Approved January 31, 1986
Date

MINUTES OF THE Senate COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Sen. Neil H. Arasmith
Chairperson
at

9 00 a.m./~~p.m.~~ on January 29, 1986 in room 529-S of the Capitol.

All members were present except:

Committee staff present:

Bill Wolff, Legislative Research
Myrta Anderson, Legislative Research
Bruce Kinzie, Revisor of Statutes

Conferees appearing before the committee:

Sen. Robert Talkington
T. C. Anderson, Kansas Society of Certified Public Accountants
Bud Grant, Kansas Chamber of Commerce and Industry
Dick Brock, Kansas Insurance Department
Larry Magill, Independent Insurance Agents of Kansas
Jerry Slaughter, Kansas Medical Society
Glenda Sherman, Kansas Board of Accountancy

The minutes of January 28 were approved.

The hearing began on SB 436 dealing with qualifications for a CPA permit. The bill was introduced by Sen. Talkington who testified in support of the bill. He explained that the bill adds another item on lines 47 and 48 that would allow a person who had passed the CPA examination to receive a license if he has five years of practice as a municipal public accountant. The five years experience replaces the requirement for two years of practical experience. He informed the committee that action by the Board of Accountancy tomorrow on this subject may make this bill unnecessary.

Sen. Talkington called on T. C. Anderson of the Kansas Society of Certified Public Accountants to answer any questions from the committee. Sen. Harder asked if the board has the authority to do this, and Mr. Anderson answered that it was his understanding that it does have such authority. After a few other brief questions for Mr. Anderson, Glenda Sherman of the Kansas Board of Accountancy appeared to confirm Sen. Talkington's statement that the board will be taking this up tomorrow, and it has copies of this bill. With this, the hearing on SB 436 was concluded.

The committee's attention was turned to bill requests. The Chairman called on Bud Grant, Kansas Chamber of Commerce and Industry, for his request for a bill which would exempt consumer goods from filing under the UCC. (See Attachment I). He said that Kansas is the only state that has to file a UCC 1 form for consumer goods.

Sen. Harder made a motion to introduce the bill and refer it back to committee. Sen. Burke seconded, and the motion carried.

Dick Brock of the Kansas Insurance Department followed with several requests for bills and a brief explanation for each. (See Attachments II through VIII).

Sen. Harder made a motion that the bills be introduced and referred back to committee. Sen. Reilly seconded, and the motion carried.

The Chairman began the hearing on SB 382 which provides for a refund of the premium surcharge from the health care stabilization fund and which was held from last session due to the fact that it was introduced late in the session.

Larry Magill, Independent Insurance Agents of Kansas, testified in support of the bill. (See Attachment IX).

The Chairman asked Mr. Magill to define surcharge as used in his testimony and to define the term "tail" coverage. Mr. Magill said the surcharge refers to the percentage

charged health care providers to fund the Health Care Stabilization Fund and is a percentage of the medical malpractice insurance premiums. "Tail" coverage refers to coverage after a policy is no longer in effect. Future claims relating to that past coverage are covered.

Sen. Harder asked what effect the bill would have on the fund itself. Mr. Magill answered that it doesn't appear it will have a significant effect. Health care providers will not fail to pay premiums because they must have malpractice coverage. Sen. Harder replied that those who leave the state will get a refund so that would cause some effect. Mr. Brock stated that his department has no statistics to offer on this, but it feels that there will not be a significant effect on the fund.

Sen. Werts began a discussion with Mr. Brock regarding the reporting by premium finance companies of default in payments and safeguards that prevent the cancellation of policies taking place without the knowledge of the insured. Mr. Brock concluded that the department supports the bill and has had requests from health care providers for financing of surcharges.

Jerry Slaughter, Kansas Medical Society, appeared in support of SB 382. He informed the committee that the ability to finance a premium determines if a new doctor can establish a practice or not. He added that the "tail" coverage is being funded by the surcharge so there is no "free ride". He requested to amend the bill by changing the effective date to "on publication in the Kansas Register". This concluded the hearing on SB 382.

Sen. Harder made a motion to amend SB 382 to be in effect upon publication in the Kansas Register. Sen. Gannon seconded, and the motion carried.

Sen. Harder made a motion to amend the statutory citations in the title to up date the bill. Sen. Burke seconded, and the motion carried.

Sen. Burke made a motion to recommend SB 382 favorably as amended. Sen. Kerr seconded, and the motion carried.

The Chairman announced that there would be a meeting on Friday for discussion of SB 432 regarding branch banking.

Copies of a statement from the Kansas Farm Bureau in support of SB 432 had been distributed to the committee. (Attachment X)

The meeting was adjourned.

