Approved 2-16-87
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Rep. Dale Sprague at
Chairperson

3:30 ~~XX~~ a.m./p.m. on February 11, 1987 in room 531-N of the Capitol.

All members were present except:
Rep. Littlejohn, excused

Committee staff present:
Emalene Correll, Chris Courtwright, Research Department
Bill Edds, Revisor's Office
Deanna Willard, Committee Secretary

Conferees appearing before the committee:
Ed Hund, Kansas Trial Lawyers Association
Rep. Al Ramirez
Rep. Clyde Graeber
Rep. Bill Reardon
Margaret Gebhardt, Bonner Springs, Kansas
Lyndon Drew, Department on Aging
Clarence Arndt, Silver Haired Legislature
Jack Roberts, Blue Cross and Blue Shield
Walt Whalen, Pyramid Life Insurance Company
Richard Harmon, American Family Life Assurance Company
Steve Robertson, Health Insurance Association of America
Wayne Morris, Security Benefit Group

The meeting was called to order by the Chairman.

Mr. Ed Hund, KTLA, requested the introduction of two bills. The first bill would relate to unfair claim settlement practices and allow an individual to bring suit against an insurance company without having to prove that the act in question was a general business practice. (Att. 1.)

The second bill would grant more control over insurance rates to the Commissioner of Insurance; it would shift the burden of proof for a rate request to the applicant and establish standards for rate setting. (Att. 2.)

Rep. Gross made a motion that the bills be introduced; the motion was seconded by Rep. Sawyer. The motion carried.

Hearing on: HB 2090 - Notice of termination and premium due on medicare supplement policies

Rep. Al Ramirez, co-sponsor of the bill, urged favorable consideration of this legislation designed to help protect the elderly. (Att. 3.)

Rep. Clyde Graeber stated that there is nothing more important to senior citizens than their hospitalization coverage, that the bill requires little of insurance companies and that it provides that a policy will be put back in force if the premium is paid within 15 days of a certified mailing of a lapse notice.

Rep. Bill Reardon cited an incident in which a waiting period of six months was required before a policy would be reinstated. He

said that having to sign for a document being received would make an impact on an elderly person.

Mrs. Margaret Gebhardt, Bonner Springs, Kansas, spoke in favor of the bill. (Att. 4.) She said she would be willing to pay a higher premium to allow insurance companies to perform this service.

Mr. Lyndon Drew, Department on Aging, presented testimony which recommended passage of HB 2090 to ensure that policyholders receive notice of policy termination so there is not an unintended loss of coverage. (Att. 5.)

Mr. Clarence Arndt, Silver Haired Legislator from Overland Park, Kansas, urged support of this bill as a protective measure to the aging.

Mr. Jack Roberts, Blue Cross and Blue Shield, said that they have had a very liberal reinstatement policy for medicare supplemental policies. They will reinstate with no question when premium is paid in three months. Also, during January through March, a person can renew a policy with no restrictions. He distributed a postcard that is mailed whenever a policy is lapsed (Att. 6) and a memo from Dave Manley, Blue Cross and Blue Shield mailroom personnel, which estimated the mailing costs of the bill. (Att. 7.) A copy of the cover letter which is sent with the postcard was also distributed at the request of a Committee member. (Att. 8.) He mentioned that the bill contains a provision that the certified notice is not required if a person has let the policy lapse more than twice in a 12-month period.

Staff mentioned that the bill doesn't seem to speak to group coverage; it appears the sponsors intended it to be for individuals.

Mr. Walt Whalen, Vice President of Pyramid Life Insurance Company, said that they recognize the underlying humanitarian purpose of the bill but that it is unnecessary, expensive, and has technical problems. He said that most insurance companies send at least three notices: one 15 days before the due date, one 15 days after the due date, and another 38 days after the policy has lapsed. Also, the agent is notified of the lapse, and he will usually contact the policyholder. If the bill were addressed to those companies who send only one notice, they would have no objection to it. He said the majority of medicare policies lapse because of death, other coverage, and because the cost is prohibitive; the cost of this legislation would further increase the cost of the coverage.

According to Mr. Whalen, the cost of the postage is minor; the major expense would be the separate handling that would be involved.

He mentioned that if they cannot charge premium for the time the policy was lapsed, it would be discriminatory against those

persons whose policies did not lapse. Also, Kansas law provides a 10-day waiting period for a lapsed policy, which would conflict with the bill. He suggested that printing on the outside of the envelope indicate a premium notice and that automatic bank drafts be used, for which his company gives a 10% discount.

Mr. Richard Harmon, American Family Life Assurance Company, presented testimony as to the ineffectiveness of the bill and suggested notice on the envelope as an alternative. (Att. 9.)

Mr. Steve Robertson, Health Insurance Asssociation of America, presented a letter from a company he represents which described the negative effect of the bill on their business. (Att. 10.) He said that just because it wouldn't cost much isn't reason enough to institute the requirement, that companies would already be doing this if it would be beneficial as they do everything possible to retain policies.

Mr. Dick Brock, Kansas Insurance Department, was asked if the bill would apply to companies who offer a medicare supplemental policy on TV. He responded that it would for those companies admitted to do business in Kansas.

Mr. Wayne Morris, Security Benefit Group, offered reasons for opposition to the bill. (Att. 11.) He said Lines 23-26 would apply to any health policy of a person over 65, that it would be especially difficult for companies who operate in other states than just Kansas, that the notice would go to the insured--not necessarily the policyholder, that the receipt of a certified notice wouldn't mean that a person understood what they were receiving, and that requiring automatic bank drafts would relieve the situation.

The meeting was adjourned at 5:00 p.m.

