibles, to such provider in the event of nonpayment by the health maintenance organization for any services which have been performed under contracts between such enrollees and the health maintenance organization.

(c) No contract form or amendment to an approved contract form shall be issued unless it is filed with the commissioner. Such contract form or amendment shall become effective within thirty (30) days of such filing unless the commissioner finds that such contract form or amendment does not comply with the requirements of this section.

(d) Every contract shall include a clear and understandable description of the health maintenance organization's method for resolving enrollee grievances.

(e) The rate of payment for a health maintenance contract shall be a part of the contract and shall be stated in individual contracts by endorsement or certificate of coverage issued to enrollees.

Sec. 2. K.S.A. 40-3209 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

Explanatory Memorandum For
Legislative Proposal No. 6

This proposal will simply require all insurers to participate in the Insurance Regulatory Information System administered by the National Association of Insurance Commissioners. This system often referred to as the "early warning system" is designed to assist insurance regulators in regulating for solvency by subjecting the annual financial data of insurers to a series of solvency tests and, if appropriate, hands-on scrutiny by a team of financial examiners from various states. Through this system, regulators are able to obtain advance warning of insurance companies that are encountering financial difficulty and are thereby able to take appropriate steps to limit the impact on the insuring public and in some cases state revenues.

Revised

LEGISLATIVE PROPOSAL NO. 6

AN ACT relating to insurance; insurance regulatory information system; participation required.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:

1 Section 1. The provisions of this act shall apply to all domestic,
2 foreign and alien insurers who are authorized to transact business in this
3 state and eligible to participate in the insurance regulatory information
4 system administered by the national association of insurance commissioners.

5 Sec. 2. (A) Each domestic, foreign and alien insurer who is eligible
6 to do so shall annually on the first day of January or within 60 days
7 thereafter, file with the national association of insurance commissioners a
8 copy of its annual statement convention blank for the preceding year. The
9 information filed with the national association of insurance commissioners
10 shall be in the same format and scope as that required by K.S.A. 40-225 and
11 shall include the signed jurat page and the actuarial certification. Any
12 amendments and addendums to the annual statement filing subsequently filed
13 with the commissioner shall also be filed with the national association of
14 insurance commissioners.
15 (B) Foreign insurers domiciled in a state which has a law substantially
16 similar to subsection (A) of this section shall be deemed in compliance with
17 this section.

18 Sec. 3. In the absence of actual malice, members of the national
19 association of insurance commissioners, their duly authorized committees,
20 subcommittees, and task forces, their delegates, national association of
21 insurance commissioners' employees, and all others charged with the
22 responsibility of collecting, reviewing, analyzing and disseminating the
23 information developed from the filing of the annual statement convention
24 blanks shall be acting as agents of the commissioner under the authority of
25 this act and shall not be subject to civil liability for libel, slander or
26 any other cause of action by virtue of their collection, review, and
27 analysis or dissemination of the data and information collected from the
28 filings required here under.

29 Sec. 4. The commissioner may assess a monetary penalty of $500 per
30 month or suspend, revoke or refuse to renew the certificate of authority of
31 any insurer failing to file its annual statement with the national
32 association of insurance commissioners when due or within any extension of
33 time which the commissioner, for good cause, may have granted.

34 Sec. 5. Prior to an order of insolvency by a court of competent
35 jurisdiction, no data or information provided or made available to the state
36 by the national association of insurance commissioners shall be a public
37 record as defined in K.S.A. 1984 Supp. 45-217.

38 Sec. 6. This act shall take effect and be in force from and after its
39 publication in the statute book.

Explanatory Memorandum For
Legislative Proposal No. 7

This proposal consists of several housekeeping amendments to the statutes governing the activities of the State Committee on Surety Bonds and Insurance. This Committee is comprised of the Commissioner of Insurance, Attorney General and the State Treasurer and is charged with the responsibility of purchasing most of the insurance required by state agencies. The most significant change suggested by this proposal is an increase in the minimum amount of purchase that subjects such purchase to a competitive bidding procedure. Currently, any purchase made by a state agency through the Committee of more than $50 must be through competitive bidding. The amount for other goods and services purchased for the state by the Division of Purchases was increased several years ago to $500. Because of the expense involved in carrying out the competitive bidding process and so that state purchasing requirements would be consistent one with the other, this proposal suggests that the amount be increased from $50 to $500 in order that it would be the same as that utilized for other purchases.

# LEGISLATIVE PROPOSAL NO. 7

AN ACT relating to insurance; committee on surety bonds and insurance; purchase of insurance by state agencies; requirements; limitations; amending K.S.A. 75-4101, 75-4101a, 75-4105, 75-4109 and repealing the existing sections.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:

1 Section 1. K.S.A. 75-4101 is hereby amended to read as follows: 75-
2 4101. (a) There is hereby created a committee on surety bonds and
3 insurance, which shall consist of the state treasurer, the attorney general
4 and the commissioner of insurance or their designee. The commissioner of
5 insurance shall be the chairperson of the committee and the director of
6 purchases, or a designee, shall be ex officio secretary. The committee
7 shall meet on call of the chairperson and at such other times as the
8 committee shall determine but at least once a month on the second Monday in
9 each month. Meetings shall be held in the office of the commissioner of
10 insurance. The members of the committee shall serve without compensation.
11 The secretary shall be the custodian of all property, records and
12 proceedings of the committee. Except as provided in subsection (b) and in
13 K.S.A. 74-4925 and 74-4927, and amendments thereto, and in K.S.A. 75-6501 to
14 75-6511, inclusive, no state agency shall purchase any insurance of any kind
15 or nature or any surety bonds upon state officers or employees, except as
16 provided in this act. Effective on August 1, 1984, and except as otherwise
17 provided in this section, health care coverage and health care services of a
18 health maintenance organization for state officers and employees designated
19 under subsection (c) of K.S.A. 75-6501 shall be provided in accordance with
20 the provisions of K.S.A. 75-6501 to 75-6511, inclusive.
21 (b) The Kansas turnpike authority may purchase group life, health and
22 accident insurance or health care services of a health maintenance
23 organization for its employees or members of the highway patrol assigned, by
24 contract or agreement entered pursuant to K.S.A. 68-2025, and amendments
25 thereto, to police toll or turnpike facilities, independent of the committee
26 on surety bonds and insurance and of the provisions of K.S.A. 75-6501 to 75-
27 6511, inclusive. Such authority may purchase liability insurance covering
28 all or any part of its operations and may purchase liability and related
29 insurance upon all vehicles owned or operated by the authority~~,~~ independent
30 of the committee on surety bonds and insurance and such insurance may be
31 purchased without complying with K.S.A. 75-3738 to 75-3744, inclusive, and
32 amendments thereto. Any board of county commissioners may purchase such
33 insurance or health care services, independent of such committee, for
34 district court officers and employees any part of whose total salary is
35 payable by the county. Nothing in any other provision of the laws of this
36 state shall be construed as prohibiting members of the highway patrol so
37 assigned to police toll or turnpike facilities from receiving compensation
38 in the form of insurance or health maintenance organization coverage as
39 herein authorized.