SENATE COMMITTEE

ON

FINANCIAL INSTITUTIONS AND INSURANCE

OBSERVERS
(Please print)

DATE	NAME	ADDRESS	REPRESENTING
1/29	Bud Grant	Topeka	KCCI
1/29	Terry Slaughter	Topeka	KMS
1/29	Glenda Sherman	Topeka	KS Board of Accountancy
1/29	T. C. Anderson	Topeka	KSCPA
"	Jan Vacek	Topeka	KSCPA
"	Larry Magill	Topeka	IIAK
"	Richard Harmon	Topeka	KS Assn. of Prop/Cas. Cos
"	Jud Wright	"	KCLLA
"	Terry Banaka	Manhattan	Kansas Farm Bureau
"	Dick Brock	Topeka	Ins Dept

SENATE BILL NO. _____

By Committee on Financial Institutions and Insurance

AN ACT amending the uniform commercial code; relating to security interests; amending K.S.A. 84-9-302 and repealing the existing section.

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

Section 1. K.S.A. 84-9-302 is hereby amended to read as follows: 84-9-302. (1) A financing statement must be filed to perfect all security interests except the following:

(a) A security interest in collateral in possession of the secured party under ~~section--84-9-305~~ K.S.A. 84-9-305, and amendments thereto;

(b) a security interest temporarily perfected in instruments or documents without delivery under ~~section--84-9-304~~ K.S.A. 84-9-304, and amendments thereto, or in proceeds for a ten-day period under ~~section--84-9-306~~ K.S.A. 84-9-306, and amendments thereto;

(c) a security interest created by an assignment of a beneficial interest in a trust or a decedent's estate;

(d) a security interest of a collecting bank ~~(section 84-4-208)~~ under K.S.A. 84-4-208, and amendments thereto, or arising under the article on sales (see section 84-9-113) or covered in subsection (3) ~~of this section~~;

(e) an assignment for the benefits of all creditors of the transferor~~,~~ and subsequent transfers by the assignee thereunder~~.~~;

(f) a purchase money security interest in consumer goods, except for a vehicle under paragraph (c) of subsection (3) and a vessel as defined in K.S.A. 82a-802, and amendments thereto.

(2) If a secured party assigns a perfected security interest, no filing under this article is required in order to continue the perfected status of the security interest against

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Attachment I

creditors of and transferees from the original debtor.

(3) A security interest in:

(a) Property subject to a statute of the United States which provides for national registration or filing of such security interests in such property; ~~or~~

(b) property subject to a statute of this state which provides for central filing of such property; or

(c) a vehicle~~(~~, except a vehicle held as inventory for sale~~)~~, subject to a statute of this state which requires indication on a certificate of title or a duplicate thereof of such security interests in such vehicle: can be perfected only by presentation, for the purpose of such registration or such filing or such indication, of the documents appropriate under any such statute to the public official appropriate under any such statute and tender of the required fee to or acceptance of the documents by such public official, or by the mailing or delivery by a dealer or secured party to the appropriate state agency of a notice of security interest as prescribed by K.S.A. 8-135, and amendments thereto. Such presentation and tender or acceptance, or mailing or delivery, shall have the same effect under this article as filing under this article, and such perfection shall have the same effect under this article as perfection by filing under this article.

Sec. 2. K.S.A. 84-9-302 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. 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.

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Attachment II

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:

Section 1. No policy of property or casualty insurance, other than accident and sickness, used primarily for business or professional needs that has been in effect for 90 days or more may be cancelled except for one of the following reasons:

(a) Non-payment of premium;

(b) the policy was issued because of a material misrepresentation;

(c) any insured violated any of the material terms and conditions of the policy;

(d) unfavorable underwriting factors exist that were not present at the inception of the policy; or

(e) a determination by the commissioner that continuation of coverage could place the insurer in a hazardous financial condition or in violation of the laws of this state.

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

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. 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.

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Attachment III

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

(5) file with the commissioner, no later than January 15 of each year or within 60 days thereafter, the product liability loss experience data report required by K.S.A. 1984 Supp. 40-1132.

(B) Risk retention groups chartered in Bermuda or the Cayman Islands, in addition to the requirements of subsection (A) above, must:

(1) be chartered or licensed and authorized to do business under the laws of Bermuda or the Cayman Islands before January 1, 1985;

(2) file with the commissioner of this state a copy of the certification filed with the commissioner of at least one state that satisfies the capitalization requirements of that state, together with evidence that such certification has been accepted by the commissioner of that state as meeting the requirements of that state; and

(3) file, with the commissioner of the state in which it certifies its capitalization, a waiver of any secrecy laws of the jurisdiction in which it is chartered.

Sec. 4. Agents and Brokers.