Date: Feb. 11, 1987

GUEST REGISTER

HOUSE
COMMITTEE ON INSURANCE

NAME	ORGANIZATION	ADDRESS	PHONE
Dick Brock	Ins Dept	Topeka	
Wayne D. Morris	Security Benefit Group, Inc.	"	
JACK ROBERTS	BLUE CROSS-BLUE SHIELD	TOPEKA	
Steve Robertson	Health Ins. Assn of America	Des Plaines, Ill.	312-297 1490
Walter Whalen	Pyramid Life Ins Co	Mission, KS	913 722-3110
Richard Harmon	American Family	Topeka	232-0545
Gerald Dean Drake	Leavenworth County Commission	Leavenworth Ks	913 682-7611
Johnie Frank	Leavenworth County Commission	Leavenworth KS	913 682-7611
EDWARD POWERS	LEAVENWORTH CO. COMMISSION	LEAVENWORTH, KS	913 682-7611
Larry Nagel	IIAK	TOPEKA	
John Myers	Menter Hospital	Topeka	233-1903
Richard Mason	KTLA	"	232-7756
Lyndon Drew	KDOA	Topeka	296-4986
Margaret L. Gebhardt	Sr. Citizens	Bonner Springs Ks.	422-1071
CLARENCE W. ARNDT	SILVER HAIRED LEGIS.	OVERLAND PARK, KS	642-6233
IVA C ARNDT	VISITOR	" "	"
Rep. Clyde Graeber	Ks. House		
Gail Hamilton	KSNOW.	Lawrence	842-6294
Andrea Lebard	KS Hospital Assoc.	Topeka	233-7436

HOUSE BILL NO. _____

By Committee on Insurance

AN ACT concerning insurance; relating to certain unfair claim settlement practices; amending K.S.A. 40-2404 and repealing the existing section.

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

Section 1. K.S.A. 40-2404 is hereby amended to read as follows: 40-2404. (a) 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)~~ (A) Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

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

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

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

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

~~(h)~~ (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 such 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)~~ (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)~~ (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 peson.

(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)~~ (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 anuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

~~(b)~~ (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.

(8) Rebates. ~~(a)~~ (A) Except as otherwise expressly provided by law, knowingly permiting 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)~~ (B) Nothing in subsection ~~(7)~~ **or paragraph (a) of this subsection** (a)(7) or (a)(8) (A) 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; or

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

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

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

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

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

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

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

~~(k)~~ (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)~~ (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)~~ (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; or

~~(n)~~ (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~~ The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of ~~these~~ the 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~~ means 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. 40-1515 and amendments thereto.

(13) Disclosure of information relating to adverse underwriting decisions, as defined in K.S.A. 40-2,111 and amendments thereto. 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.

(b) An individual may bring suit against an insurance company for engaging in any practice described in subsection (a) (9). For the purposes of the individual action, it is not necessary to prove that the act was committed or performed with such frequency as to indicate a general business practice. If the individual prevails in the action, the individual is entitled to reasonable attorney fees, settlement of the claim and any other damages allowed by law.

(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. 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.

THE INSURANCE REFORM ACT OF 1987

AN ACT concerning insurance; relating to the making of rates relating to the cost of a review of rates by the insurance commissioner; the burden of proof in a rate hearing; the power of the insurance commissioner to adjust premiums after review; relating to recording and reporting of loss and expense experience; creating advisory committee to the commissioner; amending K.S.A. 40-1112, 40-1113, 40-937, and 40-1118 and repealing the existing sections.

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

Section 1. K.S.A. 40-1112 is hereby amended to read as follows: 40-1112. All rates shall be made in accordance with the following provisions:

~~(1)~~ (a) Due consideration ~~may~~ shall be given: (1) To past and prospective loss experience within and outside the state;

(2) to catastrophe hazards, if any;

(3) to a reasonable margin for profit and contingencies;

(4) to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policy holders, members or subscribers;

(5) to policyholders' dividends in the case of participating insurers; and

(6) Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The commissioner may promulgate rules utilizing reasonable techniques of actuarial science and economics to specify the manner in which insurers shall calculate investment income attributable to such classes of insurance written in this State and the manner in which such investment income shall be used in the calculation of insurance rates; and

(7) to all other relevant factors within and outside the state.

~~(2)~~ (b) The systems of expense provisions included in the rates for use by an insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect

the requirements of the operating methods of any such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination of the commissioner of insurance, ~~hereinafter referred to as commissioner~~, approves the application of separate expense provisions; but. This ~~subdivision~~ paragraph shall not be construed to require uniformity among all insurers with respect to the application of other subdivisions paragraphs of this section.

~~(3)~~(c) Risks may be grouped by classifcations for the establishment of rates and minimum premiums. Classification rates for personal lines of property and casualty insurance may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Classification rates for commercial lines of property and casualty insurance may be modified to produce rates for individual risks in accordance with rules and regulations promulgated by the commissioner establishing reasonable standards for rating plans, including experience rating plans, schedule rating plans, individual risk premium modification plans and expense reduction plans, designed to modify rates in the development of premiums for individual risks insured in a property and casualty market. Such standards shall permit recognition of expected differences in loss or expense characteristics, and shall be designed so that such plans are reasonable and equitable in their application, and are not unfairly discriminatory, violative of public policy or otherwise contrary to the best interests of the people of this state. Such standards shall not prevent the development of new or innovative rating methods which otherwise comply with this act. Such rating plans shall be filed or refiled by insurers in compliance with the rules and regulations. The commissioner shall review such plans and shall disapprove a plan that does not comply with the rules and regulations. The rules and regulations shall establish maximum debits and credits that may result from the application of a rating plan, encourage loss control, safety programs, and other methods of risk management and require insurers to maintain documentation of the basis of the debits and credits applied under any plan. Once it has been filed and approved, use of the rating plan shall become mandatory and such plan shall be applied uniformly for eligible risks in a manner that is not unfairly discriminatory.

~~(4)~~(d) Rates shall be reasonable, adequate and not unfairly discriminatory.