40 Sec. 2. K.S.A. 75-4101a is hereby amended to read as follows: 75-
41 4101a. All insurance contracts or contracts for health care services of a
42 health maintenance organization purchased by the Kansas turnpike authority
43 pursuant to K.S.A. 75-4101, and amendments thereto, shall be purchased by
44 the authority in the manner prescribed for the purchase of supplies,
45 material, equipment or contractual services under K.S.A. 75-3738 to 75-3744,
46 inclusive, and amendments thereto. Any such contract having a premium or
47 rate in excess of ~~fifty dollars ($50)~~ $500 shall be purchased on sealed bids.

48 Sec. 3. K.S.A. 75-4105 is hereby amended to read as follows: 75-4105.
49 All surety bonds and insurance contracts purchased pursuant to this act
50 shall be purchased by the committee in the manner prescribed for the
51 purchase of supplies, materials, equipment or contractual services under
52 K.S.A. 75-3738 to 75-3744, inclusive, and amendments thereto. The director
53 of accounts and reports shall not pay any premium or rate on any surety bond
54 or insurance contract until the purchase of such surety bond or contract
55 shall have been approved by the secretary of the committee. Surety bonds or
56 insurance contracts having a premium or rate in excess of ~~$50~~ $500 purchased
57 hereunder shall be purchased on sealed bids as provided by law for the
58 purchase of other materials, equipment or contractual services. Where more
59 than one state agency is covered by any bond or insurance contract, the
60 committee shall prorate the cost of premiums or rates on any and all such

61 bonds or contracts, except as provided in K.S.A. 75-4114 and amendments
62 thereto, purchased as charges upon the funds of the state agency wherein any
63 covered state officers or employees are employed or covered property is
64 located or controlled. Such prorated charges shall constitute a lawful
65 charge by the committee upon the funds available to any such state agency
66 and shall be paid by each such state agency to the committee, or to the
67 surety or insurance carrier if the committee requires it, in the manner
68 provided by law for the payment of other obligations of such state agency.

69 Sec. 4. K.S.A. 75-4109 is hereby amended to read as follows: 75-4109.
70 (a) The committee, at least once every three years, shall approve the
71 property and casualty insurance coverages that shall be purchased by each
72 state agency.
73 (b) The committee shall require that each state agency purchase the
74 insurance coverages prescribed by K.S.A. 75-2728 and by K.S.A. 74-4703, 74-
75 4705 and 74-4707, and amendments thereto, and shall prescribe the terms,
76 conditions and amounts of such coverage giving due regard to the operations
77 and requirements of the agencies involved.
78 (c) The committee shall, in addition to the coverages specified in
79 subsection (b), designate the insurance coverages to be purchased by each
80 state agency that are deemed by the committee to be necessary to protect the
81 state for property of others that may be in the possession or control of
82 such state agencies.
83 (d) Such coverages as are specified in subsections (b) and (c) may also
84 include coverage on property of the state that are deemed by the committee
85 to be incidental to the basic coverages herein required, and the committee
86 shall prescribe the terms, conditions and amounts of all insurance coverages
87 purchased pursuant to this section. Property of the state board of regents
88 of any university or college which is referred to in subsection (b) may be
89 self-insured as provided under this act.
90 (e) No property insurance coverage may be purchased by the committee
91 except as provided herein or specifically required by other Kansas statutes
92 and appropriations.

93 Sec. 5. K.S.A. 75-4101, 75-4101a, 75-4105 and 75-4109 are hereby
94 repealed.

95 Sec. 6. This act shall take effect and be in force from and after its
96 publication in the statute book.

Explanatory Memorandum For
Legislative Proposal No. 8

Legislative Proposal No. 8 amends the minimum education requirement that applies to life and accident and health insurance agents. The amendments are nonsubstantive in that some of the course numbers and descriptions set forth in the statute for compliance with the minimum education requirements have been changed. This proposal simply brings the numbers and description of the courses into conformity with current nomenclature.

Revised

LEGISLATIVE PROPOSAL NO. 8

AN ACT relating to insurance; agents; minimum education; requirements; amending K.S.A. 1984 Supp. 40-240b and repealing the existing section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:

Section 1. K.S.A. 1984 Supp. 40-240b is hereby amended to read as follows: 40-240b. All agents to whom this act applies must, within five years of initial licensing, furnish evidence satisfactory to the insurance commissioner that they have successfully completed one of the following:

(a) Two parts of the life underwriter training council curriculum, one of which must be a life course (part one or part two); or

(b) course one (parts one and two) of the life office management association curriculum; or

(c) any two of parts ~~HS301, HS303, HS308, HS309 and HS310~~ HS320, HS324, HS325, HS326, HS327, HS330 and HS331 of the American college of life underwriters CLU diploma curriculum or any additional parts of such curriculum or such similar and equivalent study courses as may be approved by the commissioner; or

(d) six credit hours, or the equivalent, of insurance courses taught by an accredited college, university or community college; or

(e) any two research and review service of America, inc. correspondence courses on life insurance, two pictorial publishers, inc., two pentera group, inc., or such similar and equivalent supervised study courses on life insurance as may be approved by the commissioner; or

(f) two parts (INS 21 and 23) of the insurance institute of America's certificate of general insurance program or any additional parts of such program or such similar and equivalent study courses as may be approved by the commissioner; or

(g) parts one and two of the American institute of property and liability underwriters CPCU diploma curriculum or any additional parts of such curriculum or such similar and equivalent study courses as may be approved by the commissioner; or

(h) any two of parts one, ~~three and~~ two, five, and six of the college for financial planning certified financial planner curriculum or any additional parts of such curriculum or such similar and equivalent study courses as may be approved by the commissioner; or

(i) the life and health institute course of the society of certified insurance counselors curriculum in combination with 1/2 of any option outlined in subparagraphs (a), (c), (d), (e), (f), (g), and (h); or

(j) a combination of 1/2 each of any two options outlined in subparagraphs (a), (c), (d), (e), (f), (g), and (h).