(A) (1) Any person who is a resident of this state, acting or offering to act as an agent or broker for a risk retention group, whose activities include, but are not limited to the solicitation, negotiation and placement of insurance on behalf of a risk retention group operating in this state, or any of its members in this state, must obtain a license as an agent or broker in accordance with the applicable provisions of articles 2 and 37 of chapter 40 Kansas statutes annotated.

(2) An agent or broker duly licensed by another state and residing outside of this state may act as an agent or broker for a risk retention group operating in this state or any of its members in this state in the same manner as a resident agent or broker, upon obtaining a license in accordance with K.S.A. 1984 Supp. 40-246.

(3) Any agent or broker licensed in accordance with subsections (1) or (2) above, in addition must report to the commissioner the activities and scope of services they are providing to the risk retention group.

(B) Before placing business with a risk retention group, each agent or broker shall secure from the appropriate insurance regulatory authority a certified copy of the certificate of authority verifying that such insurer is authorized in its domiciliary jurisdiction to write the product liability or completed operations insurance policy proposed to be procured from it by said agent or broker.

(C) Every policy or contract of insurance placed by an agent or broker with a risk retention group chartered or licensed in this state shall bear across its face in not less than ten point bold red type the following legend: "The insurance hereby evidenced is written by a risk retention group licensed by the state of Kansas but in the event of insolvency of this risk retention group, is not protected by the Guaranty Fund of this state."

(D) Every policy or contract of insurance placed by an agent or broker with a risk retention group not chartered or licensed in this state shall bear across its face in not less than ten point bold red type the following legend: "The insurance hereby evidenced is written by a risk retention group not licensed by the state of Kansas, not subject to its supervision and not protected, in the event of the insolvency of this risk retention group by the Guaranty Fund of this state."

Sec. 5. Other Service Providers.

(A) Service providers who are not licensed agents or brokers must:

(1) register with the commissioner; and

(2) report the activities and scope of services which they are providing to the risk retention group.

(B) This section shall not be interpreted to allow service providers whose activities otherwise require licensing in this state to act on behalf of risk retention groups without such a license.

Sec. 6. Taxes.

(A) All risk retention groups shall be subject to taxation and shall be deemed to be insurers for the purpose of assessing and collecting taxes in accordance with the provisions of K.S.A. 1984 Supp. 40-252 and subject to the same interest, fines and penalties for nonpayment.

(B) Agents and brokers shall report and pay the taxes upon the premiums for risks which they have placed with or on behalf of a risk retention group not chartered in this state.

Sec. 7. Restrictions. A risk retention group may not:

(A) insure any risks other than those of its member companies;

(B) provide any insurance or insurance related service other than for product liability or completed operations unless it obtains a license in this state and becomes subject to all the laws and regulations of this state with respect to those additional lines of insurance and related services; or

(C) exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person.

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

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

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

Sec. 11. Examination for Financial Impairment.

(A) A risk retention group chartered in this state must submit to examinations to determine its financial condition as deemed necessary by the commissioner.

(B) A risk retention group not chartered in this state, and doing business in this state, must submit to an examination if:

(1) the commissioner has reason to believe the risk retention group is in a financially impaired condition; and

(2) the commissioner of the state or the public official having supervision over insurance in the jurisdiction in which the group is chartered has not begun or has refused to initiate an examination of the group.

(C) Such examination shall be conducted in accordance with the laws, regulations and procedures applicable to insurers licensed in this state (K.S.A. 1984 Supp. 40-222).

Sec. 12. Delinquency Proceedings.

(A) A risk retention group chartered and licensed in this state must comply with all lawful orders issued in a delinquency proceeding commenced by the commissioner.

(B) A risk retention group not chartered in this state and doing business in this state must comply with a lawful order issued in a delinquency proceeding commenced by the commissioner if the commissioner of the state or the public official having supervision over insurance in the jurisdiction in which the group is chartered has failed to initiate such a proceeding after notice of a finding of financial impairment under section 11 of this act.

Sec. 13. Penalties.

(A) A risk retention group which is chartered and licensed under sections 2 or 3 of this act and which violates any provision of this act will be subject to fines and penalties applicable to licensed insurers generally, including revocation of its license and/or the right to do business in this state.

(B) A risk retention group doing business in this state and which is not chartered or licensed in accordance with either sections 2 or 3 of this act, will be deemed an unauthorized insurer and subject to the fines and penalties of chapter 40 Kansas statutes annotated.

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

Sec. 15. This act shall take effect and be in force from and after its 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.