(e) In addition to the rate standards provided in paragraph (d), a rate may be found by the commissioner to be

excessive, inadequate, or unfairly discriminatory based upon the following standards:

(1) Rates shall be deemed excessive if they are likely to produce a profit from Kansas business that is unreasonably high in relation to the risk involved in the class of business or rates are based on expenses that are unreasonably high in relation to services rendered.

(2) Rates shall be deemed excessive if the rate structure established by a stock insurance company provides for any replenishment of surpluses from premiums, when the need for replenishment is attributable to investment losses.

(3) Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

(4) One rate shall be deemed unfairly discriminatory in relation to another in the same class if it fails to clearly and equitably reflect the difference in expected losses and expenses.

(5) A rate shall be deemed inadequate as to the premium charged to a risk or group of risks if discounts or credits are allowed which exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks.

(6) A rate shall be deemed unfairly discriminatory as to a risk or group of risks if the application of premium discounts or credits among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.

Sec. 2. K.S.A. 40-1112 is hereby repealed.

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

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

K.S.A. 40-1113 is hereby amended to read as follows: 40-1113.

Filing of rates and rating information; approval or disapproval; notice and hearings; orders. (a) Every insurer shall file with the commissioner every manual of classifications, rules and rates, every rating plan and every modification of any of the foregoing which it proposes to use. Every such filing shall indicate the character and extent of the coverage contemplated and shall be accompanied by the information upon which the insurer supports the filing. A filing and any supporting information shall be open to public inspection after it is filed with the commissioner.

(b) An insurer may satisfy its obligation to make such filings by authorizing the commissioner to accept on its behalf the filings made by a licensed rating organization or another insurer. Nothing contained in this act shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization.

(c) Any filing made pursuant to this section shall be approved by the commissioner unless the commissioner finds that such filing does not meet the requirements of this act or establishes an unreasonable or excessive rate. As soon as reasonably possible after the filing has been made the commissioner shall in writing approve or disapprove the same, except that any filing shall be deemed approved unless disapproved within thirty (30) days.

(d) In reviewing a rate filing the commissioner may require the insurer to provide at the insurer's expense all information necessary to evaluate the condition of the company and the reasonableness of the filing acording to the criteria enumerated in this Section.

(e) Any such filing with respect to a fidelity, surety or guaranty bond shall be deemed approved from the date of filing to the date of such formal approval or disapproval.

(f) In the event that the commissioner disapproves a filing, the commissioner shall specify in what respect he or she finds that such filing does not meet the requirements of this act. In any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory.

(g) If at any time the commissioner finds that a filing so approved no longer meets the requirements of this act, the commissioner may, after a hearing held on not less than twenty (20) days' written notice, specifying the matters to be considered at such hearing, to every insurer and rating organization which made such filing, issue an order withdrawing his or her approval thereof. Said order shall specify in what respects the commissioner finds that such filing no longer meets the requirements of this act and shall be effective not less than thirty (30) days after its issuance. Copies of such order shall be sent to every such insurer and rating organization.

(h) Any person or organization aggrieved by the action of the commissioner with respect to any filing may, within

thirty (30) days after such action, make written request to the commissioner for a hearing thereon. This section shall not apply to any insurer or rating organization with respect to a withdrawal of a filing made by it. The commissioner shall hear such aggrieved party within thirty (30) days after receipt of such request and shall give not less than ten (10) days' written notice of the time and place of the hearing to the insurer or rating organization which made the filing and to any other aggrieved party. Within thirty (30) days after such hearing the commissioner shall affirm, reverse or modify his or her previous action specifying the reasons therefor. Pending such hearing and decision thereon the commissioner may suspend or postpone the effective date of his or her previous action. In the event the commissioner finds that a rate or rate change is excessive, inadequeate, or unfairly discriminatory after hearing, the commissioner shall issue an order disapproving said rate or rate change and specifying that a new rate or rate schedule be filed by the insurer which responds to the findings of the commissioner within 30 days. The commissioner shall further order that premiums be adjusted retroactively to the effective date of the rate or rate change to reflect the findings of the commissioner regarding the rate or rate change.

(i) No insurer shall make or issue a contract or policy except in accordance with filings which have been approved for said insurer as provided in this act.

HISTORY: L. 1945, ch. 215, 3; L. 1978, ch. 177, 2; L. 1979, ch. 141, 2; July 1.

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

Section 1. K.S.A. 40-937 is hereby amended to read as follows: 40-937. (a) Recording and reporting of loss and expense experience. The commissioner shall ~~promulgate~~ develop reasonable ~~rules and~~ statistical plans, ~~reasonably adopted to each of the rating systems on file with, which may be modified from time to time and~~ which shall be used thereafter by each insurer in the recording and reporting of its loss and ~~country wide~~ expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid ~~him~~ the commissioner in determining whether rating systems comply with the standards set forth in K.S.A. 40-927, and amendments thereto. Information supplied by the statistical plan shall include but not be limited to the following: (1) Premiums earned;

(2) premiums written;

(3) number of claims;

(4) number of new claims during the reporting period;

(5) number of claims closed during the reporting period and actual payouts;

(6) number of claims outstanding at the end of the reporting period;

(7) total losses incurred;

(8) total losses incurred as a percentage of premiums earned;

(9) total number of policies in force on the last day of the reporting period;

(10) total number of policies cancelled;

(11) total number of policies nonrenewed;

(12) net underwriting gain or loss;

(13) separate allocating of expenses for commissions, other acquisition costs, general office expenses, taxes, licenses, fees and other expenses;

(14) whether or not the company sets reserves for claims for losses which have been incurred, but not reported;

(15) all reserves established in connection with the company's casualty line;

(16) how dollars reserved are treated in each of the categories listed for federal income tax purposes;

(17) with respect to amounts paid in claims for the year next preceding the filing of each annual report, each company shall provide the following information:

(A) Total amounts reserved with respect to those claims;

(B) the year in which the reserves were set; and

(C) the amounts set in each year;

(18) the value of the securities held in the company's investment portfolio as of December 31 of the year next preceding the filing of each annual report. Such information should be submitted in the same manner as provided by K.S.A. 40-225 and amendments thereto; and

(19) any published annual reports to shareholders or policyholders shall be submitted with the report.

