Approved January 29, 1987
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

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

9:00 a.m./~~p.m.~~ on January 27, 1987 in room 529-S of the Capitol.

All members were present except:

Committee staff present:

Bill Wolff, Legislative Reserach
Myrta Anderson, Legislative Research
Bill Edds, Revisor of Statutes

Conferees appearing before the committee:

Bud Grant, Kansas Chamber of Commerce and Industry
Mel Battin, Consumer Credit Commissioner
Dick Brock, Kansas Insurance Department
Sylvia Hougland, Health Care Plus
Dick Brummett, M. D., Health Care Plus

The minutes of January 22 were approved.

Bud Grant, Kansas Chamber of Commerce and Industry, requested the introduction of a bill dealing with the inclusion of consumer goods in the requirement that a financing statement be filed under the uniform commercial code. The bill was heard last session (SB 502), was amended by the House committee, but never got debated on the floor. (See Attachment I).

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

Mel Battin, Consumer Credit Commissioner's Office, followed with a request for the introduction of a bill amending the uniform consumer credit code. (See Attachment II.)

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

Dick Brock, Kansas Insurance Department, requested the introduction of six bills. (See Attachments III through VIII.)

Sen. Werts made a motion to introduce the package of bills and refer them back to committee, Sen. Burke seconded, and the motion carried.

At this time, the chairman announced that there would be a committee meeting this coming Thursday, January 29, for the introduction of two more bills and for committee discussion of the bills heard last week.

The chairman called on Sylvia Hougland, Health Care Plus, for her informational presentation regarding managed health care. (See Attachments IX, X, and XI.) After a few introductory comments regarding her outline (See Attachment IX), she introduced Dr. Dick Brummett also with Health Care Plus to continue with the presentation. Dr. Brummett dealt mainly with how organized medicine can control the cost of health care.

After a short discussion as to the meaning of "defensive medicine" by Sen. Burke, Dr. Brummett, and Mrs. Hougland, the chairman noted that there are none of these organizations in Western Kansas. Dr. Brummett said his organization operates best where there is a large population which explains why there are none in Western Kansas. Sen. Karr stated that creative ways need to be developed to reach the uninusred and the indigent, and he feels that this should be a concern of Equicor. Mrs. Hougland said the PPOs and Medicaid work with indigents whereas the HMOs are for the employed. Dr. Brummett felt that the responsibility is with the government and private industry.

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE,

room 529-S, Statehouse, at 9:00 a.m./~~p.m.~~ on January 27, 1987.

The chairman asked for a definition of "competitive medical plan". Mrs. Hougland explained that it is a phrase used for Medicare contracts with HMOs for older people's service. The chairman asked further if there is a conversion provision for HMOs when a company goes out of business. Mrs. Hougland said that the business must offer a conversion plan, however, those under COBRA benefits receive a continuation of benefits.

The meeting was adjourned.

SENATE COMMITTEE

ON

FINANCIAL INSTITUTIONS AND INSURANCE

OBSERVERS
(Please print)

DATE	NAME	ADDRESS	REPRESENTING
1-27/87	Ron Todd	Topeka	Ins. Dept.
	Bob Arbuthnot	Topeka	KTLA
	Richard Harmon	Topeka	Health Care Plus
	Dick Brummett, MD	Wichita	Health Care Plus
	Sylvia Hougland	—	Health Care Plus
	Tom Palace	Topeka	Savings League Services
	Mark Biberstein	Emporia	Sen. Burke
	Dick Brock	Topeka	Ins. Dept.
	Bill Curtis	Topeka	Ks. Assoc. of School Bds.
	Marilyn Bradt	Lawrence	Kansans for Improvement of Nursing Homes
	Mel Battini	Topeka	Consumer Credit Comm
	Larry Magill	Topeka	IIAK
	Mark Intermill	Topeka	Kansas Coalition on Aging
	Walter Darling	Topeka	Division of Budget
	Bud Grant	"	KCCI

As Amended by House Committee

Session of 1986

SENATE BILL No. 502

By Committee on Financial Institutions and Insurance

1-29

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 a consumer ~~goods~~ **good with a value of $1,000 or less,** *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

Attachment I
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filing under this article is required in order to continue the perfected status of the security interest against 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.

7 RS 009

Draft

SENATE BILL NO. _____

AN ACT amending the uniform consumer credit code; concerning consumer credit insurance; relating to rules and regulations; amending K.S.A. 16a-2-501 and 16a-3-206 and repealing the existing sections.

