Approved FEBRUARY 3, 1988
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by REPRESENTATIVE DALE SPRAGUE at
Chairperson

3:30 XXX a.m./p.m. on JANUARY 27, 19 88 in room 531-N of the Capitol.

All members were present except: Representative Cribbs, excused
Representative Sawyer, excused

Committee staff present: Chris Courtwright, Research Department
Bill Edds, Revisor of Statutes Office
Nancy Wolff, Secretary

Conferees appearing before the committee:

Dick Brock, Insurance Department

The meeting was called to order by the Chairman.

The minutes of the January 20, 1988 meeting were approved as written.

Chris Courtwright, Research Department reviewed the carryover bills in the committee. They are:

House Bill 2255: Liability insurance for coroners.

House Bill 2312: Cancellation of accident and sickness insurance, specifically excluding dependants.

House Bill 2314: Disallows age as a basis to cancel accident and sickness insurance.

House Bill 2329: Allows motor vehicle insurance discounts for certain persons over 55.

House Bill 2332: Creates an insurance rate review board for KPERS retirants.

House Bill 2366: Concerns making of insurance rates.

House Bill 2380: Limits rate making to Kansas experience.

House Bill 2483: Individuals could bring suit against insuror for unfair claim practices.

House Bill 2485: Makes false claims for insurance benefits a Class C felony.

House Bill 2493: Concerns suspension of drivers' license.

House Bill 2495: Concerns motor vehicle liability insurance, proof of financial security. Sought to clarify.

House Bill 2502: Established rate making advisory committee to commissioner.

House Bill 2521: Brought ATV's under no-fault law.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE,

room 531-N, Statehouse, at 3:30 P.M. a.m./p.m. on JANUARY 27, 1988, 19__.

Senate Bill 22: Requires notice before increasing premiums for property and casualty insurance.

Senate Bill 232: Required insurance adjustors to obtain two independant estimates when exceeding $5,000.

Senate Bill 133: In conference committee.

Dick Brock, Kansas Insurance Department, presented the legislation proposed by the Insurance Commissioner to ask for introduction by the committee.

Legislative Proposal No. 1 (Exhibit 1) was developed by the National Fraternal Congress to bring a greater degree of uniformity to the operation and regulation of fraternal benefit societies doing business in Kansas.

Legislative Proposal No. 2 (Exhibit 2) is the result of an Agent's Licensing Study Group. This proposal is being held for future introduction.

Legislative Proposal No. 3 (Exhibit 3) was introduced by the Senate on 1-27-88 and relates to the statutes governing the formation, operation and regulation of health maintenance organizations (HMO's).

Legislative Proposal No. 4 (Exhibit 4) was also introduced by the Senate on 1-27-88 and relates to health maintenance organizations and would require such organizations to make a conversion contract available to persons who are terminated from a group but remain in the HMO's service area and for persons whose coverage in an HMO is terminated because the HMO is ceasing to do business in the service area.

Legislative Proposal No. 5 (Exhibit 5) would permit the Commissioner of Insurance to require insurance companies and other insurance mechanisms doing business in Kansas to be audited annually by an independent certified public accountant.

Legislative Proposal No. 6 (Exhibit 6) was introduced by the Senate and would require all mutual nonprofit hospital and medical service corporations doing business in this state to offer an additional conversion option to persons who are terminated from a group accident and sickness contract.

Legislative Proposal No. 7 (Exhibit 7) was another piece of legislation introduced by the Senate which would prevent accident and health insurance companies from accepting only the healthy members of a group (as determined by the insurer's underwriting standards) and rejecting those whose health condition or some other perceived infirmity does not meet the insurer's standards.

Legislative Proposal No. 8 (Exhibit 8) suggested several enhancements in the system governing examinations of insurance companies.

Representative Harper made a motion that the House Insurance Committee introduce Legislative Proposals 1, 5 & 8. Representative Hoy seconded the motion. The motion carried.