Sec. 2. K.S.A. 1984 Supp. 40-240b is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

Explanatory Memorandum For
Legislative Proposal No. 9

Legislative Proposal No. 9 amends the unfair trade practices act by inserting provisions that would make it a defined unfair trade practice for an insurer to refuse to insure or refuse to continue to insure or limit the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the coverage solely because of blindness or partial blindness. This provision was promoted and supported by the National Federation of the Blind and, through an agreement with the National Association of Insurance Commissioners, most states are attempting to obtain passage of the legislation.

LEGISLATIVE PROPOSAL NO. 9

AN ACT relating to insurance; unfair and deceptive acts; refusal to insure; limitations of coverage; blind persons; amending 1984 Supp. 40-2404 and repealing the existing section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:

1 Section 1. K.S.A. 1984 Supp. 40-2404 is hereby amended to read as
2 follows: 40-2404. The following are hereby defined as unfair methods of
3 competition and unfair or deceptive acts or practices in the business of
4 insurance:
5 (1) Misrepresentations and false advertising of insurance policies.
6 Making, issuing, circulating or causing to be made, issued or circulated,
7 any estimate, illustration, circular, statement, sales presentation,
8 omission or comparison which:
9 (a) Misrepresents the benefits, advantages, conditions or terms of any
10 insurance policy;
11 (b) misrepresents the dividends or share of the surplus to be received
12 on any insurance policy;
13 (c) makes any false or misleading statements as to the dividends or
14 share of surplus previously paid on any insurance policy;
15 (d) is misleading or is a misrepresentation as to the financial
16 condition of any person, or as to the legal reserve system upon which any
17 life insurer operates;
18 (e) uses any name of title of any insurance policy or class of
19 insurance policies misrepresenting the true nature thereof;
20 (f) is a misrepresentation for the purpose of inducing or tending to
21 induce the lapse, forfeiture, exchange, conversion or surrender of any
22 insurance policy;
23 (g) is a misrepresentation for the purpose of effecting a pledge or
24 assignment of or effecting a loan against any insurance policy; or
25 (h) misrepresents any insurance policy as being shares of stock.
26 (2) False information and advertising generally. Making, publishing,
27 disseminating, circulating or placing before the public, or causing,
28 directly or indirectly, to be made, published, disseminated, circulated or
29 placed before the public, in a newspaper, magazine or other publication, or
30 in the form of a notice, circular, pamphlet, letter or poster, or over any
31 radio or television station, or in any other way, an advertisement,
32 announcement or statement containing any assertion, misrepresentation or
33 statement with respect to the business of insurance or with respect to any
34 person in the conduct of such person's insurance business, which is untrue,
35 deceptive or misleading.
36 (3) Defamation. Making, publishing, disseminating or circulating,
37 directly or indirectly, or aiding, abetting or encouraging the making,
38 publishing, disseminating or circulating of any oral or written statement or
39 any pamphlet, circular, article or literature which is false, or maliciously
40 critical of or derogatory to the financial condition of any person, and
41 which is calculated to injure person.
42 (4) Boycott, coercion and intimidation. Entering into any agreement to
43 commit, or by any concerted action committing, any act of boycott, coercion
44 or intimidation resulting in or tending to result in unreasonable restraint
45 of the business of insurance, or by any act of boycott, coercion or
46 intimidation monopolizing or attempting to monopolize any part of the
47 business of insurance.
48 (5) False statements and entries. (a) Knowingly filing with any
49 supervisory or other public official, or knowingly making, publishing,
50 disseminating, circulating or delivering to any person, or placing before
51 the public, or knowingly causing directly or indirectly, to be made,
52 published, disseminated, circulated, delivered to any person, or placed
53 before the public, any false material statement of fact as to the financial
54 condition of a person.
55 (b) Knowingly making any false entry of a material fact in any book,
56 report or statement of any person or knowingly omitting to make a true entry
57 of any material fact pertaining to the business of such person in any book,
58 report or statement of such person.
59 (6) Stock operations and advisory board contracts. Issuing or
60 delivering or permitting agents, officers or employees to issue or deliver,
61 agency company stock or other capital stock, or benefit certificates or
62 shares in any common-law corporation, or securities or any special or
63 advisory board contracts or other contracts of any kind promising returns

and profits as an inducement to insurance. Nothing herein shall prohibit the acts permitted by K.S.A. 40-232 and amendments thereto.

(7) Unfair discrimination. (a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(c) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. With respect to all other conditions, including the underlying cause of the blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons. Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured loses his or her eyesight. However, an insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness when such condition existed at the time the policy was issued.

(8) Rebates. (a) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon, or paying or allowing, or giving or offering to pay, allow or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing or offering to give, sell or purchase as inducement to such insurance contract or annuity or in connection therewith, any stocks, bonds or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

(b) Nothing in subsection (7) or paragraph (a) of this subsection shall be construed as including within the definition of discrimination or rebates any of the following practices:

(i) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance. Any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(ii) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses;

(iii) readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(9) Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice of any of the following:

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(b) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(d) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