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

Section 1. K.S.A. 16a-2-501 is hereby amended to read as follows: 16a-2-501. (1) In addition to the finance charge permitted by the parts of this article on maximum finance charges for consumer credit sales and consumer loans (parts 2 and 4), a creditor may contract for and receive the following additional charges in connection with a consumer credit transaction:

(a) Official fees and taxes;

(b) charges for insurance as described in subsection (2);

(c) annual charges, payable in advance, for the privilege of using a lender credit card which entitles the user to purchase goods or services from at least ~~one-hundred-(100)~~ 100 persons not related to the issuer of the lender credit card, under an arrangement pursuant to which the debts resulting from the purchases are payable to the issuer;

(d) charges for other benefits, including insurance, conferred on the consumer, if the benefits are of value to ~~him~~ the consumer and if the charges are reasonable in relation to the benefits, are of a type which is not for credit, and are excluded as permissible additional charges from the finance charge by ~~rule~~ rules and regulations adopted by the administrator.

(2) An additional charge may be made for insurance written in connection with the transaction, including vendor's single interest insurance with respect to which the insurer has no right of subrogation against the consumer but excluding other insurance

protecting the creditor against the consumer's default or other credit loss~~,~~:

(a) With respect to insurance against loss of or damage to property, or against liability, if the creditor furnishes a clear and specific statement in writing to the consumer setting forth the cost of the insurance if obtained from or through the creditor and stating that the consumer may choose the person through whom the insurance is to be obtained; and~~,~~

(b) with respect to consumer credit insurance providing life, accident~~,-or~~ and health, or loss of employment coverage, if the insurance coverage is not a factor in the approval by the creditor of the extension of credit, and this fact is clearly disclosed in writing to the consumer, and if, in order to obtain the insurance in connection with the extension of credit, the consumer gives specific affirmative written indication of ~~his~~ the consumer's desire to do so after written disclosure to ~~him~~ the consumer of the cost thereof.

Sec. 2. K.S.A. 16a-3-206 is hereby amended to read as follows: 16a-3-206. ~~(1)~~ A creditor shall disclose to the consumer the information required by the rules and regulations adopted by the administrator pursuant to K.S.A. 16a-6-117, and amendments thereto.

~~(2)--In-this-section,-creditor-includes-a-person-who-in--the ordinary-course-of-business-regularly-extends-or-arranges-for-the extension--of--credit,--or-offers-to-arrange-for-the-extension-of credit.~~

Sec. 3. K.S.A. 16a-2-501 and 16a-3-206 are hereby repealed.

Sec. 4. 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

Legislative Proposal No. 2 suggests the establishment of various requirements and standards relating to long-term care insurance.

The definition of long-term care insurance contained in this proposal is particularly important because it is intended to allow maximum flexibility in the design of long-term care benefits while assuring that the public's reasonable expectations for long-term care protection are met. Worthy of specific note is the fact that this definition is not intended to require that long-term care be medically necessary before coverage would be effective. To the contrary, it is becoming increasingly evident that residential or custodial type care is a very significant, perhaps the most significant, concern of senior citizens and the definition has been purposely drafted in a way that will permit long-term care insurance products to meet this need.

The proposal does not mandate any type of coverage. It does, however, authorize the commissioner to adopt regulations that will establish specific standards for customary contractual provisions. These would include terms of renewability, coverage of dependents, waiting periods, preexisting conditions, termination, exclusions, etc. In addition, the proposal itself contains specific minimum provisions relating to preexisting conditions.

Finally, the proposal would require the delivery of a written outline of coverage. Such outline would provide the insured a brief description of the benefits, a summary of exclusions, exceptions and limitations and various other information designed to enhance consumer understanding of the long-term care insurance product they have purchased.

It is to be emphasized that enactment of Legislative Proposal No. 2 will not resolve all the needs and desires of the public regarding long-term care. Enactment would, however, define the subject, authorize the commissioner to establish minimum standards applicable to the terms of various contractual provisions and require delivery of an outline of coverage to applicants for an individual long-term care insurance policy.

Enactment of this proposal will not solve all the problems relating to long-term care insurance. It will, however, establish a foundation which can serve as a guide to product development and, more important, it will establish minimum performance and disclosure requirements that will enable senior citizens to become better informed purchasers.

LEGISLATIVE PROPOSAL NO. 2

AN ACT relating to insurance; long-term care insurance; definitions; disclosure requirements.