The Chairman presented the Insurance Reform Act of 1988 which was the culmination of numerous discussions between the Kansas Trial Lawyers Association and Insurance Commissioner Fletcher Bell. This proposed legislation would enact specific criteria under which the Insurance Commissioner could reject rates for fire, marine, inland marine, allied lines and property and casualty insurance as excessive, inadequate or unfairly discriminatory. (Exhibit 9)

A motion was made by Representative Bryant that the Insurance Reform Act of 1988 be introduced by the Committee. Representative Gross seconded the motion. The motion carried.

The meeting was adjourned at 4:15 p.m.

Explanatory Memorandum For
Legislative Proposal No. 1

Legislative Proposal No. 1 was developed by the National Fraternal Congress to bring a greater degree of uniformity to the operation and regulation of fraternal benefit societies doing business in the several states. In addition and of more significance to Kansas, the proposal, if enacted, would require fraternal benefit societies to submit their policy forms and riders to the Insurance Department for approval and require the licensing or registration of agents representing such entities. As a result, enactment of this proposal would narrow the differences between the regulation of fraternals and commercial life insurance companies as well as modernize the statutory provisions currently contained in Article 7, Chapter 40 of the Kansas Statutes Annotated.

EXHIBIT 1

LEGISLATIVE PROPOSAL NO. 1

AN ACT relating to insurance; fraternal benefit societies; formation; operation; regulation; repealing K.S.A. 40-701 through 40-736.

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

New Section 1. Any incorporated society, order or supreme lodge, without capital stock conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which provides benefits in accordance with this article, is hereby declared to be a fraternal benefit society.

New Sec. 2. (a) A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected initiated or admitted in accordance with its laws, rules and ritual. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once in each month in furtherance of the purposes of the society.

(b) A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of such children, nor shall they have a voice or vote in the management of the society.

New Sec. 3. A society has a representative form of government when:

(a) it has a supreme governing body constituted in one of the following ways:

(1) Assembly. The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than two-thirds of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected and shall meet at least once every four years and

shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws.

(2) Direct election. The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws. A society may provide for election of the board by mail. Each term of a board member may not exceed four years. Vacancies on the board between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society.

(b) the officers of the society are elected by the supreme governing body or by the board of directors;

(c) only benefit members are eligible for election to the supreme governing body, the board of directors or any intermediate assembly; and

(d) each voting member shall have one vote; no vote may be cast by proxy.

New Sec. 4. As used in this act: (a) "Agent" means an individual as defined in K.S.A. 40-239.

(b) "Benefit contract" means the agreement for provision of benefits authorized by New Sec. 5(a), as that agreement is described in New Sec. 12.

(c) "Benefit member" means an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract.

(d) "Certificate" means the document issued as written evidence of the benefit contract.

(e) "Premiums" means premiums, rates, dues or other required contributions by whatever name known, which are payable under the certificate.

(f) "Laws" means the society's articles of incorporation, constitution and bylaws, however designated.

(g) "Rules" means all rules, regulations or resolutions adopted by the supreme governing body or board of directors which are intended to have general application to the members of the society.

(h) "Society" means fraternal benefit society, unless otherwise indicated.

(i) "Lodge" means subordinate member units of the society, known as camps, courts, councils, branches or by any other designation.

New Sec. 5. (a) A society shall operate for the benefit of members and their beneficiaries by:

(1) Providing the following benefits:

(A) Death benefits;

(B) endowment benefits;

(C) annuity benefits;

(D) temporary or permanent disability benefits;

(E) hospital, medical or nursing benefits; and

(F) such other benefits as authorized for life insurers and which are not inconsistent with this article;

(2) operating for one or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic or religious purposes for the benefit of its members, which may also be extended to others.

Such purposes may be carried out directly by the society, or indirectly through subsidiary corporations or affiliated organizations.

(b) A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in (a), consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

(c) Every society shall have the power to adopt laws and rules for the government of the society, the admission of its members, and the management of its affairs. It shall have the power to change, alter, add to or amend such laws and rules and shall have such other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

New Sec. 6. (a) A society shall specify in its laws or rules:

(1) Eligibility standards for each and every class of membership, provided that if benefits are provided on the lives of children, the minimum

age for adult membership shall be set at not less than age 15 and not greater than age 21;

(2) the process for admission to membership for each membership class; and

(3) the rights and privileges of each membership class, provided that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

(b) A society may also admit social members who shall have no voice or vote in the management of the insurance affairs of the society.