134 (f) not attempting in good faith to effectuate prompt, fair and
135 equitable settlements of claims in which liability has become reasonably
136 clear;
137 (g) compelling insureds to institute litigation to recover amounts due
138 under an insurance policy by offering substantially less than the amounts
139 ultimately recovered in actions brought by such insureds;
140 (h) attempting to settle a claim for less than the amount to which a
141 reasonable person would have believed that such person was entitled by
142 reference to written or printed advertising material accompanying or made
143 part of an application;
144 (i) attempting to settle claims on the basis of an application which
145 was altered without notice to, or knowledge or consent of the insured;
146 (j) making claims payments to insureds or beneficiaries not accompanied
147 by a statement setting forth the coverage under which payments are being
148 made;
149 (k) making known to insureds or claimants a policy of appealing from
150 arbitration awards in favor of insureds or claimants for the purpose of
151 compelling them to accept settlements or compromises less than the amount
152 awarded in arbitration;
153 (l) delaying the investigation or payment of claims by requiring an
154 insured, claimant or the physician of either to submit a preliminary claim
155 report and then requiring the subsequent submission of formal proof of loss
156 forms, both of which submissions contain substantially the same information;
157 (m) failing to promptly settle claims, where liability has become
158 reasonably clear, under one portion of the insurance policy coverage in
159 order to influence settlements under other portions of the insurance policy
160 coverage;
161 (n) failing to promptly provide a reasonable explanation of the basis
162 in the insurance policy in relation to the facts or applicable law for
163 denial of a claim or for the offer of a compromise settlement.
164 (10) Failure to maintain complaint handling procedures. Failure of any
165 person, who is an insurer on an insurance policy, to maintain a complete
166 record of all the complaints which it has received since the date of its
167 last examination under K.S.A. 40-222 and amendments thereto; but no such
168 records shall be required for complaints received prior to the effective
169 date of this act. This record shall indicate the total number of
170 complaints, their classification by line of insurance, the nature of each
171 complaint, the disposition of these complaints, the date each complaint was
172 originally received by the insurer and the date of final disposition of each
173 complaint. For purposes of this subsection, "complaint" shall mean any
174 written communication primarily expressing a grievance related to the acts
175 and practices set out in this section.
176 (11) Misrepresentation in insurance applications. Making false or
177 fraudulent statements or representations on or relative to an application
178 for an insurance policy, for the purpose of obtaining a fee, commission,
179 money or other benefit from any insurer, agent, broker or individual.
180 (12) Statutory violations. Any violation of any of the provisions of
181 K.S.A. 40-276a or 40-1515 and amendments thereto.
182 (13) Disclosure of information relating to adverse underwriting
183 decisions. Failing to provide applicants, policyholders and individuals
184 proposed for coverage with the information required under K.S.A. 40-2,112
185 and amendments thereto within the time prescribed in such section.
186 (14) Rebates and other inducements in title insurance. (a) No title
187 insurance company or title insurance agent, or any officer, employee,
188 attorney, agent or solicitor thereof, may pay, allow or give, or offer to
189 pay, allow or give, directly or indirectly, as an inducement to obtaining
190 any title insurance business, any rebate, reduction or abatement of any rate
191 or charge made incident to the issuance of such insurance, any special favor
192 or advantage not generally available to others of the same classification,
193 or any money, thing of value or other consideration or material inducement.
194 The words "charge made incident to the issuance of such insurance" includes,
195 without limitations, escrow, settlement and closing charges.
196 (b) No insured named in a title insurance policy or contract nor any
197 other person directly or indirectly connected with the transaction involving
198 the issuance of the policy or contract, including, but not limited to,
199 mortgage lender, real estate broker, builder, attorney or any officer,
200 employee, agent representative or solicitor thereof, or any other person may
201 knowingly receive or accept, directly or indirectly, any rebate, reduction
202 or abatement of any charge, or any special favor or advantage or any
203 monetary consideration or inducement referred to in paragraph (a) of this
204 section.
205 (c) Nothing in this section shall be construed as prohibiting:

206 (i) The payment of reasonable fees for services actually rendered to a
207 title insurance agent in connection with a title insurance transaction;
208 (ii) the payment of an earned commission to a duly appointed title
209 insurance agent for services actually performed in the issuance of the
210 policy of title insurance; or
211 (iii) the payment of reasonable entertainment and advertising expenses.
212 (d) Nothing in this section prohibits the division of rates and charges
213 between or among a title insurance company and its agent, or one or more
214 title insurance companies and one or more title insurance agents, if such
215 division of rates and charges does not constitute an unlawful rebate under
216 the provisions of this section and is not in payment of a forwarding fee or
217 a finder's fee.

218 Sec. 2. K.S.A. 1984 Supp. 40-2404 is hereby repealed.

219 Sec. 3. This act shall take effect and be in force from and after its
220 publication in the statute book.

Explanatory Memorandum For
Legislative Proposal No. 10

Legislative Proposal No. 10 simply makes the unfair trade practices act applicable to health maintenance organizations and clarifies the act by specifically noting that the combined mutual nonprofit hospital and nonprofit medical services corporations are also subject to the act.

LEGISLATIVE PROPOSAL NO. 10

AN ACT relating to health maintenance organizations; nonprofit hospital and medical service corporations; regulation of trade practices; definitions; amending K.S.A. 40-2402 and repealing the existing section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:

Section 1. K.S.A. 40-2402 is hereby amended to read as follows: 40-2402. When used in this act:

(a) "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers and adjusters. "Person" shall also mean mutual nonprofit hospital service organizations and nonprofit medical service corporations as defined in articles 18, ~~and~~ 19 and 19c of chapter 40 of the Kansas Statutes Annotated and acts amendatory thereof and supplemental thereto and health maintenance organizations .

(b) "Commissioner" shall mean the commissioner of insurance of this state.

(c) "Insurance policy" or "insurance contract" shall mean any contract of insurance, indemnity, medical or hospital service, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any person.

Sec. 2. K.S.A. 40-2402 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

Explanatory Memorandum For
Legislative Proposal No. 11

This proposal amends the statutes governing agents' licenses. The specific and primary change proposed would be to remove from the statute the specific amount to be charged as an examination fee. In lieu thereof, the statute would permit such fee to be established by regulations adopted by the Commissioner. Several innovative changes in the agents' examination process are currently being explored including multi-state testing and examinations produced, conducted and graded through electronic data processing. While Kansas has not reached any conclusions whatsoever as to the adoption of changes of this kind, the experimentation suggests that it would be wise to have the flexibility to adopt changes once they have proven themselves and would seem to enhance the examination process. In most cases, the current fee of $10 would not support any enhancements. However, not knowing what such enhancements would cost suggests the wisdom of removing the specific amount from the statute and permitting it to be established by regulation which continues to give the legislature oversight over the precise amount.