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

Section 1. This act may be known and cited as the "Long-Term Care Insurance Act".

Sec. 2. The requirements of this act shall apply to policies delivered or issued for delivery in this state on or after the effective date of this act. This act is not intended to supersede the obligation of entities subject to this act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this act, except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care insurance. A policy which is not primarily advertised, marketed or offered as long-term care insurance need not meet the requirements of this act.

Sec. 3. Unless the context requires otherwise, the definitions in this section apply throughout this act.

(a) "Long-Term Care Insurance" means any insurance policy primarily advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or diagnostic, preventive, therapeutic, rehabilitative, maintenance, custodial, residential or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations, or any similar organization. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or

specified accident coverage, or limited benefit health coverage but the inclusion or attachment of long-term care insurance coverage to one of the foregoing products shall not exempt it from the requirements of this act.

(b) "Applicant" means:

(1) In the case of an individual long-term care insurance policy, the person who seeks to contract for such benefits, and

(2) in the case of a group long-term care insurance policy, the proposed certificateholder.

(c) "Certificate" means, for the purposes of this act, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

(d) "Commissioner" means the insurance commissioner of this state.

(e) "Group long-term care insurance" means a long-term care insurance policy:

(1) Delivered or issued for delivery in this state and issued to a group as defined in K.S.A. 40-2209:

(2) No group long term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group defined in (e)(1), unless this state or another state having statutory and regulatory long term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

(f) "Policy" means, except as otherwise provided in subsection 3(e)(2) of this act, any individual or group policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization or any similar organization.

Sec. 4. Disclosure and performance standards for long-term care insurance. (a) The commissioner may issue reasonable regulations:

(1) To establish specific standards for policy provisions of long-term care insurance policies. Such standards shall be in addition to and in accordance with applicable laws of this state, and shall address terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, probationary periods, limitations,

exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms; or

(2) To specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair or unfairly discriminatory to any person insured under a long-term care insurance policy.

(b) Regulations issued by the commissioner shall:

(1) Recognize the unique, developing and experimental nature of long-term care insurance; and

(2) recognize the appropriate distinctions necessary between group and individual long-term care insurance policies.

(c) The commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

(d) No long-term care insurance policy may:

(1) Be cancelled, nonrenewed, or otherwise terminated solely on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificateholder; or,

(2) Contain a provision establishing any new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

(e) Preexisting condition:

(1) No long-term care insurance policy or certificate shall use a definition of "preexisting condition" which is more restrictive than the following: Preexisting condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment, or a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within the limitation periods specified in (A) and (B) below:

(A) Six months preceding the effective date of coverage of an insured person who is 65 years of age or older on the effective date of coverage; or

(B) twenty-four months preceding the effective date of coverage of an insured person who is under age 65 on the effective date of coverage.

(2) No long-term care insurance policy may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within the periods specified in (A) or (B) below:

(A) Six months following the effective date of coverage of an insured person who is 65 years of age or older on the effective date of coverage; or

(B) twenty-four months following the effective date of coverage of an insured person who is under age 65 on the effective date of coverage.

(3) The commissioner may extend the limitation periods set forth in subsections 4(e)(1) and 4(e)(2) above as to specific age group categories or specific policy forms upon finding that the extension is not contrary to the best interest of the public.

(4) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards.

(f) No long-term care insurance policy shall require prior institutionalization as a condition precedent to the payment of benefits.

(g) In order to provide for fair disclosure in the sale of long-term care insurance policies:

(1) An outline of coverage shall be delivered to an applicant for a long-term care insurance policy at the time of application. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. Such outline of coverage shall include:

(A) A description of the principal benefits and coverage provided in the policy;

(B) a statement of the principal exclusions, reductions and limitations contained in the policy;

(C) a statement of the renewal provisions, including any reservation in the policy of a right to change premiums; and

(D) a statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy should be consulted to determine governing contractual provisions.

(2) A certificate issued pursuant to a group long-term care insurance policy which policy is delivered or issued for delivery in this state shall include the information required by K.S.A. 40-2209(B)(4).

(h) No policy may be advertised, marketed or offered as long-term care insurance unless it complies with the provisions of this act.

Sec. 5. This act shall take effect and be in force on and after January 1, 1988 and its publication in the statute book.