(c) Membership rights in the society are personal to the member and are not assignable.

New Sec. 7. (a) The principal office of any domestic society shall be located in this state. The meetings of its supreme governing body may be held in any state, district, province or territory wherein such society has at least one subordinate lodge, or in such other location as determined by the supreme governing body, and all business transacted at such meetings shall be as valid in all respects as if such meetings were held in this state. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

(b)(1) A society may provide in its laws for an official publication in which any notice, report, or statement required by law to be given to members, including notice of election, may be published. Such required reports, notices and statements shall be printed conspicuously in the publication. If the records of a society show that two or more members have the same mailing address, an official publication mailed to one member is deemed to be mailed to all members at the same address unless a member requests a separate copy.

(2) Not later than June 1 of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society or, in lieu thereof, such synopsis may be published in the society's official publication.

(c) A society may provide in its laws or rules for grievance or complaint procedures for members.

New Sec. 8. (a) The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

(b) Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by, and liabilities imposed upon, such person in connection with or arising out of any action, suit or proceeding, whether civil, criminal; administrative or investigative, or threat thereof, in which the person may be involved by reason of the fact that he or she is or was a director, officer, employee or agent of the society or of any firm, corporation or organization which he or she served in any capacity at the request of the society. A person shall not be so indemnified or reimbursed (1) in relation to any matter in such action, suit or proceeding as to which he or she shall finally be adjudged to be or have been guilty of breach of a duty as a director, officer, employee or agent of the society or (2) in relation to any matter in such action, suit or proceeding, or threat thereof, which has been made the subject of a compromise settlement; unless in either such case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, had no reasonable cause to believe that his or her conduct was unlawful. The determination whether the conduct of such person met the standard required in order to justify indemnification and reimbursement in relation to any matter described in subpoints (1) or (2) of the preceding sentence may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to such action, suit or proceeding or by a court of competent jurisdiction. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of no contest, as to such person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement. The foregoing right of indemnification and reimbursement shall not be exclusive of other rights to which such person may be entitled as a matter of law and shall inure to the benefit of his or her heirs, executors and administrators.

(c) A society shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee or agent of

the society, or who is or was serving at the request of the society as a director, officer, employee or agent of any other firm, corporation, or organization against any liability asserted against such person and incurred by him or her in any such capacity or arising out of his or her status as such, whether or not the society would have the power to indemnify the person against such liability under this section.

New Sec. 9. The laws of the society may provide that no subordinate body, nor any of its subordinate officers or members shall have the power or authority to waive any of the provisions of the laws of the society. Such provision shall be binding on the society and every member and beneficiary of a member.

New Sec. 10. (a) The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

(b) A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member, provided the portion so paid shall not exceed $1,500.

(c) If, at the death of any person insured under a benefit contract, there is no lawful beneficiary to whom the proceeds shall be payable, the amount of such benefit, except to the extent that funeral benefits may be paid as hereinbefore provided, shall be payable to the estate of the deceased insured the same as other property not exempt, provided that if the owner of the certificate is other than the insured, such proceeds shall be payable to such owner.

New Sec. 11. No money or other benefit, charity, relief or aid to be paid, provided or rendered by any society, shall be liable to attachment, garnishment or other process, or to be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any

debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.

New Sec. 12. (a) Every society authorized to do business in this state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided thereby. The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each thereof, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

(b) Any changes, additions or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate, shall bind the owner and the beneficiaries, and shall govern and control the benefit contract in all respects the same as though such changes, additions or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance, except that the consent of a parent, guardian or conservator shall not be required for an application for insurance by a minor.

(c) Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application, and subject to requirements as provided in K.S.A. 40-237.

(d) A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of such deficiency as ascertained by its board, and that if the payment is not made either (1) it shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates;

or (2) in lieu of or in combination with (1), the owner may accept a proportionate reduction in benefits under the certificate. The society may specify the manner of the election and which alternative is to be presumed if no election is made.