This proposal also would change the law so that any amount submitted for certification or examination would not be refunded for any reason. Currently, some applicants schedule an examination and then fail to appear even though the expenses incurred in processing their application and doing what is necessary to prepare for their taking the examination have already been incurred. Further, many agents without need to do so submit a certification fee along with their fee for the examination. If they fail the examination or fail to appear for the examination, the certification fee must be returned. This is needless expense that can be avoided by both the applicant and the Department by simply inserting a no refund provision.

Revised

LEGISLATIVE PROPOSAL NO. 11

AN ACT relating to insurance; agents' licenses; examinations; fees; penalties; amending K.S.A. 1984 Supp. 40-241 and repealing the existing section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:

Section 1. K.S.A. 1984 Supp. 40-241 is hereby amended to read as follows: 40-241. If the commissioner of insurance is satisfied that the applicant for an agent's license is of good business reputation and is otherwise qualified in the line of business, the applicant shall be given a written examination to determine whether such applicant possesses the competence and knowledge of the kinds of insurance and transactions under the license applied for, of the duties and responsibilities of such a license and of the pertinent provisions of the laws of this state. The applicant shall be tested on each class or subclassification of insurance which may be written. ~~An~~ A reasonable examination fee in ~~the~~ an amount ~~of $10 to~~ prescribed in regulations adopted by the commissioner shall be paid by the applicant and shall be required for each class of insurance for each attempt to pass the examination. ~~and~~ Such examination fee shall be in addition to the ~~license~~ certification fee required under K.S.A. 40-252, and acts amendatory thereof or supplemental thereto. There shall be three classes of insurance for the purposes of this act, which are:

(1) Life, including health and accident;
(2) casualty and allied lines;
(3) fire and allied lines.

The commissioner of insurance shall establish rules and regulations with respect to the scope, subclassification, type and conduct of such written examination. Examinations shall be given to applicants as follows: Class one examinations at least twice a month in Topeka, Kansas, and at least quarterly in other convenient locations in the state of Kansas; class two and three examinations not more frequently than twice a month in Topeka, Kansas, and concurrently in other convenient locations in the state of Kansas. The commissioner shall publish or arrange for the publication of information and material which applicants can use to prepare for such written examination. One or more rating organizations, advisory organizations or other associations may be designated by the commissioner to assist in, or assume responsibility for, distribution of the study manuals to applicants and other interested parties. Persons purchasing the study manual shall be charged a reasonable fee established or approved by the commissioner. In the event the publication and distribution of the study material is delegated to private firms, organizations or associations and the state incurs no expense or obligation, the provisions of K.S.A. 75-3738 to 75-3744, inclusive, and amendments thereto, shall not apply. If the commissioner of insurance finds that the applicant is trustworthy, competent and has satisfactorily completed the written examination, the commissioner shall forthwith issue to the applicant a license as an insurance agent but the issuance of such license shall confer no authority to transact business in this state until the agent has been certified by a company pursuant to K.S.A. 40-241i. If the applicant fails to satisfactorily complete the written examination, such examination may be retaken ~~following~~ no more than twice in a 12 month period. A waiting period of not less than 14 days from the date of the last attempt shall be served before the examination can be retaken. ~~If an applicant fails to qualify for, or is refused a license, the license fee shall be returned.~~ The certification and examination fee shall not be returned for any reason. No insurance agent shall be required to take an examination for continuation of the agent's license for any class or subclassification of business which the agent was ~~licensed~~ certified to write prior to May 1, 1963, or for which the agent has previously been examined by the commissioner of insurance. The commissioner of insurance shall keep a permanent record of all agents' licenses issued and the insurance companies that the respective agents were certified to represent under such licenses for a period of 10 years.

Sec. 2. K.S.A. 1984 Supp. 40-241 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

Explanatory Memorandum For
Legislative Proposal No. 12

During the course of the current market situation, there have been several instances brought to our attention where a company has renewed a risk's insurance policy and subsequently billed the insured for a premium significantly greater than that paid the previous year. While it is understandable that premium rates rise and fall depending on the insurance environment on a given point of time, it is not appropriate for an insured to become bound by an insurance contract when the consideration for that contract has not been agreed to. Accordingly, this proposal would provide that the premium for any renewal policy would be the same as previously paid until the insured has been notified of any difference. Upon notification, the premium would then change but not sooner than the date of such notice.

Revised

# LEGISLATIVE PROPOSAL NO. 12

AN ACT relating to insurance; continuation and renewal; rate and premium increases; notice required.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:

1 Section 1. The premium for any contract of property or casualty
2 insurance continued or renewed following the effective date of this act
3 shall be no greater than that charged for the immediately preceding policy
4 period unless and until the insured is notified of any applicable increase.

5 Sec. 2. This act shall take effect and be in force from and after its
6 publication in the Kansas Register.

Explanatory Memorandum For
Legislative Proposal No. 13

Legislative Proposal No. 13 results from discussions held by the Interim Committee on Financial Institutions and Insurance. Specifically, testimony presented to that committee indicated that a part of the problem any residual market mechanism for accident and health insurance would address could be resolved if insurers were not permitted to individually underwrite persons insured in a group. In other words, if a company wished to insure a group accident and sickness risk, they should underwrite the group as opposed to offering a group policy that is underwritten on an individual basis. At the request of the Interim Committee on Financial Institutions and Insurance, this proposal was developed which would prohibit individual underwriting of persons to be covered by a group contract.

# LEGISLATIVE PROPOSAL NO. 13

AN ACT relating to insurance; group sickness and accident; eligibility; individual underwriting prohibited; amending K.S.A. 1984 Supp. 40-2209 and repealing the existing section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF KANSAS:

Section 1. K.S.A. 1984 Supp. 40-2209 is hereby amended to read as follows: 40-2209. (A) Group sickness and accident insurance is declared to be that form of sickness and accident insurance covering groups of persons, with or without one or more members of their families or one or more dependents, or one or more members of their families or one or more dependents~~, -- and~~ . Except at the option of the employee or member, no individual employee or member of an insured group consisting of 25 or more persons and no individual dependent or family member may be excluded from eligibility or coverage under a policy issued to such group upon the following basis:

(1) Under a policy issued to an employer or trustees of a fund established by an employer, who is the policyholder, insuring at least five employees of such employer, for the benefit of persons other than the employer. The term "employees" shall include the officers, managers, employees and retired employees of the employer, the partners, if the employer is a partnership, the proprietor, if the employer is an individual proprietorship, the officers, managers and employees and retired employees of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, employees and retired employees of individuals and firms, the business of which and of the insured employer is under common control through stock ownership contract, or otherwise. The policy may provide that the term "employees" may include the trustees or their employees, or both, if their duties are principally connected with such trusteeship. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials.