Attachment III
Senate F &I & I - January 27, 1987

Explanatory Memorandum For
Legislative Proposal No. 3

K.S.A. 40-447 was enacted by the 1977 Session of the Kansas Legislature. The purpose and intent of this legislation was quite clear in that it was designed to provide life insurers an incentive to pay death claims quickly and to require the payment of interest if they didn't. However, there is an inconsistency contained within this law which requires clarification. Specifically, subsection (a) of this bill provides that, if interest on death proceeds becomes payable, it shall be computed from the date due proof of death is received whereas subsection (c) requires the beneficiary to be notified that interest is payable from the date of death.

Since subsection (a) is the operative section that imposes the actual obligation on the insurer, since subsection (c) simply requires the beneficiary to be notified of the insurer's obligation; and since the legislative sponsor of the bill has confirmed it was his intent that interest be computed from the date of receipt of due proof of death; it has generally been assumed the language of subsection (a) controls the manner in which the interest is computed. Despite several previous efforts, the inconsistency between the two subsections has not been changed and Legislative Proposal No. 3 will address the problem.

LEGISLATIVE PROPOSAL NO. 3

AN ACT relating to insurance; interest on death proceeds; amending K.S.A. 40-447 and repealing the existing section.

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

Section 1. K.S.A. 40-447 is hereby amended to read as follows: 40-447. (a) Notwithstanding any other provision of law, each insurer admitted to transact life insurance in the state of Kansas which fails or refuses to pay the proceeds of, or payments under, any policy of life insurance issued by it within ten (10) days after the receipt of due proof of death in the manner and form requested by the policy, shall pay interest on any moneys payable and unpaid after the expiration of such ten (10) day period at a rate of not less than the current rate of interest on death proceeds left on deposit with the insurer computed from the date of said receipt. This section shall apply only to deaths of insureds which occur on or after July 1, 1977.

(b) Nothing in this section shall be construed to allow any insurer admitted to transact life insurance in this state to withhold payment of money payable under a life insurance policy to any beneficiary for a period longer than reasonably necessary to transmit such payment.

(c) In any case in which interest on the proceeds of, or payments under, any policy of life insurance becomes payable pursuant to subsection (a), the insurer shall notify the named beneficiary or beneficiaries at their last known address that interest will be paid on the proceeds of, or payments under, such policy from ~~the date~~ receipt of due proof of death of the named insured. Such notice shall specify the rate of interest to be paid.

(d) This section shall not require the payment of interest in any case in which the beneficiary elects in writing delivered to the insurer to receive the proceeds of, or payments under, the policy by any means other than a lump sum payment thereof.

(e) The commissioner of insurance may adopt such rules and regulations necessary to provide for the enforcement and administration of this act.

Sec. 2. K.S.A. 40-447 is hereby repealed.

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

Attachment IV
Senate F I & I - January 27, 1987

Explanatory Memorandum For
Legislative Proposal No. 4

Legislative Proposal No. 4 amends the unfair trade practices act by inserting provisions that would make it a defined unfair trade practice for an insurer to refuse to insure or refuse to continue to insure or limit the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the coverage solely because of blindness or partial blindness. This provision was promoted and supported by the National Federation of the Blind and, through an agreement with the National Association of Insurance Commissioners, most states are attempting to obtain passage of the legislation.

LEGISLATIVE PROPOSAL NO. 4

AN ACT relating to insurance; concerning unfair and deceptive acts; refusing to insure blind persons; 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. 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 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) 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 such person's 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. 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.

Attachment V
Senate F I & I - January 27, 1987

Explanatory Memorandum For
Legislative Proposal No. 5

The Health Care Provider Insurance Act provides for the establishment of a mechanism which enables health care providers to obtain required medical malpractice insurance if they are unable to do so from the voluntary insurance market. From the inception of the act in 1976, these particular provisions have been subject to a sunset provision whereby the requirements pertaining to the residual market mechanism or medical malpractice JUA as it is often called would expire as of a given date. Current law provides for an expiration date of July 1, 1987. This means if there is no amendment enacted into law by this session of the legislature, health care providers will still be subject to a compulsory insurance requirement but may not be able to obtain the required coverage.

Legislative Proposal No. 5 addresses this problem by suggesting that the sunset provision be totally removed from the law. An alternative would, of course, be to simply amend "1987" to some later year. However, as long as there is a compulsory insurance requirement, an availability mechanism will be necessary. Therefore, the proposal would simply eliminate the provisions relating to expiration of the plan and, by so doing eliminate periodically requiring the legislature to extend its life.