1/29/86 Sen. FI & I
Attachment IV

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:

Section 1. K.S.A. 75-4101 is hereby amended to read as follows: 75-4101. (a) There is hereby created a committee on surety bonds and insurance, which shall consist of the state treasurer, the attorney general and the commissioner of insurance or their designee. The commissioner of insurance shall be the chairperson of the committee and the director of purchases, or a designee, shall be ex officio secretary. The committee shall meet on call of the chairperson and at such other times as the committee shall determine but at least once a month on the second Monday in each month. Meetings shall be held in the office of the commissioner of insurance. The members of the committee shall serve without compensation. The secretary shall be the custodian of all property, records and proceedings of the committee. Except as provided in subsection (b) and in K.S.A. 74-4925 and 74-4927, and amendments thereto, and in K.S.A. 75-6501 to 75-6511, inclusive, no state agency shall purchase any insurance of any kind or nature or any surety bonds upon state officers or employees, except as provided in this act. Effective on August 1, 1984, and except as otherwise provided in this section, health care coverage and health care services of a health maintenance organization for state officers and employees designated under subsection (c) of K.S.A. 75-6501 shall be provided in accordance with the provisions of K.S.A. 75-6501 to 75-6511, inclusive.

(b) The Kansas turnpike authority may purchase group life, health and accident insurance or health care services of a health maintenance organization for its employees or members of the highway patrol assigned, by contract or agreement entered pursuant to K.S.A. 68-2025, and amendments thereto, to police toll or turnpike facilities, independent of the committee on surety bonds and insurance and of the provisions of K.S.A. 75-6501 to 75-6511, inclusive. Such authority may purchase liability insurance covering all or any part of its operations and may purchase liability and related insurance upon all vehicles owned or operated by the authority, independent of the committee on surety bonds and insurance and such insurance may be purchased without complying with K.S.A. 75-3738 to 75-3744, inclusive, and amendments thereto. Any board of county commissioners may purchase such insurance or health care services, independent of such committee, for district court officers and employees any part of whose total salary is payable by the county. Nothing in any other provision of the laws of this state shall be construed as prohibiting members of the highway patrol so assigned to police toll or turnpike facilities from receiving compensation in the form of insurance or health maintenance organization coverage as herein authorized.

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

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

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

Sec. 4. K.S.A. 75-4109 is hereby amended to read as follows: 75-4109. (a) The committee, at least once every three years, shall approve the property and casualty insurance coverages that shall be purchased by each state agency.

(b) The committee shall require that each state agency purchase the insurance coverages prescribed by K.S.A. 75-2728 and by K.S.A. 74-4703, 74-4705 and 74-4707, and amendments thereto, and shall prescribe the terms, conditions and amounts of such coverage giving due regard to the operations and requirements of the agencies involved.

(c) The committee shall, in addition to the coverages specified in subsection (b), designate the insurance coverages to be purchased by each state agency that are deemed by the committee to be necessary to protect the state for property of others that may be in the possession or control of such state agencies.

(d) Such coverages as are specified in subsections (b) and (c) may also include coverage on property of the state that are deemed by the committee to be incidental to the basic coverages herein required, and the committee shall prescribe the terms, conditions and amounts of all insurance coverages purchased pursuant to this section. Property of the state board of regents of any university or college which is referred to in subsection (b) may be self-insured as provided under this act.

(e) No property insurance coverage may be purchased by the committee except as provided herein or specifically required by other Kansas statutes and appropriations.

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

Sec. 6. This act shall take effect and be in force from and after its 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.

1/29/86 Sen. FI+I
Attachment V

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.

1/29/86 Sen. FI&I
Attachment VI

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:

Section 1. K.S.A. 1984 Supp. 40-2404 is hereby amended to read as follows: 40-2404. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies. Making, issuing, circulating or causing to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission or comparison which:

(a) Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

(b) misrepresents the dividends or share of the surplus to be received on any insurance policy;

(c) makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy;

(d) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates;

(e) uses any name of title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;

(f) is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion or surrender of any insurance policy;

(g) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or

(h) misrepresents any insurance policy as being shares of stock.

(2) False information and advertising generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, misrepresentation or statement with respect to the business of insurance or with respect to any person in the conduct of such person's insurance business, which is untrue, deceptive or misleading.

(3) Defamation. Making, publishing, disseminating or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any person, and which is calculated to injure person.

(4) Boycott, coercion and intimidation. Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of the business of insurance, or by any act of boycott, coercion or intimidation monopolizing or attempting to monopolize any part of the business of insurance.

(5) False statements and entries. (a) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person.

(b) Knowingly making any false entry of a material fact in any book, report or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

(6) Stock operations and advisory board contracts. Issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or 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;

(f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(h) attempting to settle a claim for less than the amount to which a reasonable person would have believed that such person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(j) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

(k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(l) delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

(n) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(10) Failure to maintain complaint handling procedures. Failure of any person, who is an insurer on an insurance policy, to maintain a complete record of all the complaints which it has received since the date of its last examination under K.S.A. 40-222 and amendments thereto; but no such records shall be required for complaints received prior to the effective date of this act. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, the date each complaint was originally received by the insurer and the date of final disposition of each complaint. For purposes of this subsection, "complaint" shall mean any written communication primarily expressing a grievance related to the acts and practices set out in this section.