Such ~~rules and~~ plans may also provide the recording and reporting of expense experience items which are specially applicable to this state ~~and are not susceptible of determination by a prorating of country wide expense experience.~~ In ~~promulgating such rules and~~ developing such plans, the commissioner shall give due consideration to the rating systems on file with ~~him~~ the commissioner and, in order that such ~~rules and~~ plans may be as uniform as is practicable among the several states, ~~to the rules and~~ to the form of the plans used for such rating systems in other states. ~~No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it.~~ The commissioner may designate one or more rating organizations or other agencies to assist ~~him~~ the commissioner in gathering such experience and making compilations thereof, and such compilations shall be made available, ~~subject to reasonable rules promulgated~~ by the commissioner, to insurers and rating organizations. ~~Provided, That nothing in this act shall be counstrued to require, nor shall the commissioner adopt any rule to require, and insurer to record or report its loss or expense experience on any basis or statistical plan not consistent with the rating system filed by it.~~

(b) Interchange of rating plan data. Reasonable ~~rules and~~ plans ~~may~~ shall be ~~promulgated~~ developed by the commissioner for the interchange of data necessary for the application of rating plans.

(c) Consultation with other states. In order to further uniform administration of rate regulatory laws, the commissioner and every insurer and rating organization may exchange information and experience data with insurance supervisory officials, insurers and rating organizations in other states and may consult with them with respect to rate making and the application of rating systems.

(d) Rules and regulations. The commissioner ~~may~~ shall make reasonable rules and regulations necessary to effect the purposes of this act.

Sec. 2. K.S.A. 40-1118 is hereby amended to read as follows:

40-1118. (a) Recording and reporting of loss and expense experience. The commissioner shall ~~promulgate rules and~~ develop statistical plans, ~~reasonably adopted to each of the rating systems on file with him, which may be modified from~~

~~time to time and~~ which shall be used ~~thereafter~~ by each insurer in the recording and reporting of its loss and ~~country wide~~ expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid ~~him~~ the commissioner in determining whether rating systems comply with the standards set forth in K.S.A. 40-1112, and amendments thereto. Information supplied by the statistical plan shall include but not be limited to the following: (1) Premiums earned;

(2) premiums written;

(3) number of claims;

(4) number of new claims during the reporting period;

(5) number of claims closed during the reporting period and actual payouts;

(6) number of claims outstanding at the end of the reporting period;

(7) total losses incurred;

(8) total losses incurred as a percentage of premiums earned;

(9) total number of policies in force on the last day of the reporting period;

(10) total number of policies cancelled;

(11) total number of policies nonrenewed;

(12) net underwriting gain or loss;

(13) separate allocating of expenses for commissions, other acquisition costs, general office expenses, taxes, licenses, fees and other expenses;

(14) whether or not the company sets reserves for claims for losses which have been incurred, but not reported;

(15) all reserves established in connection with the company's casualty line;

(16) how dollars reserved are treated in each of the categories listed for federal income tax purposes;

(17) with respect to amounts paid in claims for the year next preceding the filing of each annual report, each company shall provide the following information:

(A) Total amounts reserved with respect to those claims;

(B) the year in which the reserves were set; and

(C) the amounts set in each year;

(18) the value of the securities held in the company's investment portfolio as of December 31 of the year next preceding the filing of each annual report. Such information should be submitted in the same manner as provided by K.S.A. 40-225 and amendments thereto; and

(19) any published annual reports to shareholders or policyholders shall be submitted with the report.

Such ~~rules and~~ plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state ~~and are not susceptible of determination by a prorating of country wide expense experience.~~ In promulgating such ~~rules and~~ plans, the commissioner shall give due consideration to the rating systems on file with ~~him~~ the commissioner and, in order that such ~~rules and~~ plans may be as uniform as is practicable among the several states, ~~to the rules and~~ to the form of the plans used for such rating systems in other states. ~~No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it.~~ The commissioner may designate one or more rating organizations or other agencies to assist ~~him~~ the commissioner in gathering such experience and making compilations thereof, and such compilations shall be made available, ~~subject to reasonable rules promulgated~~ by the commissioner, to insurers and rating organizations. ~~Provided, That nothing in this act shall be construed to require, nor shall the commissioner adopt any rule to require, any insurer to record or report its loss or expense experience on any basis or statistical plan not consistent with the rating system filed by it.~~

(b) Interchange of rating plan data. Reasonable ~~rules and~~ plans ~~may~~ shall be ~~promulgated~~ developed by the commissioner for the interchange of data necessary for the application of rating plans.

(c) Consultation with other states. In order to further uniform administration of rate regulatory laws, the commissioner and every insurer and rating organization may

exchange information and experience data with insurance supervisory officials, insureres and rating organizations in other states and may consult with them with respect to ratemaking and the application of rating systems.

(d) Rules and regulations. The commissioner ~~may~~ shall make reasonable rules and regulations necessary to effect the purposes of this act.

New Sec. 3. (a) There is hereby created the advisory committee on insurance data and information. Such advisory committee shall be advisory to the commissioner of insurance.

(b) The advisory committee shall consist of five members. No more than three members shall be members of the same political party. Advisory committee members shall be appointed as follows: One member shall be appointed by the governor, one member shall be appointed by the president of the senate, one member shall be appointed by the speaker of the house of representatives, one member shall be appointed by the minority leader of the senate and one member shall be appointed by the minority leader of the house of representatives. Each member of the committee shall be appointed for a two-year term. In the case of a vacancy on such board, the person appointing the member creating the vacancy shall appoint a successor who shall serve for the remainder of the term of the member creating the vacancy.