LEGISLATIVE PROPOSAL NO. 5

AN ACT relating to insurance; health care provider liability insurance; apportionment of risks; expiration of plan; amending K.S.A. 40-3413 and repealing the existing section.

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

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

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

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

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

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

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

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

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

(d) If, after a hearing, the commissioner finds that any activity or practice of any insurer or rating organization in connection with the operation of such plan or plans is unfair or unreasonable or otherwise inconsistent with the provisions of this act, the commissioner may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this act and requiring discontinuance of such activity or practice.

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

and one member shall be a health care provider. The members shall be appointed for a term of two years.

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

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

Sec. 2. K.S.A. 40-3413 is hereby repealed.

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

Attachment VI
Senate F I & I - January 27, 1987

Explanatory Memorandum For
Legislative Proposal No. 9

This proposal suggests a relaxation of requirements regarding the errors and omissions liability coverage required as a condition of obtaining a Kansas broker's license. Specifically, it would remove the requirement that coverage remain in effect for 2 years after termination of the broker's license; that evidence of such coverage be provided the commissioner; that coverage be continuous; and, that any self-retention be covered by a faithful performance bond. Removal of the requirement for continuous coverage will, in turn, permit abrogation of a requirement that the Commissioner be provided 30 days advance notice of any cancellation.

The constriction in liability insurance markets has produced an environment where it is very difficult for brokers and excess lines agents to obtain errors and omissions coverage because of the unique Kansas requirements. This occurs at the same time insurance purchasers are in need of as many insurance market facilities as possible. As a result, a moderation of Kansas requirements seems to be in order even though doing so will reduce the public safeguards currently in place.

LEGISLATIVE PROPOSAL NO. 9

AN ACT relating to insurance; relating to applicants for a brokers license, requirements; errors and omissions coverage, amount; self retention; dishonesty bond, amount, form, cancellation.

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

Section 1. K.S.A. 40-3711 is hereby amended to read as follows: 40-3711. Every applicant for a broker's license shall ~~file with the commissioner, and upon approval such applicant's application,~~ maintain in force while licensed ~~and for at least two years following termination of such license, evidence satisfactory to the commissioner of~~ an errors and omissions policy covering the individual applicant in an amount of not less than $100,000 total liability limit per occurrence, subject to not less than $100,000 annual aggregate for all claims made during the policy period; or, covering the applicant under blanket liability policy or policies, which policy or policies can include other coverage on an excess basis over $100,000 primary, insuring other insurance agents or brokers in an amount of not less than $500,000 total liability limit per occurrence subject to not less than $500,000 annual aggregate for all claims made during the policy period. Such policy shall be issued by an authorized insurance company or as authorized by K.S.A. 40-246b or 40-246c, and amendments thereto, ~~shall be continuous in form and shall provide coverage acceptable to the commissioner~~ for errors and omissions of the broker. Self-retention shall be permitted ~~to a maximum of $10,000 on policies covering an individual and $50,000~~ on ~~blanket~~ liability policies covering the applicant. ~~Self-retention in excess of these amounts shall be permitted only upon filing with the commissioner a faithful performance bond in a form prescribed by the commissioner. Such bond shall be continuous in nature issued by a surety authorized to transact business in Kansas and be in a principal sum equal to the amount of self retention in excess of that otherwise permitted. In addition to such errors and omissions policy and faithful performance bond if applicable,~~ The applicant shall file with the commissioner a dishonesty bond in the amount of $5,000 executed by an authorized surety company in

Attachment VII
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favor of the people of Kansas. Such bond shall be issued in a form prescribed by the commissioner and shall be continuous in nature. The surety may cancel the bond upon 30 days' written notice to the commissioner.

Sec. 2. K.S.A. 40-3711 is hereby repealed.

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

Attachment VII
Senate F I & I - January 27, 1987

Explanatory Memorandum For
Legislative Proposal No. 10

This proposal suggests a relaxation of requirements regarding the errors and omissions liability coverage required as a condition of obtaining a Kansas excess lines license. Specifically, it would remove the requirement that coverage remain in effect for 2 years after termination of the excess lines license; that evidence of such coverage be provided the commissioner; that coverage be continuous; and, that any self-retention be covered by a faithful performance bond. Removal of the requirement for continuous coverage will, in turn, permit abrogation of a requirement that the Commissioner be provided 30 days advance notice of any cancellation.