(2) Under a policy issued to a labor union which shall have a constitution and bylaws insuring at least 25 members of such union.

(3) Under a policy issued to the trustees of a fund established by two or more employers or business associations or by one or more labor unions or by one or more employers and one or more labor unions, which trustees shall be the policyholder, to insure employees of the employers or members of the union or members of the association for the benefit of persons other than the employers or the unions or the associations. The term "employees" shall include the officers, managers, employees and retired employees of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(4) A policy issued to a creditor, who shall be deemed the policyholder, to insure debtors of the creditor, subject to the following requirements: (a) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor whose indebtedness is repayable in installments, or all of any class or classes determined by conditions pertaining to the indebtedness or to the purchase giving rise to the indebtedness. (b) The premium for the policy shall be paid by the policyholder, either from the creditor's funds or from charges collected from the insured debtors, or from both.

(5) A policy issued to an association which has been organized and is maintained for the purposes other than that of obtaining insurance, insuring at least 25 members, employees, or employees of members of the association for the benefit of persons other than the association or its officers. The term "employees" shall include retired employees. The premiums for the policies shall be paid by the policyholder, either wholly from association funds, or funds contributed by the members of such association or by employees of such members or any combination thereof.

(6) Under a policy issued to any other type of group which the commissioner of insurance may find is properly subject to the issuance of a group sickness and accident policy or contract.

(B) Each such policy shall contain in substance: (1) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and

64 that no statement made by any person insured shall be used in any contest
65 unless a copy of the instrument containing the statement is or has been
66 furnished to such person or the insured's beneficiary.
67 (2) A provision setting forth the conditions under which an
68 individual's coverage terminates under the policy, including the age, if
69 any, to which an individual's coverage under the policy shall be limited,
70 or, the age, if any, at which any additional limitations or restrictions are
71 placed upon an individual's coverage under the policy.
72 (3) Provisions setting forth the notice of claim, proofs of loss and
73 claim forms, physical examination and autopsy, time of payment of claims, to
74 whom benefits are payable, payment of claims, change of beneficiary, and
75 legal action requirements. Such provisions shall not be less favorable to
76 the individual insured or the insured's beneficiary than those corresponding
77 policy provisions required to be contained in individual accident and
78 sickness policies.
79 (4) A provision that the insured will furnish to the policyholder, for
80 the delivery to each employee or member of the insured group, an individual
81 certificate approved by the commissioner of insurance setting forth in
82 summary form a statement of the essential features of the insurance coverage
83 of such employee or member, the procedure to be followed in making claim
84 under the policy and to whom benefits are payable. Such certificate shall
85 also contain a summary of those provisions required under (2) and (3) of
86 this subsection in addition to the other essential features of the insurance
87 coverage. If dependents are included in the coverage, only one certificate
88 need be issued for each family unit.
89 (C) No group disability income policy which integrates benefits with
90 social security benefits, shall provide that the amount of any disability
91 benefit actually being paid to the disabled person shall be reduced by
92 changes in the level of social security benefits resulting either from
93 changes in the social security law or due to cost of living adjustments
94 which become effective after the first day for which disability benefits
95 become payable.
96 (D) A group policy of insurance delivered or issued for delivery or
97 renewed which provides hospital, surgical or major medical expense
98 insurance, or any combination of these coverages, on an expense incurred
99 basis, shall provide that an employee or member or such employee's or
100 member's covered dependents whose insurance under the group policy has been
101 terminated for any reason, including discontinuance of the group policy in
102 its entirety or with respect to an insured class, and who has been
103 continuously insured under the group policy or under any group policy
104 providing similar benefits which it replaces for at least three months
105 immediately prior to termination, shall be entitled to have such coverage
106 nonetheless continued under the group policy for a period of six months and
107 have issued to the employee or member of such employee's or member's covered
108 dependents by the insurer, at the end of such six-month period of
109 continuation, a policy of health insurance which conforms to the applicable
110 requirements specified in this subsection. This requirement shall not apply
111 to a group policy which provides benefits for specific diseases or for
112 accidental injuries only. An employee or member or such employee's or
113 member's covered dependents shall not be entitled to have such coverage
114 continued or a converted policy issued to the employee or member of such
115 employee's or member's covered dependents if termination of the insurance
116 under the group policy occurred because: (a) The employee or member or
117 such employee's or member's covered dependents failed to pay any required
118 contribution after receiving reasonable notice of such required contribution
119 from the insurer in accordance with rules and regulations adopted by the
120 commissioner of insurance; (b) any discontinued group coverage was replaced
121 by similar group coverage within 31 days; (c) the employee or member is or
122 could be covered by medicare (title XVIII of the United States social
123 security act as added by the social security amendments of 1965 or as later
124 amended or superseded); or (d) the employee or member is or could be covered
125 by any other insured or noninsured arrangement which provides expense
126 incurred hospital, surgical or medical coverage and benefits for individuals
127 in a group under which the person was not covered prior to such
128 termination. In the event the group policy is terminated and not replaced
129 the employee or member, at the option of the employee or member or at the
130 option of the insurer, may be issued a conversion policy or certificate
131 which otherwise meets these provisions in lieu of the right to continue
132 group coverage required herein. The continued coverage and the issuance of
133 a converted policy shall be subject to the following conditions:

134 (1) Written application for the converted policy shall be made and the
135 first premium paid to the insurer not later than 31 days after termination
136 of coverage under the group policy.
137 (2) The converted policy shall be issued without evidence of
138 insurability.
139 (3) The terminated employee or member shall pay to the insurer the
140 premium for the six-month continuation of coverage and such premium shall be
141 the same as that applicable to members or employees remaining in the group.
142 Failure to pay such premium shall terminate coverage under the group policy
143 at the end of the period for which the premium has been paid. The premium
144 rate charged for converted policies issued subsequent to the period of
145 continued coverage shall be such that can be expected to produce an
146 anticipated loss ratio of not less than 80% based upon conversion, morbidity
147 and reasonable assumptions for expected trends in medical care costs. In
148 the event the group policy is terminated and is not replaced, converted
149 policies may be issued at self-sustaining rates that are not unreasonable in
150 relation to the coverage provided based on conversion, morbidity and
151 reasonable assumptions for expected trends in medical care costs. The
152 frequency of premium payment shall be the frequency customarily required by
153 the insurer for the policy form and plan selected, provided that the insurer
154 shall not require premium payments less frequently than quarterly.
155 (4) The effective date of the converted policy shall be the day
156 following the termination of insurance under the group policy.
157 (5) The converted policy shall cover the employee or member and the
158 employee's or member's dependents who were covered by the group policy on
159 the date of termination of insurance. At the option of the insurer, a
160 separate converted policy may be issued to cover any dependent.
161 (6) The insurer shall not be required to issue a converted policy
162 covering any person if such person is or could be covered by medicare (title
163 XVIII of the United States social security act as added by the social
164 security amendments of 1965 or as later amended or superseded).
165 Furthermore, the insurer shall not be required to issue a converted policy
166 covering any person if:
167 (a)(i) such person is covered for similar benefits by another hospital,
168 surgical medical or major medical expense insurance policy or hospital or
169 medical service subscriber contract or medical practice or other prepayment
170 plan or by any other plan or program, or
171 (ii) such person is eligible for similar benefits (whether or not
172 covered therefor) under any arrangement of coverage for individuals in a
173 group, whether on an insured or uninsured basis, or
174 (iii) similar benefits are provided for or available to such person,
175 pursuant to or in accordance with the requirements of any state or federal
176 law, and
177 (b) the benefits provided under the sources referred to in (i) above
178 for such person or benefits provided or available under the sources referred
179 to in (ii) and (iii) above for such person, together with the benefits
180 provided by the converted policy, would result in over-insurance according
181 to the insurer's standards. The insurer's standards must bear some
182 reasonable relationship to actual health care costs in the area in which the
183 insured lives at the time of conversion and must be filed with the
184 commissioner of insurance prior to their use in denying coverage.
185 (7) A converted policy may include a provision whereby the insurer may
186 request information in advance of any premium due date of such policy of any
187 person covered as to whether:
188 (a) Such person is covered for similar benefits by another hospital,
189 surgical, medical or major medical expense insurance policy or hospital or
190 medical service subscriber contract or medical practice or other prepayment
191 plan or by any other plan or program;
192 (b) such person is covered for similar benefits under any arrangement
193 of coverage for individuals in a group, whether on an insured or uninsured
194 basis; or
195 (c) similar benefits are provided for or available to such person,
196 pursuant to or in accordance with the requirements of any state or federal
197 law.
198 The converted policy may provide that the insurer may refuse to renew
199 the policy and the coverage of any person insured for the following reasons
200 only:
201 (a) Either the benefits provided under the sources referred to in (i)
202 and (ii) above for such person or benefits provided or available under the
203 sources referred to in (iii) above for such person, together with the
204 benefits provided by the converted policy, would result in over-insurance
205 according to the insurer's standards on file with the commissioner of

206 insurance, or the converted policyholder fails to provide the requested
207 information;
208 (b) fraud or material misrepresentation in applying for any benefits
209 under the converted policy;
210 (c) eligibility of the insured person for coverage under medicare
211 (title XVIII of the United States social security act as added by the social
212 security amendments of 1965 or as later amended or superseded) or under any
213 other state or federal law providing for benefits similar to those provided
214 by the converted policy; or
215 (d) other reasons approved by the commissioner of insurance.
216 (8) An insurer shall not be required to issue a converted policy which
217 provides coverage and benefits in excess of those provided under the group
218 policy from which conversion is made.
219 (9) The converted policy shall not exclude a preexisting condition not
220 excluded by the group policy. The converted policy may provide that any
221 hospital, surgical or medical benefits payable may be reduced by the amount
222 of any such benefits payable under the group policy after the termination of
223 the individual's insurance. The converted policy may also include
224 provisions so that during the first policy year the benefits payable under
225 the converted policy, together with the benefits payable under the group
226 policy, shall not exceed those that would have been payable had the
227 individual's insurance under the group policy remained in force and effect.
228 (10) Subject to the provisions and conditions of this act, if the group
229 insurance policy from which conversion is made insures the employee or
230 member for basic hospital or surgical expense insurance, the employee or
231 member shall be entitled to obtain a converted policy providing, at the
232 insured's option, coverage on an expense incurred basis under any one of the
233 plans meeting the following requirements:
234 Plan A
235 (a) hospital room and board daily expense benefits in a maximum dollar
236 amount approximating the average semi-private rate charged in metropolitan
237 areas of this state, for a maximum duration of 70 days,
238 (b) miscellaneous hospital expense benefits of a maximum amount of 10
239 times the hospital room and board daily expense benefits, and
240 (c) surgical operation expense benefits according to a surgical
241 schedule consistent with those customarily offered by the insurer under
242 group or individual health insurance policies and providing a maximum
243 benefit of $800, or
244 Plan B
245 (a) hospital room and board daily expense benefits in a maximum dollar
246 amount equal to 75% of the maximum dollar amount determined for plan A, for
247 a maximum duration of 70 days,
248 (b) miscellaneous hospital expense benefits of a maximum amount of 10
249 times the hospital room and board daily expense benefits, and
250 (c) surgical operation expense benefits according to a surgical
251 schedule consistent with those customarily offered by the insurer under
252 group or individual health insurance policies and providing a maximum
253 benefit of $600, or
254 Plan C
255 (a) hospital room and board daily expense benefits in a maximum dollar
256 amount equal to 50% of the maximum dollar amount determined for plan A, for
257 a maximum duration of 70 days,
258 (b) miscellaneous hospital benefits of a maximum amount of 10 times the
259 hospital room and board daily expense benefits, and
260 (c) surgical operation expense benefits according to a surgical
261 schedule consistent with those customarily offered by the insurer under
262 group or individual health insurance policies and providing a maximum
263 benefit of $400.
264 The maximum dollar amounts of plan A shall be determined by the
265 commissioner of insurance and may be redetermined by such official from time
266 to time as to converted policies issued as new policies subsequent to such
267 redetermination. At the request of the insured, such redetermined amounts
268 shall, subject to the provisions of condition (17) and submission of
269 reasonable evidence of insurability, be made available to the holders of
270 converted policies which have been in effect at least three years on the
271 date the redetermined amounts become effective. At the option of the
272 insurer, any such requested increase or decrease in coverage on outstanding
273 policies or any renewal thereof need not be made effective until the first
274 policy anniversary date following the insured's request. Such
275 redetermination shall not be made more often than once in three years. The
276 maximum dollar amounts in plans A, B and C shall be rounded to the nearest
277 multiple of $10.