(e) Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

(f) No certificate shall be delivered or issued for delivery in this state unless a copy of the form has been filed with the commissioner of insurance in the manner provided for like policies issued by life insurers in this state. Every life, accident, health, or disability insurance certificate and every annuity certificate issued on or after one year from the effective date of this article shall meet the standard contract provision requirements not inconsistent with this article for like policies issued by life insurers in this state, except that a society may provide for a grace period for payment of premiums of one full month in its certificates. The certificate shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

(g) Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control of ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and may provide in all other respects for the regulation, government and control of such certificates and all rights, obligations and liabilities incident thereto and connected therewith.

Ownership rights prior to such transfer shall be specified in the certificate.

(h) A society may specify the terms and conditions on which benefit contracts may be assigned.

New Sec. 13. (a) For certificates issued prior to one year after the effective date of this article, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall comply with the provisions of law applicable immediately prior to the effective date of this article.

(b) For certificates issued on or after one year from the effective date of this article for which reserves are computed on the commissioner's 1941 standard ordinary mortality table, the commissioner's 1941 standard industrial table or the commissioner's 1958 standard ordinary mortality table, or the commissioner's 1980 standard mortality table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits based upon such tables.

New Sec. 14. A society shall invest its funds only in such investments as are authorized by the laws of this state for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this state which invests its funds in accordance with the laws of the state, district, territory, country or province in which it is incorporated, shall be held to meet the requirements of this section for the investment of funds.

New Sec. 15. (a) All assets shall be held, invested and disbursed for the use and benefit of the society and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

(b) A society may create, maintain, invest, disburse and apply any special fund or funds necessary to carry out any purpose permitted by the laws of such society.

(c) A society may, pursuant to resolution of its supreme governing body, establish and operate one or more separate accounts and issue

contracts on a variable basis, subject to the provisions of law regulating life insurers establishing such accounts and issuing such contracts. To the extent the society deems it necessary in order to comply with any applicable federal or state laws, or any rules issued thereunder, the society may adopt special procedures for the conduct of the business and affairs of a separate account, may, for persons having beneficial interests therein, provide special voting and other rights, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account, and may issue contracts on a variable basis to which subsections (b) and (d) of New Sec. 12 shall not apply.

New Sec. 16. Except as herein provided, societies shall be governed by this article and shall be exempt from all other provisions of the insurance laws of this state unless they be expressly designated therein, or unless it is specifically made applicable by this article.

New Sec. 17. (a) Standards of valuation for certificates issued prior to one year after the effective date of this article shall be those provided by the laws applicable immediately prior to the effective date of this article.

(b) The minimum standards of valuation for certificates issued on or after one year from the effective date of this article shall be based on the following tables:

(1) For certificates of life insurance - the commissioner's 1941 standard ordinary mortality table, the commissioner's 1941 standard industrial mortality table, the commissioner's 1958 standard ordinary mortality table, the commissioner's 1980 standard ordinary mortality table or any more recent table made applicable to life insurers;

(2) for annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits and for non-cancellable accident and health benefits - such tables as are authorized for use by life insurers in this state.

All of the above shall be under valuation methods and standards (including interest assumptions) in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits.

(c) The commissioner of insurance may, in his or her discretion, accept other standards for valuation if the commissioner finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard herein prescribed. The commissioner of insurance may, in his or her discretion, vary the standards of mortality applicable to all benefit contracts on substandard lives or other extra hazardous lives by any society authorized to do business in this state.

(d) Any society, with the consent of the commissioner of insurance of the state of domicile of the society and under such conditions, if any, which the commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any benefit member shall not be affected thereby.

New Sec. 18. (a) Reports shall be filed in accordance with K.S.A. 40-225, subject to penalty as provided in K.S.A. 40-226 for failure to file.

(b) As part of the annual statement herein required, each society shall, on or before the first day of March, file with the commissioner of insurance a valuation of its certificates in force on December 31 last preceding, providing the commissioner of insurance may, in his or her discretion for cause shown, extend the time for filing such valuation for not more than two calendar months. Such valuation shall be done in accordance with the standards specified in New Sec. 17. Such valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

New Sec. 19. Societies which are now authorized to transact business in this state, and all societies hereafter licensed, may continue such business as provided in K.S.A. 40-215, upon payment of the fee prescribed in K.S.A. 40-252. A duly certified copy or duplicate of such license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of this article.