The constriction in liability insurance markets has produced an environment where it is very difficult for brokers and excess lines agents to obtain errors and omissions coverage because of the unique Kansas requirements. This occurs at the same time insurance purchasers are in need of as many insurance market facilities as possible. As a result, a moderation of Kansas requirements seems to be in order even though doing so will reduce the public safeguards currently in place.

LEGISLATIVE PROPOSAL NO. 10

AN ACT relating to insurance; relating to excess lines agents; errors and omissions coverage required.

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

Section 1. K.S.A. 40-246f is hereby amended to read as follows: 40-246f. Every applicant for an excess lines license shall ~~file with the commissioner and upon approval of such applicant's application~~ maintain in force while licensed ~~and for at least two years following termination of such license, evidence satisfactory to the commissioner of~~ an errors and omissions policy covering the individual applicant in an amount of not less than $100,000 total liability limit per occurrence, subject to not less than $100,000 annual aggregate for all claims made during the policy period or covering the applicant under blanket liability policy or policies, which policy or policies can include other coverage on an excess basis over $100,000 primary, insuring other insurance agents or brokers in an amount of not less than $500,000 total liability limit per occurrence subject to not less than $500,000 annual aggregate for all claims made during the policy period. Such policy shall be issued by an authorized insurance company or as authorized by K.S.A. 40-246b or 40-246c, and any amendments thereto, ~~shall be continuous in form and shall provide coverage acceptable to the commissioner~~ for errors and omissions of the excess lines agent. Self-retention shall be permitted ~~to a maximum of $10,000 on policies covering an individual and $50,000~~ on ~~blanket~~ liability policies covering the applicant. ~~Self-rentention in excess of the aforesaid amounts shall be permitted only upon filing with the commissioner a faithful performance bond in a form prescribed by the commissioner. Such bond shall be continuous in nature, issued by a surety authorized to transact business in Kansas and be in a principal sum equal to the amount of self retention in excess of that otherwise permitted.~~

Sec. 2. K.S.A. 40-246f is hereby repealed.

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

Attachment VIII
Senate F I & I - January 27, 1987

A GUIDE TO MANAGED CARE

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

PREFERRED PROVIDER ORGANIZATIONS (PPOs)

COMPETITIVE MEDICAL PLANS (CMPs)

HEALTH CARE PLUS OF AMERICA
2959 ROCK ROAD
WICHITA, KANSAS 67226

Attachment XI
Senate F I & I - Jan.27,1987

GUIDE TO MANAGED CARE: HMOs, PPOs, and CMPs

Today, there are major changes going on in both the health care and health insurance systems.

In response to rising costs and the need for greater efficiency and cost containment, a variety of alternatives have been developed to meet the market needs of Government and Business.

HMOs, PPOs, and CMPs are critical elements in these managed care systems.

We offer this brief guide to assist you in understanding HMOs and PPOs.

WHAT IS AN HMO

An HMO combines the delivery of Health Care and the insurance of health care into one organization (or legal entity).

HMOs provide or arrange for the delivery of all health care through physicians and hospitals they contract with or who work for them.

Usually, the HMO contracts with an employer to provide HMO health care to its employees as an alternative to regular health insurance.

A fixed pre-paid charge is paid to the HMO on a capitated basis to deliver the health care services.

These payments (pre-determined and fixed) are made on behalf of each person or family unit enrolled, usually paid monthly, regardless of the amount of actual services used by the member. The HMO must provide all the health care services agreed on.

If costs are higher than the capitations, the HMO loses money. If they stay below estimates they make money or increase reserves.

The incentive in a pre-paid system is to decrease utilization through more preventive care, greater utilization controls, and emphasis on the whole health of the person rather than on a specific illness.

HOW DO HMOs WORK

HMO members must use the HMO's organized services. Referrals to all health Care is made by the HMO physician chosen by the member.

Hospital costs, preventive care, ancillary services, home health etc. are paid by the HMO according to the structure of the HMO.

Since the HMO is capitated, services must be provided through the HMO system for them to be paid. There are always provisions for payment for emergency and urgently needed services under the guidelines of each HMO.

Members select their physician from the doctor who works for or contracts with the HMO.

Generally, the physician selected becomes the Primary Care Physician (PCP) or the "Gatekeeper". The PCP oversees and directs the care by referring to specialists when needed, admitting to the hospital, and overseeing all other health services for the person.