(11) Misrepresentation in insurance applications. Making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money or other benefit from any insurer, agent, broker or individual.

(12) Statutory violations. Any violation of any of the provisions of K.S.A. 40-276a or 40-1515 and amendments thereto.

(13) Disclosure of information relating to adverse underwriting decisions. Failing to provide applicants, policyholders and individuals proposed for coverage with the information required under K.S.A. 40-2,112 and amendments thereto within the time prescribed in such section.

(14) Rebates and other inducements in title insurance. (a) No title insurance company or title insurance agent, or any officer, employee, attorney, agent or solicitor thereof, may pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to obtaining any title insurance business, any rebate, reduction or abatement of any rate or charge made incident to the issuance of such insurance, any special favor or advantage not generally available to others of the same classification, or any money, thing of value or other consideration or material inducement. The words "charge made incident to the issuance of such insurance" includes, without limitations, escrow, settlement and closing charges.

(b) No insured named in a title insurance policy or contract nor any other person directly or indirectly connected with the transaction involving the issuance of the policy or contract, including, but not limited to, mortgage lender, real estate broker, builder, attorney or any officer, employee, agent representative or solicitor thereof, or any other person may knowingly receive or accept, directly or indirectly, any rebate, reduction or abatement of any charge, or any special favor or advantage or any monetary consideration or inducement referred to in paragraph (a) of this section.

(c) Nothing in this section shall be construed as prohibiting:

(i) The payment of reasonable fees for services actually rendered to a title insurance agent in connection with a title insurance transaction;

(ii) the payment of an earned commission to a duly appointed title insurance agent for services actually performed in the issuance of the policy of title insurance; or

(iii) the payment of reasonable entertainment and advertising expenses.

(d) Nothing in this section prohibits the division of rates and charges between or among a title insurance company and its agent, or one or more title insurance companies and one or more title insurance agents, if such division of rates and charges does not constitute an unlawful rebate under the provisions of this section and is not in payment of a forwarding fee or a finder's fee.

Sec. 2. K.S.A. 1984 Supp. 40-2404 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.

1/29/86 Sen. FI+I

Attachment VII

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:

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

Sec. 2. This act shall take effect and be in force from and after its 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.

1/29/86 S. FI&I
Attachment VIII

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

that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or the insured's beneficiary.

(2) A provision setting forth the conditions under which an individual's coverage terminates under the policy, including the age, if any, to which an individual's coverage under the policy shall be limited, or, the age, if any, at which any additional limitations or restrictions are placed upon an individual's coverage under the policy.

(3) Provisions setting forth the notice of claim, proofs of loss and claim forms, physical examination and autopsy, time of payment of claims, to whom benefits are payable, payment of claims, change of beneficiary, and legal action requirements. Such provisions shall not be less favorable to the individual insured or the insured's beneficiary than those corresponding policy provisions required to be contained in individual accident and sickness policies.

(4) A provision that the insured will furnish to the policyholder, for the delivery to each employee or member of the insured group, an individual certificate approved by the commissioner of insurance setting forth in summary form a statement of the essential features of the insurance coverage of such employee or member, the procedure to be followed in making claim under the policy and to whom benefits are payable. Such certificate shall also contain a summary of those provisions required under (2) and (3) of this subsection in addition to the other essential features of the insurance coverage. If dependents are included in the coverage, only one certificate need be issued for each family unit.

(C) No group disability income policy which integrates benefits with social security benefits, shall provide that the amount of any disability benefit actually being paid to the disabled person shall be reduced by changes in the level of social security benefits resulting either from changes in the social security law or due to cost of living adjustments which become effective after the first day for which disability benefits become payable.

(D) A group policy of insurance delivered or issued for delivery or renewed which provides hospital, surgical or major medical expense insurance, or any combination of these coverages, on an expense incurred basis, shall provide that an employee or member or such employee's or member's covered dependents whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy or under any group policy providing similar benefits which it replaces for at least three months immediately prior to termination, shall be entitled to have such coverage nonetheless continued under the group policy for a period of six months and have issued to the employee or member of such employee's or member's covered dependents by the insurer, at the end of such six-month period of continuation, a policy of health insurance which conforms to the applicable requirements specified in this subsection. This requirement shall not apply to a group policy which provides benefits for specific diseases or for accidental injuries only. An employee or member or such employee's or member's covered dependents shall not be entitled to have such coverage continued or a converted policy issued to the employee or member of such employee's or member's covered dependents if termination of the insurance under the group policy occurred because: (a) The employee or member or such employee's or member's covered dependents failed to pay any required contribution after receiving reasonable notice of such required contribution from the insurer in accordance with rules and regulations adopted by the commissioner of insurance; (b) any discontinued group coverage was replaced by similar group coverage within 31 days; (c) the employee or member is or could be covered by 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 (d) the employee or member is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. In the event the group policy is terminated and not replaced the employee or member, at the option of the employee or member or at the option of the insurer, may be issued a conversion policy or certificate which otherwise meets these provisions in lieu of the right to continue group coverage required herein. The continued coverage and the issuance of a converted policy shall be subject to the following conditions:

(1) Written application for the converted policy shall be made and the first premium paid to the insurer not later than 31 days after termination of coverage under the group policy.

(2) The converted policy shall be issued without evidence of insurability.

(3) The terminated employee or member 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 members or employees remaining in the group. Failure to pay such premium shall terminate coverage under the group policy at the end of the period for which the premium has been paid. The premium rate charged for converted policies issued subsequent to the period of continued coverage shall be such that can be expected to produce an anticipated loss ratio of not less than 80% based upon conversion, morbidity and reasonable assumptions for expected trends in medical care costs. In the event the group policy is terminated and is not replaced, converted policies may be issued at self-sustaining rates that are not unreasonable in relation to the coverage provided based on conversion, morbidity and reasonable assumptions for expected trends in medical care costs. The frequency of premium payment shall be the frequency customarily required by the insurer for the policy form and plan selected, provided that the insurer shall not require premium payments less frequently than quarterly.

(4) The effective date of the converted policy shall be the day following the termination of insurance under the group policy.

(5) The converted policy shall cover the employee or member and the employee's or member's dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent.

(6) The insurer shall not be required to issue a converted policy covering any person if such person is or could be covered by 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). Furthermore, the insurer shall not be required to issue a converted policy covering any person if:

(a)(i) such person is covered for similar benefits by another hospital, surgical medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program, or

(ii) such person is eligible for similar benefits (whether or not covered therefor) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or

(iii) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law, and

(b) the benefits provided under the sources referred to in (i) above for such person or benefits provided or available under the sources referred to in (ii) and (iii) above for such person, together with the benefits provided by the converted policy, would result in over-insurance according to the insurer's standards. The insurer's standards must bear some reasonable relationship to actual health care costs in the area in which the insured lives at the time of conversion and must be filed with the commissioner of insurance prior to their use in denying coverage.

(7) A converted policy may include a provision whereby the insurer may request information in advance of any premium due date of such policy of any person covered as to whether:

(a) Such person is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program;

(b) such person is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

(c) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law.

The converted policy may provide that the insurer may refuse to renew the policy and the coverage of any person insured for the following reasons only:

(a) Either the benefits provided under the sources referred to in (i) and (ii) above for such person or benefits provided or available under the sources referred to in (iii) above for such person, together with the benefits provided by the converted policy, would result in over-insurance according to the insurer's standards on file with the commissioner of

insurance, or the converted policyholder fails to provide the requested information;

(b) fraud or material misrepresentation in applying for any benefits under the converted policy;

(c) eligibility of the insured person 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 other state or federal law providing for benefits similar to those provided by the converted policy; or

(d) other reasons approved by the commissioner of insurance.

(8) An insurer shall not be required to issue a converted policy which provides coverage and benefits in excess of those provided under the group policy from which conversion is made.

(9) The converted policy shall not exclude a preexisting condition not excluded by the group policy. The converted policy may provide that any hospital, surgical or medical benefits payable may be reduced by the amount of any such benefits payable under the group policy after the termination of the individual's insurance. The converted policy may also include provisions so that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group policy, shall not exceed those that would have been payable had the individual's insurance under the group policy remained in force and effect.

(10) 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 basic hospital or surgical expense insurance, the employee or member shall be entitled to obtain a converted policy providing, at the insured's option, coverage on an expense incurred basis under any one of the plans meeting the following requirements:

Plan A

(a) hospital room and board daily expense benefits in a maximum dollar amount approximating the average semi-private rate charged in metropolitan areas of this state, for a maximum duration of 70 days,

(b) miscellaneous hospital expense benefits of a maximum amount of 10 times the hospital room and board daily expense benefits, and

(c) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of $800, or

Plan B

(a) hospital room and board daily expense benefits in a maximum dollar amount equal to 75% of the maximum dollar amount determined for plan A, for a maximum duration of 70 days,

(b) miscellaneous hospital expense benefits of a maximum amount of 10 times the hospital room and board daily expense benefits, and

(c) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of $600, or

Plan C

(a) hospital room and board daily expense benefits in a maximum dollar amount equal to 50% of the maximum dollar amount determined for plan A, for a maximum duration of 70 days,

(b) miscellaneous hospital benefits of a maximum amount of 10 times the hospital room and board daily expense benefits, and

(c) surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of $400.