(c) The advisory committee shall elect one of its members as chairperson and one as secretary.

(d) The advisory committee shall have the following functions, powers and duties:

(1) Evaluate the usefulness of the existing information and data gathered by the commissioner to analyze insurance companies in areas such as financial condition, loss and expense experience and the making of rates; and

(2) make recommendations to the commissioner as to information and data that should be collected by the commissioner in order to analyze the financial condition of insurance companies, and review the loss and expense experience and the making of rates by insurance companies.

(e) The chairperson shall call meetings of the committee.

(f) Members of the advisory committee attending meetings of such committee shall be paid compensation,

subsistence allowances, mileage and expenses in addition to mileage and subsistence allowances provided in K.S.A. 75-3223 and amendments thereto.

(g) The provisions of this section shall expire on June 30, 1989.

Sec. 4. K.S.A. 40-937 and 40-1118 are hereby repealed.

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

STATE OF KANSAS

ALFRED RAMIREZ
REPRESENTATIVE, FORTIETH DISTRICT
LEAVENWORTH AND WYANDOTTE COUNTIES
913 SHEIDLEY
BONNER SPRINGS, KANSAS 66012

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER EDUCATION
FEDERAL AND STATE AFFAIRS
GOVERNMENTAL ORGANIZATION

Testimony before the House Insurance Committee

February 11, 1987

Thank you Mr. Chairman and Committee Members.

I appreciate the opportunity to speak to you regarding House Bill #2090.

The bill would require an insurer, including health maintenance organizations, to send to an insured notice by certified mail before termination of coverage under a medicare supplement policy because of failure to pay premiums when due. The notice would have to be sent not later than 45 days after the premium due date, with the policy automatically reinstated upon payment of the delinquent amount by the insured within 15 days of notice.

I introduced this legislation after being informed by one of my elderly constituents that her policy had been terminated for nonpayment of premium. She was not aware she had failed to remit her premium until she reviewed her checking account. To her knowledge she never received notice that her premium was overdue.

Hopefully we are all aware of the possibility of oversight regarding some of our financial matters, especially our elderly.

I hope that after reviewing this piece of legislation, you will give it favorable consideration, and help protect our elderly.

Thank you Mr. Chairman and members of the Committee.

I am Margaret L. Gebhardt, from Bonner Springs, Wyandotte County.

I wish to speak in behalf of HB 2090. This bill is not a new issue, but this is the third attempt to do justice for our Kansas citizens. It deserves our attention and hopefully will receive your support and will pass this year.

When this was brought up before, the Insurance Companies would have us believe they sent a certified letter to the payee's who had failed to send their premium in for one reason or another, warning them they were past due, that they would go in the red.

I would predict in my home town of 6,000 population plus, there might be one or two that might need to be sent a certified letter. Could this be a cost factor to a Health Insurance Company that pays only 20% of the approved amount made by Medicare, which pays 80%. And sometimes they don't pay the 20%. Also hospitals are forced by medicare and the insurance companies to release a patient before the stitches are removed or able to be up and do for themselves, so actually the hospital cost is lessened and the patient is sent to a Nursing Home or home without adequate care for which there is nothing paid by the health insurance companies.

If we were furnished an annual report of the Health Insurance Companies, do you think you would find they have a deficit or made a very sizable profit. I'm sure the latter would be the rule.

Therefore rather than to allow anyone to lose their protection I pray you'll vote in favor of this Bill 2090 and have it become law.

You will feel great if you have kept just one person from having their hospital insurance cancelled, leaving them without any protection.

Thanks for your support, you won't regret your insuring each hospital insurance policy holder of this guarantee for so little cost.

TESTIMONY ON H.B. 2090
TO
HOUSE INSURANCE COMMITTEE
BY
KANSAS DEPARTMENT ON AGING
FEBRUARY 11, 1987

Bill Summary:

Requires certified mail notice of premium due before cancellation of Medicare supplement policies and other accident and sickness policies insuring persons age 65 and over.

Bill Brief:

1. Prohibits termination of insurance policies issued or delivered in this state unless the insurer has sent a certified notice of termination for failure to pay the premium.

2. Requires automatic reinstatement as continuous coverage without lapse if premium paid within 15 days of notice being mailed.

3. Certified mail requirements are not applicable when payment is made through pre-authorized check or bank drafts; two certified notices are sent within the preceeding 12-month period; or if the billing is sent to someone rather than the insured, a guardian, conservator or trustee of the insured.

4. Requirements also apply to health maintenance organizations.

Bill Testimony:

Owning a Medicare supplement policy or another type of health insurance coverage is a necessity for most Medicare beneficiaries since Medicare pays less than one-half of the total health care bill of the 65 and older population. The result of termination of coverage could therefore be disastrous for people who suddenly find themselves uninsured or in some incidences uninsurable.

Premium notices may not reach the insured; premium payments may not reach the insurance company. H.B. 2090 would help protect policyholders from loss of coverage due to unintentional nonpayment of premium.

Recommended Action:

The Kansas Department on Aging recommends passage of H.B. 2090. The ability of Older Kansans to not only obtain insurance coverage but retain that coverage is vitally important. It seems only fair that insurance companies take this step to "ensure" that their policyholders receive notice of potential policy termination and that there is not a serious unintended loss of coverage. Certified mail guarantees that these people receive adequate notice.