This "Gatekeeper" system is essential to the HMO concept.

ELIGIBILITY, ENROLLMENT, AND COMMUNITY RATING

Generally, since HMOs are offered through employers, any employee and their family is eligible to join during an open enrollment period.

Few HMOs in Kansas enroll individuals outside of the employer group.

Only medicare beneficiaries under Medicare Risk Contract HMOs are enrolled individually.

Federally qualified HMOs are community and not experience rated. In Kansas, there are no specific provisions in statute preventing state licensed HMOs from experience rating. Review is on a case basis. As of now, there are no experience rated HMOs.

Most HMOs do not have pre-existing condition clauses.

CHOICE

Employees generally have a choice between regular indemnity type of insurance and the HMOs. HMOs generally fall into one of four basic organizational groups based on their relationship with their physicians:

- Staff Model
- Group Model
- Network Model
- IPA (Independent Physician Association)

A federally qualified HMO has been approved by the Office of Prepaid Health Care for complying with a set of quality assurance and financial standards.

In order to be federally qualified, the HMO must conform to the 42 CFR which outlines the Health Benefits, Community rating requirements, availability and accessibility, organizational and fiscal requirements.

KANSAS STATUTE
KSA - 40-3201 thru 40-3227
Health Maintenance Organization

Regulatory authority rests in the Commissioner of Insurance and covers application, contracts, investment and fiduciary responsibilities, rates and examinations, as well as the definitions, responsibilities, and powers of the HMO.

The original Legislation was drafted in 1974.

BASIC HEALTH SERVICES

All federally qualified HMOs must offer a basic level of health services and may offer supplemental health services. The combination of optional health services vary from company to company and are determined, as in indemnity, by the employer, based on need and cost.

In Kansas, the benefits offered under a State Qualified Only HMO is less specific covering broad categories.

Federally qualified HMOs are required to offer the following comprehensive services to all enrollees:

- Physician services (including consultant and referral)
- Inpatient and outpatient hospital services
- Diagnostic laboratory services
- Home health services
- Mental health services (including 20 outpatient visits)
- Preventive services
    a. voluntary family planning services
    b. periodic health examinations for adults
    c. eye examinations for children
    d. children's hearing examinations
    e. pediatric and adult immunization
    f. well-child care from birth
- Health education
- Medical social services

HOW COSTS ARE CONTROLLED BY HMOS

Many employers offer HMO coverage because they believe

(1) the managed care aspects will lower health care costs,

(2) and they want to give their employees a comprehensive benefit package at a fixed monthly budget.

HMOs have few out-of-pocket costs for members; the pre-paid fixed amount can be budgeted, and consumers don't have to complete claim forms.

The incentive in the HMO system is to control high costs while providing complete health care service. Patients in an HMO, on the average, spend fewer days in a hospital and other acute care settings. The overall costs are reduced by eliminating unnecessary hospitalization. Nationally HMOs experience 440 inpatient hospital days per 1000 enrollees vs. 800 inpatient days covered under insurance.

STATE LICENSING AND FEDERAL QUALIFICATION

All HMOs must be licensed in Kansas through the Kansas Insurance Commission. Many HMOs will also apply for federal qualification. You do not need to be federally qualified to offer HMO services. State Licensed Only HMOs may offer services to employers.

State Licensed HMOs must conform to state law as outlined. Like in indemnity products state regulation stresses adequacy of fiscal reserves.

PPOS (PREFERRED PROVIDERS ORGANIZATION)

WHAT IS A PPO

PPOs are the newest form of a managed system. There is no one definition of a PPO. Generally, PPOs are formed through negotiations between those who pay for care, employers and insurers, and providers who deliver care, hospitals, physicians, and practioners.

They combine health care financing and delivery by providing financial incentives to consumers to utilize a particular panel of providers.

HOW DO THEY WORK

Payers, employees or insurers, agree to encourage their employees or subscribers to use providers who have agreed to supply services at a lower cost. The PPO is usually reimbursed on a negotiated fee-for-service basis or on a predetermined set of charges for the services covered.

The agreement between the providers and payers should insure lower costs for the payer and a greater supply of patients for the providers.

Employees or subscribers generally may choose or not choose to use the provider panel; if they do not, they pay an additional charge. There is a financial incentive to the consumer to use the PPO.

There is generally an emphasis on strong utilization controls such as pre-certificat authorization, and concurrent reviews. Like HMOs, control of cost is emphasized.