The maximum dollar amounts of plan A shall be determined by the commissioner of insurance and may be redetermined by such official from time to time as to converted policies issued as new policies subsequent to such redetermination. At the request of the insured, such redetermined amounts shall, subject to the provisions of condition (17) and submission of reasonable evidence of insurability, be made available to the holders of converted policies which have been in effect at least three years on the date the redetermined amounts become effective. At the option of the insurer, any such requested increase or decrease in coverage on outstanding policies or any renewal thereof need not be made effective until the first policy anniversary date following the insured's request. Such redetermination shall not be made more often than once in three years. The maximum dollar amounts in plans A, B and C shall be rounded to the nearest 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

other state or federal law providing for benefits similar to those provided by the converted policy.

(16) Subject to the conditions set forth above, the continuation and conversion privileges shall also be available:

(a) To the surviving spouse, if any, at the death of the employee or member, with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death, otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or, if the group policy provides for continuation of dependents' coverage following the employee's or member's death, at the end of such continuation;

(b) to the spouse of the employee or member upon termination of coverage of the spouse, while the employee or member remains insured under the group policy, by reason of ceasing to be a qualified family member under the group policy, with respect to the spouse and such children whose coverage under the group policy terminates at the same time; or

(c) to a child solely with respect to such child upon termination of such coverage by reason of ceasing to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided above with respect to such termination.

(17) If the benefit levels required in condition (10) exceed the benefit levels provided under the group policy, the conversion policy may offer benefits which are substantially similar to those provided under the group policy either at the time the group policy was discontinued in its entirety and not replaced or as the group policy is in effect at the time the benefits under the converted policies are determined or redetermined in lieu of those required in condition (10).

(18) The insurer may elect to provide group insurance coverage which complies with this act in lieu of the issuance of a converted individual policy.

(19) A notification of the conversion privilege shall be included in each certificate of coverage.

(20) A converted policy which is delivered outside this state must be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

(21) The insurer shall give the employee or member and such employee's or member's covered dependents reasonable notice of the right to convert at least once during the six-month continuation period in accordance with rules and regulations adopted by the commissioner of insurance.

Sec. 2. K.S.A. 1984 Supp. 40-2209 is hereby repealed.

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

January 29, 1986
Testimony on SB 382
Before the Senate Financial Institutions
and Insurance Committee
By: Larry W. Magill, Jr., Executive Vice President
Independent Insurance Agents of Kansas

We are here today to ask this committee to amend SB 382 to allow easy and convenient financing of health care stabilization fund surcharges without tying up the health care providers' line of credit with their bank. With the recent surge in HCSF surcharges brought on by a variety of factors and especially with the present surcharge of 110%, we are convinced there will be a significant need among health care providers to finance their surcharge payments.

The Fund has never been allowed to refund premium except where insurance companies were changed mid-term. If carriers were changed mid-term, then once the new primary coverage was confirmed by the Insurance Department, the Fund would return any excess surcharge based on a new lower primary premium (the converse would also be true).

A premium financing company's only security when they finance insurance premiums is the return of the unearned premium in the event of nonpayment. Generally they require a 25% down payment with a maximum of nine installments. If the premium (including surcharge) is approximately $5,000 or greater, they will charge somewhere between 2-2 1/2 points over prime.

If an installment is not paid, they have the authority under the premium financing agreement to request cancellation by the company who returns any unearned premium to the

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finance company. Since the fund has been unable to return unearned premiums for a health care provider, premium financing or surcharge financing has not been available as an option to health care providers.

Financing offers advantages to the health care provider of not tying up their bank line of credit, no collateral is required and the financing agreement is convenient and easy to enter into.

Our amendment would first of all include the HCSF surcharge under the definition of premium in the premium finance company statute, K.S.A. 40-2601 et seq.

Secondly, by amending K.S.A. 40-3403, it would allow the Department to return unearned premium to the premium finance company - an absolutely essential ingredient for them to agree to finance premiums or surcharges.

This would not change present statutes, which require 30 days notice to cancel medical malpractice coverage and that the notice must be sent to the Department, the licensing board and the health care provider. It would be up to the board in the case of nonpayment, to take disciplinary proceedings if the health care provider failed to obtain other insurance without a gap in coverage.

In the interest of equity, our amendment also would allow the Department to return premium to: (a) deceased health care providers; (b) retiring health care providers; and (c) HCP's moving out of state.