New Sec. 20. (a) The commissioner of insurance, or any person he or she may appoint, may examine any domestic, foreign or alien society transacting or applying for admission to transact business in this state in the same manner as authorized for examination of domestic, foreign or alien insurers. Requirements of notice and an opportunity to respond before

findings are made public as provided in the laws regulating insurers shall also be applicable to the examination of societies.

(b) The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued, upon statements furnished by the commissioner of insurance.

New Sec. 21. No foreign or alien society shall transact business in this state without a license issued by the commissioner of insurance as provided in K.S.A. 40-214. Any such society desiring admission to this state shall comply substantially with the requirements and limitations of this article applicable to domestic societies, the applicable provisions of K.S.A. 40-209, and upon filing with the commissioner of insurance:

(a) A duly certified copy of its articles of incorporation;

(b) a copy of its bylaws, certified by its secretary or corresponding officer;

(c) a power of attorney to the commissioner of insurance as prescribed in New Sec. 40;

(d) a statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the commissioner of insurance, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province or country, satisfactory to the commissioner of insurance of this state;

(e) certificate from the proper official of its home state, territory, province or country that the society is legally incorporated and licensed to transact business therein;

(f) copies of its certificate forms; and

(g) such other information as the commissioner of insurance may deem necessary;

and upon a showing that its assets are invested in accordance with the provisions of this article.

New Sec. 22. (a) When the commissioner of insurance upon investigation finds that a domestic society:

(1) Has exceeded its powers;

(2) has failed to comply with any provision of this article;

(3) is not fulfilling its contracts in good faith;

(4) has a membership of less than 400 after an existence of one year or more; or

(5) is conducting business fraudulently or in a manner hazardous to its members, creditors, the public or the business;

the commissioner shall notify the society of such deficiency or deficiencies and state in writing the reasons for his or her dissatisfaction. The commissioner shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After such notice the society shall have a 30 day period in which to comply with the commissioner's request for correction, and if the society fails to comply the commissioner shall notify the society of such findings of noncompliance and require the society to show cause on a date named why it should not be enjoined from carrying on any business until the violation complained of shall have been corrected, or why an action in quo warranto should not be commenced against the society.

(b) If on such date the society does not present good and sufficient reasons why it should not be so enjoined or why such action should not be commenced, the commissioner of insurance may present the facts relating thereto the the attorney general who shall, if he or she deems the circumstances warrant, commence an action to enjoin the society from transacting business or in quo warranto.

(c) The court shall thereupon notify the officers of the society of a hearing. If after a full hearing it appears that the society should be so enjoined or liquidated or a receiver appointed, the court shall enter the necessary order. No society so enjoined shall have the authority to do business until:

(1) The commissioner of insurance finds that the violation complained of has been corrected.

(2) the costs of such action shall have been paid by the society if the court finds that the society was in default as charged;

(3) the court has dissolved its injunction; and

(4) the commissioner of insurance has reinstated the certificate of authority.

(d) If the court orders the society liquidated, it shall be enjoined from carrying on any further business, whereupon the receiver of the society shall proceed at once to take possession of the books, papers, money and

other assets of the society and, under the direction of the court, proceed forthwith to close the affairs of the society and to distribute its funds to those entitled thereto.

(e) No action under this section shall be recognized in any court of this state unless brought by the attorney general upon request of the commissioner of insurance. Whenever a receiver is to be appointed for a domestic society, the court shall appoint the commissioner of insurance as such receiver.

(f) The provisions of this section relating to hearing by the commissioner of insurance, action by the attorney general at the request of the commissioner of insurance, hearing by the court, injunction and receivership shall be applicable to a society which shall voluntarily determine to discontinue business.