CHOICE AND SELECTION

Since PPOs are not specifically regulated in Kansas, it is not clear how many Kansans are currently enrolled. Estimates run over 100,000, with approximately 60,000 in Wichita and Sedgwick Counties alone. There are between 9-13 PPOs in Kansas. Kansas PPOs usually are sponsored by Insurance companies or hospitals and physicians jointly. Generally, they are offered along with indemnity health insurance. Many employers select triple option plans that include HMOs, PPOs, and health insurance.

Employers choose PPOs because they can offer premium savings. The employee gets to choose from a network of practitioners and participating hospitals.

The PPO is generally offered along with traditional health insurance allowing the PPO to give reduced costs. Consumers receive a financial incentive to use the PPO but may also use the regular health insurance offered.

STATE AND FEDERAL REGULATION

PPOs that are sponsored by insurance companies are regulated by the Insurance Commissioner through regulation of the company. Hospital and physician sponsored PPOs are not specifically regulated. Self-Insured PPOs have broad outlines under ERISA.

COMPETITIVE MEDICAL PLANS (CMPs)

There is no real certainty on what constitutes a CMP. The term was first used in TEFRA-Tax Equity and Fiscal Responsibility Act.

The term generally applied to Medicare patients under the provisions enacted in 1985, which allowed medicare to pay for Elderly beneficiaries care through HMOs. It allowed HMOs to contract with medicare to provide service to older persons. HMOs are offered on an individual basis , to medicare enrollees.

FACTS ABOUT GROWTH: HMOs AND PPOs

Kansas (Sept. 1986)	U.S.A. (June 1986)
350,000 members (Approx. 9/86)	23.7 million members
10 HMOs State Certified	595 HMOs (1985)
8 Federally Qualified	438 Federally Qualified
2 State Licensed Only	157 State Licensed Only
9-13 PPOs	332 PPOs

Models:

- 2 Staff Models
- 1 Group Model
- 1 IPA
- 5 Combined IPA, Network, and Group Model
- 1 Non-operational for new members

*Initial HMO regulation enacted 1974.

*Only one HMO was in operation prior to 1981.

*3 HMOs have begun since 1985.

*4 HMO Applications are pending.

*25% of the Insured Population are expected to be in HMOs by 1990.

*40% of all Insured are supposed to be in PPOs and HMOs by 1990, reaching over 70 million.

Locations:

3 HMOs cover primarily Kansas counties

6 HMOs primarily serve Greater Kansas City area.

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MANAGED CARE: HMO'S, PPO'S, AND CMP'S

Presented to the
Senate Committee on
Financial Institutions and Insurance
Chairman Neil Arasmith

I. Changing Health Care and Health Insurance System

- A. Government and Market impetus for change
- B. Pre-paid vs. fee-for-service

II. Managed Care defined

- A. HMO's (Health Maintenance Organization)
- B. PPO's - (Preferred Provider Organization)
- C. CMP's - (Competitive Medical Plan)

III. HMO's

- A. Health delivery and insurance combined
- B. Variable operations and structures
- C. Basic health services
- D. Enrollment, eligibility and choice
- E. Risks and incentives
- F. Federal and State Regulations

IV. PPO's: Preferred Provider Organizations

- A. Forms and structures
- B. Enrollment, eligibility and choice
- C. Providers, buyers and payers
- D. Regulation

V. State Regulation

VI. Kansas HMO's and PPO's

VII. Trend toward national/multiple product insurance and health care companies--EQUICOR.

HEALTH CARE PLUS OF AMERICA

FACT SHEET

- Over 135,000 members
- 330 employees
  - 209 employees in Kansas
  - 175 employees in Wichita
- Network and IPA Model
- KANSAS LOCATIONS
  - Wichita
  - Lawrence
  - Salina
  - Hutchinson
  - Topeka
  - Emporia
  - Manhattan
  - Johnson County - Kansas City
  - Tri-County (McPherson, Marion, Harvey)
- Counties or portions of Counties covered (34)
  - Jefferson, Leavenworth, Miami, Anderson, Franklin, Douglas Shawnee, Osage, Coffee, Lyons, Greenwood (P), Waubaunsee, Pottawatomie, Riley, Geary, Clay, Dickson, Morris, Chase, Butler, Sedqwick, Sumner, Kingman, Harvey, Marion, McPherson, Saline, Ottawa, Ellsworth, Rice, Reno, Stafford, Pawnee, Rush, Barton.