On this last point, before the 1984 changes to the Health Care Provider Insurance Availability Act, it was felt that since the fund did not charge for "tail" coverage, there

should be no return premium when a health care provider re[illegible]d, died or moved out of state. Now under the accrual system implemented in 1984, the fund does include in the surcharge the ultimate expected claims cost for each year plus some "catch-up" for past accrued liabilities. In view of how the surcharge is now set, it seems logical to return the unearned premium if the future exposure to loss ceases, i.e., death, retirement or move out of state.

HB 2661 does require at least three payments of the annual HCSF surcharge to qualify for the unlimited "tail" coverage.

Further, as a practical matter under present law, a smart health care provider and/or agent can get around the present "no return" policy by obtaining a short-term policy at renewal if they know they will be retiring or moving on a certain date, thus reducing their surcharge.

Because health care providers pay their surcharge based on the primary coverage policy period, we recommend that the bill be amended to be effective on publication in the Kansas Register. This will provide immediate relief for those providers whose coverage renews between now and July 1, 1986.

With the present 110% surcharge, our amendment would be an extremely practical change for the legislature to consider making and one with some urgency for all health care providers. We appreciate the committee's favorable consideration.

Ka Farm Bureau

PUBLIC POLICY STATEMENT

Statement to:
SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

RE: The Community Resources Security Act - S.B. 432

Topeka, Kansas
January 28, 1986

Presented by:
Paul E. Fleener, Director
Public Affairs Division
KANSAS FARM BUREAU

Mr. Chairman and members of the Committee:

My name is Paul Fleener. I am the Director of Public Affairs for Kansas Farm Bureau. We are here today as PROPONENTS of S.B. 432, the Community Resources Security Act.

As every member of this committee ... indeed, every member of the Legislature certainly knows, agricultural credit has been uppermost in the minds of farmers and ranchers, of bankers and other lenders, and of Legislators for the past two or three years. In 1985, in this Legislature, there were some attempts to come to grips with some of the credit needs of farmers. There have been numerous proposals advanced in the Congress of the United States dealing with the Farm Credit System and the health of our banking and farm lending institutions.

At the 1985 Annual Meeting of Kansas Farm Bureau, farmers and ranchers from the 105 counties of Kansas who were delegates to that meeting and represented the thousands of farmers who are members of Farm Bureau in Kansas, redirected their efforts and their policy position concerning Agricultural Credit. Throughout the year 1985 "credit" was the focus of countless meetings in our

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county Farm Bureaus, was the topic of discussion at numerous meetings of our members and the staff of the organization. We all watched as banks failed around our state. We directed suggestions to members of the Kansas Congressional Delegation concerning some ways to retain the opportunity for borrowing and at the same time salvage the institutions which make loans to farmers. The delegates, reviewing a year of meetings and discussion, adopted the following policy position on Agricultural Credit:

Agricultural Credit

Farmers and ranchers need a variety of credit facilities to finance operating and ownership expenses. In these difficult times neither farmers nor lenders will succeed by themselves if the other fails. We need credit programs that are mutually beneficial for farmers and lenders, programs that will assist farmers and ranchers to maintain viable operations, and programs that will give lenders sufficient latitude to work with producers who have credit or debt difficulties.

Special programs should be designed at federal and state levels to specifically deal with credit and financing problems of young farmers and ranchers who are trying to get established.

Commercial banks face difficulties in continuing to work with many agricultural borrowers. We support programs which will assist banks in providing service to rural communities in Kansas. We believe commercial banking institutions should have a longer time to write off agricultural loan losses. They should also be given incentives to participate in interest buy-down proposals.

In order to help maintain the viability and vitality of rural communities in Kansas, we support legislation to permit a bank in Kansas to operate a facility in a community with only one bank **if** that one bank is found to be insolvent, or outside support would keep it solvent and prevent a collapse. Preference to operate a facility in a one-bank town whose bank has failed or is in danger of failure should be given to a bank in the same county or geographic region.

The position adopted by our farmers, and our reading and understanding of S.B. 432, indicates that we should, at this opportunity, voice our strong support for this legislation before your committee today. By passage of this measure you would be adding a new chapter to the statutes dealing with additional detached auxiliary banking service facilities. Your bill carefully directs that a BIDDING BANK "shall not include a bank which is directly or indirectly owned or controlled by a bank holding company." S.B. 432, in New Sec. 2, subsections (a), (b), and (c), specifies the conditions under which a "failed bank" may be taken over and operated as a detached auxiliary banking service facility by a "bidding bank." These conditions are the same or very similar to the conditions contained in our policy position supporting operation of a bank found to be insolvent or about to collapse.

We urge your favorable consideration and support for S.B. 432. Thank you for the opportunity to make this brief statement of behalf of the farmers and ranchers in Kansas who are members of Farm Bureau.