LD:mj
2/11/87

NAME _____ ID NUMB _____

ADDRESS _____

TELEPHONE # _____

_____ 1. It is too expensive.

_____ 2. Poor service; please explain _____

_____

_____ 3. I moved out of state.

_____ 4. I now have **YOUR** coverage through a new group.

_____ 5. I now have **OTHER** coverage through a new company.

_____ 6. Please name new company _____

_____ 7. I didn't intend to cancel my coverage. Please contact me.

_____ 8. Other _____

_____

29-132 11/85

House Insurance Committee
February 11, 1987
Att. 6

POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY CARD

FIRST CLASS PERMIT NO. 3047 TOPEKA, KANSAS

POSTAGE WILL BE PAID BY ADDRESSEE

BLUE CROSS AND BLUE SHIELD

ATTN.: CHARLENE SCOTT

P.O. BOX 239

TOPEKA, KANSAS 66601-9876

February 11, 1987

TO: Jack Roberts

FROM: Dave Manley

SUBJECT: CERTIFIED MAIL BILL

Jack, attached are twenty-five (25) pink cancellation cards and a sample letter that we send with the card. The annual cost is about $14,000 - $15,000 to send certified. According to the Mail Room, the cost to send a certified letter or a registered letter is the same. That cost breakout is as follows:

75¢	for certified and registered
70¢	for return acknowledged receipt notice
22¢	per ounce postage
$1.67	total for a 1 oz. letter

On February 16, we will mail billing notices for March. All of our billing is performed over the weekend closest to the fifteenth of the month. March premiums are due March 1. If the membership remains unpaid as of April 1, we will send the pink card and the letter notifying them of cancellation.

The following is a breakout of the number of people on our bank draft, as well as our other payment options. Keep in mind that these figures only pertain to Direct Pay situations and Plan 65 accounts for approximately 120,000.

Plan 65	
38,875	Monthly bill
64,504	Bank Plan
11,977	Quarterly Pay Plan
13,254	Semi Annual Pay Plan
2,680	One Annual Payment
131,290	

As you pointed out, if we had to use a certified mail approach, it would be extremely difficult to make liberal exceptions if a subscriber did not respond in a timely manner to the certified notice. Today we are very liberal in our reinstatement policies for our Senior Citizens.

Also attached is report which indicates the results we receive from sending the cancellation notices. The December 1986 report also includes year-to-date activity. You will note for Plan 65 that we reinstated a total of two hundred and seventy (270) memberships which represented 20% of the responses we received as the result of our mailing. You will also note that the majority of the reasons dues were not paid was due to death.

In summary, based upon the responses we received, one could draw the conclusion that 80% of the cancellations for non-payment of dues were intentional with the other 20% being accidental or unintentional cancellations which were reinstated. One way to look at this is that companies are being asked to incur additional expense for a relatively small part of the population.

If you need additional information, please let me know.

DEM/jah
attachment

January 28, 1987

TO: Wayne Johnston, Tom Miller, John Knack, Mike Mattox

FROM: Dave Manley

Here is Charlene's most recent update concerning Direct Pay Cancellations.

DATE: January 23, 1987

TO: Dave Manley

FROM: Charlene Scott

SUBJECT: DIRECT PAY CANCELLATION RESPONSES DECEMBER, 1986

Attached is the monthly report on cancellation responses received in December, 1986.

For the subscribers under age 65, requests for reinstatement continue to be the top category of response. Twenty-six and seven-tenths percent (26.7%) responses requested reinstatement. Cancellations for a new company with 15.6% and cancellation for "ridered" conditions with 15.6% were the next highest categories.

For the Plan 65 subscribers, death, representing 34.3% was the highest category of cancellation. This was followed by request for reinstatement was 29.3% of the responses. You will note that requests for cancellation because of a new company have declined.

023917
204
cs20/01m

DIRECT PAY CANCELLATION RESPONSES
DECEMBER 1986

	REGULAR BUSINESS				PLAN 65			
	Monthly		YTD		Monthly		YTD	
	#Rec	%	#Rec	%	#Rec	%	#Rec	%
Dues too high	8	12.5	165	10.3	2	2.0	47	3.5
Poor Service	4	6.3	24	1.5	5	5.1	20	1.5
Moved out of state	3	4.7	98	6.1	6	6.1	44	3.3
New Group	3	4.7	171	10.7	3	3.0	31	2.3
New Company	10	15.6	420	26.2	8	8.1	471	34.9
Reinstate	17	26.7	464	28.9	29	29.3	270	20.0
Death	0	0	51	3.2	34	34.3	455	33.7
Laid off	0	0	6	.4	0	0	0	0
Ridered	10	15.6	128	8.0	0	0	0	0
New Job	0	0	39	2.4	0	0	0	0
Medicaid	0	0	1	.1	0	0	9	.7
Nursing Home	0	0	0	0	0	0	1	.1
VA Hospital	0	0	0	0	0	0	1	.1
KU	0	0	18	1.1	0	0	0	0
Retired	0	0	0	0	0	0	1	.1
Married	0	0	5	.3	0	0	0	0
Out of Work	0	0	4	.3	0	0	0	0
Info Only	0	0	1	.1	0	0	0	0
Divorce	0	0	1	.1	0	0	0	0
Military	0	0	2	.1	0	0	0	0
Welfare	0	0	1	.1	0	0	0	0
On Parent's coverage	0	0	1	.1	0	0	0	0
Left Country	0	0	3	.2	0	0	0	0
Enrollment Requlations	0	0	1	.1	0	0	0	0
(YTD TOTAL			1604				1350)	

copy to CC 8493

1133 Topeka Avenue • P.O. Box 239 • Topeka, Kansas 66629
(913) 232-1000

Blue Cross
of Kansas

Blue Shield
of Kansas

FEBRUARY 02, 1987

OUR RECORDS INDICATE THAT YOUR COVERAGE WITH BLUE CROSS AND BLUE SHIELD OF KANSAS TERMINATED AS OF JANUARY 01, 1987. WE REGRET TO LOSE YOU AS ONE OF OUR SUBSCRIBERS.

BECAUSE WE ARE INTERESTED IN IMPROVING OUR SERVICE IN ANY WAY POSSIBLE, WE WOULD APPRECIATE IT IF YOU WOULD TAKE A FEW MINUTES AND TELL US WHY YOUR MEMBERSHIP WAS TERMINATED. PLEASE COMPLETE THE ENCLOSED CARD AND RETURN IT TO US.