(11) Subject to the provisions and conditions of this act, if the group insurance policy from which conversion is made insures the employee or member for major medical expense insurance, the employee or member shall be entitled to obtain a converted policy providing catastrophic or major medical coverage under a plan meeting the following requirements:

(a) A maximum benefit at least equal to either, at the option of the insurer, (i) or (ii) below:

(i) the smaller of the following amounts:

1. The maximum benefit provided under the group policy.

2. A maximum payment of $250,000 per covered person for all covered medical expenses incurred during the covered person's lifetime.

(ii) The smaller of the following amounts:

1. The maximum benefit provided under the group policy.

2. A maximum payment of $250,000 for each unrelated injury or sickness.

(b) Payment of benefits at the rate of 80% of covered medical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits will be paid at the rate of 100% during the remainder of such benefit period. Payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate but not less than 50%.

(c) A deductible for each benefit period which, at the option of the insurer, shall be (a) the sum of the benefits deductible and $100, or (b) the corresponding deductible in the group policy. The term "benefits deductible," as used herein, means the value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by any other hospital, surgical, or medical insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or any other plan or program whether on an insured or uninsured basis, or in accordance with the requirements of any state or federal law and, if pursuant to condition (12), the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits.

If the maximum benefit is determined by (a)(ii) above, the insurer may require that the deductible be satisfied during a period of not less than three months if the deductible is $100 or less, and not less than six months if the deductible exceeds $100.

(d) The benefit period shall be each calendar year when the maximum benefit is determined by (a)(i) above or 24 months when the maximum benefit is determined by (a)(ii) above.

(e) The term "covered medical expenses," as used above, shall include at least, in the case of hospital room and board charges 80% of the average semi-private room and board rate for the hospital in which the individual is confined and twice such amount for charges in an intensive care unit. Any surgical schedule shall be consistent with those customarily offered by the insurer under group or individual health insurance policies and must provide at least a $1,200 maximum benefit.

(12) The conversion privilege required by this act shall, if the group insurance policy insures the employee or member for basic hospital or surgical expense insurance as well as major medical expense insurance, make available the plans of benefits set forth in conditions (10) and (11). At the option of the insurer, such plans of benefits may be provided under one policy.

The insurer may also, in lieu of the plans of benefits set forth in conditions (10) and (11), provide a policy of comprehensive medical expense benefits without first dollar coverage. The policy shall conform to the requirements of condition (11). An insurer electing to provide such a policy shall make available a low deductible option, not to exceed $100, a high deductible option between $500 and $1,000, and a third deductible option midway between the high and low deductible options.

(13) The insurer may, at its option, also offer alternative plans for group health conversion in addition to those required by this act.

(14) In the event coverage would be continued under the group policy on an employee following the employee's retirement prior to the time the employee is or could be covered by medicare, the employee may elect, in lieu of such continuation of group insurance, to have the same conversion rights as would apply had such person's insurance terminated at retirement by reason of termination of employment or membership.

(15) The converted policy may provide for reduction of coverage on any person upon such person's eligibility for coverage under medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded) or under any

349 other state or federal law providing for benefits similar to those provided
350 by the converted policy.
351 (16) Subject to the conditions set forth above, the continuation and
352 conversion privileges shall also be available:
353 (a) To the surviving spouse, if any, at the death of the employee or
354 member, with respect to the spouse and such children whose coverage under
355 the group policy terminates by reason of such death, otherwise to each
356 surviving child whose coverage under the group policy terminates by reason
357 of such death, or, if the group policy provides for continuation of
358 dependents' coverage following the employee's or member's death, at the end
359 of such continuation;
360 (b) to the spouse of the employee or member upon termination of
361 coverage of the spouse, while the employee or member remains insured under
362 the group policy, by reason of ceasing to be a qualified family member under
363 the group policy, with respect to the spouse and such children whose
364 coverage under the group policy terminates at the same time; or
365 (c) to a child solely with respect to such child upon termination of
366 such coverage by reason of ceasing to be a qualified family member under the
367 group policy, if a conversion privilege is not otherwise provided above with
368 respect to such termination.
369 (17) If the benefit levels required in condition (10) exceed the
370 benefit levels provided under the group policy, the conversion policy may
371 offer benefits which are substantially similar to those provided under the
372 group policy either at the time the group policy was discontinued in its
373 entirety and not replaced or as the group policy is in effect at the time
374 the benefits under the converted policies are determined or redetermined in
375 lieu of those required in condition (10).
376 (18) The insurer may elect to provide group insurance coverage which
377 complies with this act in lieu of the issuance of a converted individual
378 policy.
379 (19) A notification of the conversion privilege shall be included in
380 each certificate of coverage.
381 (20) A converted policy which is delivered outside this state must be
382 on a form which could be delivered in such other jurisdiction as a converted
383 policy had the group policy been issued in that jurisdiction.
384 (21) The insurer shall give the employee or member and such employee's
385 or member's covered dependents reasonable notice of the right to convert at
386 least once during the six-month continuation period in accordance with rules
387 and regulations adopted by the commissioner of insurance.
388
389 Sec. 2. K.S.A. 1984 Supp. 40-2209 is hereby repealed.

390 Sec. 3. This act shall take effect and be in force from and after its
391 publication in the statute book.