IF YOU HAVE ANY QUESTIONS CONCERNING YOUR COVERAGE WITH BLUE CROSS AND BLUE SHIELD OF KANSAS, PLEASE CONTACT ONE OF OUR CUSTOMER SERVICE REPRESENTATIVES AT 1-800-432-3990 OR 232-1622 FOR TOPEKA.

THANK YOU FOR YOUR ASSISTANCE.

Charlene Scott

CHARLENE SCOTT
DIRECTOR, CUSTOMER SERVICE CENTER

House Insurance Committee
February 11, 1987
Att. 8

February 11, 1987

OUTLINE OF TESTIMONY
PRESENTED ON BEHALF OF
AMERICAN FAMILY LIFE ASSURANCE COMPANY
PERTAINING TO HOUSE BILL 2090

I. COSTS

A. Certified mail postage is greater than bulk rate postage.

B. Additional manual labor will be needed to comply with the bill.

C. Computers will need to be reprogrammed to differentiate Medicare supplement policies from other insurance policies, and to differentiate insureds over the age of 65 from all other insureds.

II. AFFORDABILITY

A. The increased costs will be incorporated into the price of the product, and may discouarge consumers from purchasing this needed protection.

III. EFFECT OF CERTIFIED MAIL

A. Certified mail only provides evidence that the sender mailed an item on a particular day.

IV. ALTERNATIVE OF CERTIFIED MAIL

A. Notices sent pursuant to this bill be enclosed in an envelope clearly identified with language, prescribed by the Insurance Commissioner, that a premium notice is enclosed.

House Insurance Committee
February 11, 1987
Att. 9

TELEX 210205
TELECOPIER
(312) 701-3100

COMBINED INSURANCE COMPANY OF AMERICA

SERVICE SECURITY STRENGTH

123 NORTH WACKER DRIVE • CHICAGO, ILLINOIS 60606

CHARLOTTE LIPTAK
COUNSEL
(312) 701-3811

February 10, 1987

Mr. Stephen W. Robertson, Counsel
Health Insurance Association of America
1350 East Touhy Avenue
Des Plaines, Illinois 60018

RE: Kansas - House Bill 2090

Dear Steve:

We have a number of different products that would be effected by the bill. The billing modes for each type vary, so premium renewal notices vary as well. Most of our products are field renewed on a biannual basis. For instance, the town of Lawrence might be a route month one; this means that an agent will be in Lawrence renewing and selling policies in January and July of each year. During January, policies could have due dates anywhere from the end of December to the beginning of February. The agent would be in Lawrence sometime during the month of January to renew those policies.

If the agent is unable to renew a policy, the renewal card is returned to the company by approximately the end of the route month. A late payment offer ("Special Offer") is then generated by the computer and sent within two weeks of when the home office receives the card. A copy of this Special Offer is attached. It tells the insured what policies are involved, the amount of the premium, the due date, and the date by which he can pay this premium and retain uninterrupted coverage. As you can see, the person can maintain continuous coverage even though premium is paid well after the grace period.

If the agent does not return the renewal card to the company, then an audit notice will be generated by the computer and sent to the insured within 10 weeks after the end of the route month. Again, the notice would list the policy numbers, the premium due, the due date and would offer reinstatement without lapse in coverage if the premium is paid by a certain date stated on the notice.

House Insurance Committee
February 11, 1987
Att. 10

For certain policies that are mail renewed only, four premium notices are sent. The first notice is sent two or three weeks before the due date. The second notice is called a "final notice", and is sent two to three weeks after the due date. The third notice is a "lapse notice" and is sent two to three weeks after the expiration of the grace period, and offers reinstatement without any lapse in coverage if premium is paid by a certain date stated on the notice. The last notice is called a "reinstatement notice" and is sent approximately six months after the due date and also offers reinstatement without lapse in coverage if the premium is paid by a certain date.

For other policies that are mail renewed only, three premium notices are sent. The first notice is sent two to three weeks before the due date. The second notice is sent approximately two weeks after the due date. The third notice is sent approximately four weeks after the due date and offers reinstatement without lapse in coverage if premium is paid and the application for reinstatement sent within a certain time stated in the notice.

For medicare supplement policies two premium renewal notices are sent. The first notice is sent approximately one month before the due date and the second notice is sent approximately on the due date.

All premium notices are sent in envelopes that are marked with the words "PREMIUM NOTICE". In addition, if a premium notice is returned undeliverable, we will check our records for a different or more recent address. We will resend the notice to this second address.

Also, our system can take into account the reasons for a nonrenewal. For instance, if the nonrenewal is because the insured has died, the agent writes "deceased" on the card and no premium notice will be generated. We note that House Bill 2090 does not take the reasons for nonrenewal into account. It would require us to send notices, even if we knew that the insured was deceased. This is an upsetting inconvenience for the surviving family and an unnecessary cost for the company.

Currently, our premium renewal notices are mailed on a "presort" basis. Approximately 99% of these notices qualify for presorting which helps control costs. The cost for each premium renewal notice sent on a presorted basis is approximately 20¢. To send notices by certified mail would cost $1.87 for each mailing to each policyholder. This does not include the cost of materials/ stationary and labor. It also does not take into account the increased time in getting materials mailed because they would have to be sent certified.

Because of the increase in the cost of mailing, the company would have to consider discontinuing any further renewal notices after the certified mail notice. For instance, a policyholder who has a sickness hospital indemnity policy currently gets an initial premium renewal notice plus two lapse notices, for a total approximate cost of 60¢. However, if we were required to send a certified mail notice, the cost of an initial premium renewal notice and just one lapse notice would be $2.07 per policyholder.

The bill would also require us to revise our data processing systems to accommodate a new procedure. This would be complicated since the bill only affects certain types of our policies and certain insureds. There are 17 different form numbers for the different types of coverage, and each form number means a different program. The insureds involved would be those only ages 65 and over, and who are not on a preauthorized check billing system.

Other items that complicate the process are:

1. Deciding on a selection date for sending the notices. If a notice is to be sent within 45 days after the due date, but after the 30 day grace period, that leaves us only a 15 day period to select individuals who need to be sent the notices. Because of the time needed to process the notices, people would be selected who had already paid an agent, but whose payment had not yet been received at the home office prior to selection. This would undoubtedly cause confusion for our policyholders.

2. Selection of policyholder by age. Currently the age of the policyholder plays no part in our billing modes. This would have to be taken into account in revising the system. Thus, for our policyholders under 65, the billing procedures would stay the same, but for those 65 and older, the billing procedures would change.

The cost to revise the programs and implement new programs, would be approximately $35,000. It would take approximately 2½ to 3 months to complete the changes. Also, there would be additional costs of approximately $100 per month for the extra computer time necessary to handle the programs.

Once data processing has revised the system, other personnel must be trained to handle the new procedures, ie. customer service, claims, and the mailing department. In addition, new materials must be devised and printed.

We do not think that the extra cost, time and effort required by the bill is necessary. We already make numerous efforts to collect renewal premiums in order to retain the business. And we find that our current procedures work well. If we had to send notices by certified mail, the increased cost would probably mean that we would have to send fewer notices. This would be less beneficial to our policyholders. Thus, the bill would actually provide less protection to policyholders, rather than more.

For all of the above reasons, we are not in favor of the bill as introduced.

Very truly yours,

Charlotte

Charlotte S. Liptak

CSL:mm
Attachment

COMBINED INSURANCE COMPANY OF AMERICA
POLICY HOLDER SERVICE CENTER
5050 BROADWAY, CHICAGO, ILL. 60640

SPECIAL OFFER

LAST OPPORTUNITY TO KEEP YOUR ACCIDENT COVERAGE IN FORCE

ACT TODAY. IF PREMIUM HAS ALREADY BEEN PAID SEE REVERSE SIDE.

POLICY NO.	FORM NO.	DUE DATE
	11860	02/28/85

SEMI-ANNUAL PREMIUM
PAY $40.00 NOW

99561031118603807104000050385099

PRE-SORT ** 98531 **

IF YOUR NAME OR ADDRESS HAS CHANGED, MARK "X" IN BOX AND MAKE CORRECTIONS ON REVERSE SIDE.

H

943 STATE HWY 507
CENTRALIA WA 98531

38 07 1 9
7081

EXPIRATION DATE
05/03/85

YOUR ACCIDENT HOSPITAL INDEMNITY POLICY HAS LAPSED.
RENEW IT NOW.

RETURN THIS PORTION WITH YOUR PAYMENT — WRITE YOUR POLICY NO. ON YOUR CHECK

DETACH AND RETAIN THIS PORTION FOR YOUR RECORDS

	POLICY NO.	FORM NO.	DATE PAID	AMOUNT	CHECK NO.
MELISSA D WOODS	99561031	11860		$	

09 38 07 1 4000 050385

OUR RECORDS SHOW THAT THE PREMIUM WAS NOT RECEIVED WHEN DUE OR WITHIN THE 31-DAY GRACE PERIOD PROVIDED. IF THE PREMIUM IS RECEIVED BEFORE THE EXPIRATION DATE NOTED ABOVE, THE POLICY WILL BE RENEWED WITHOUT LAPSE IN COVERAGE. PREMIUM RECEIVED AFTER THIS DATE WILL BE ACCEPTED IN ACCORDANCE WITH THE REINSTATEMENT PROVISION OF THE POLICY.

FORM 101512-F CODE 540F COMBINED INSURANCE COMPANY OF AMERICA - 5050 Broadway, Chicago, IL 60640

SPECIAL OFFER

Security Benefit Life Insurance Company
A Member of The Security Benefit Group of Companies

Date: February 11, 1987

To: The Honorable Dale Sprague, Chairman, and
Honorable Members, House Committee on Insurance

From: Wayne Morris, Legal Department

Re: H.B. 2090--Certified Mail for Lapse and
Reinstatement Notices

I am Wayne Morris, Assistant Counsel for Security Benefit Life Insurance Company.

Security Benefit Life joins with other members of the Kansas Life Association in strong opposition to H.B. 2090.

We oppose H.B. 2090 for many of the same reasons that we opposed a similar proposal, 1985 H.B. 2290. Although the current proposal is in some ways more limited than the earlier bill, H.B. 2090 would also impose additional new burdens in another way. Specific reasons for our opposition include:

1. The bill is unnecessary. Almost every company offering health insurance or "medigap" policies allows and even encourages policyholders to use automatic bank drafts for payment of premiums. This feature can be especially helpful to older policyholders and eliminate all possible concern about the timely payment of premiums;

2. The bill would substantially increase postage costs, along with the substantial cost to comply with what would be a law unique to Kansas;

3. If the insured is incapacitated, the receipt of a notice by certified mail will still not guarantee that the insured understands the notice;

4. The bill requires that the notice go to the insured. The policyholder -- the person who pays the premium -- maybe different from the insured and thus the notice may not reach the person responsible for premium payment; and finally

5. The bill would go further than its predecessor and require that the certified notice go to the insured after the premium was due, and that it would set forth the reinstatement procedure. "At best," this would effectively

700 Harrison, Topeka, Kansas 66636 (91

House Insurance Committee
February 11, 1987
Att. 11

give the insured up to 45 days of free insurance. "At worst," this procedure could be an unconstitutional interference with existing private contracts.

In summary, we are opposed to the particular provisions of this bill, and we are also concerned about the dangerous precedents that could be established if this bill becomes law.

Thank you for the opportunity to present our views, and I will be happy to attempt to answer any questions you may have.

sl

-Wayne