New Sec. 23. (a) When the commissioner of insurance upon investigation finds that a foreign or alien society transacting or applying to transact business in this state:

(1) Has exceeded its powers;

(2) has failed to comply with any of the provisions of this article;

(3) is not fulfilling its contracts in good faith; or

(4) is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public;

the commissioner shall notify the society of such deficiency or deficiencies and state in writing the reasons for his or her dissatisfaction. The commissioner shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After such notice the society shall have a 30 day period in which to comply with the commissioner's request for correction, and if the society fails to comply the commissioner shall notify the society of such findings of noncompliance and require the society to show cause on a date named why its license should not be suspended, revoked or refused. If on such date the society does not present good and sufficient reason why its authority to do business in this state should not be suspended, revoked or refused, the commissioner may suspend or refuse the license of the society to do business in this state until satisfactory evidence is furnished to the commissioner that such suspension or refusal should be withdrawn or the commissioner may revoke the authority of the society to do business in this state.

(b) Nothing contained in this section shall be taken or construed as preventing any such society from continuing in good faith all contracts made in this state during the time such society was legally authorized to transact business herein.

New Sec. 24. No application or petition for injunction against any domestic, foreign or alien society, or lodge thereof, shall be recognized in any court of this state unless made by the attorney general upon request of the commissioner of insurance.

New Sec. 25. (a) Except as otherwise provided in this section, agents of societies shall be licensed and certified in accordance with the provisions of the laws regulating the licensing, revocation, suspension or termination of license of resident and nonresident agents and shall be subject to the same license, certification and examination fees as apply to agents or insurance companies similarly situated.

(b) No examination or license shall be required of any regular salaried officer, employee or member of a licensed society who devotes substantially all of his or her services to activities other than the solicitation of fraternal insurance contracts from the public, and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained.

(c) Any agent, representative or member of a society who devotes, or intends to devote, less than fifty percent of such person's time to the solicitation and procurement of insurance contracts for such society shall be exempt from the requirements of subsection (a). Any person who in the preceding calendar year has solicited and procured life insurance contracts on behalf of any society in a total amount of insurance in excess of $50,000, or, in the case of any other kind or kinds of insurance which the society might write, on the persons of more than 25 individuals and who has received or will receive a commission or other compensation therefor, shall be presumed to be devoting, or intending to devote, 50 percent of time to the solicitation or procurement of insurance contracts for such society.

(d) Each society shall maintain a record of its representatives exempted from licensing pursuant to subsection (c) and furnish the names and residence addresses of such persons to the commissioner on or before April 30 of each year. Each society shall furnish such information to the

commissioner within thirty days of the employment or termination of employment of any such exempted person subsequent to April 30 of each year.

(e) Each society shall notify the commissioner within thirty days after any person exempted pursuant to subsection (c) ceases to qualify for such exemption. The commissioner shall forthwith send a notice to such person requiring that person to qualify by examination not sooner than thirty days nor later than ninety days from receipt of the notice. Thereafter such person shall be subject to continuing education requirements for full-time insurance agents writing life, health and accident insurance.

New Sec. 26. Every society and agent authorized to do business in this state shall be subject to the provisions of article 24 of chapter 40, Kansas Statutes Annotated; provided, however, that nothing in such provisions shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

New Sec. 27. A domestic society organized on or after the effective date of this article shall be formed as follows:

(a) Seven or more citizens of the United States, a majority of whom are citizens of this state, who desire to form a fraternal benefit society, may make, sign and acknowledge before some officer competent to take acknowledgement of deeds, articles of incorporation, in which shall be stated:

(1) the proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;

(2) the purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this article;

(3) the names and residences of the incorporators and the names, residences and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by

the supreme governing body, which election shall be held not later than one year from the date of issuance of the permanent certificate of authority.

(b) Such articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor, and circulars to be issued by the society and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one year shall be filed with the commissioner of insurance, who may require such further information as the commissioner deems necessary. The bond with sureties approved by the commissioner of insurance shall be in such amount, not less than $300,000 nor more than $1,500,000, as required by the commissioner of insurance. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this article and all provisions of the law have been complied with, the commissioner of insurance shall so certify, retain and file the articles of incorporation and furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

(c) No preliminary certificate of authority granted under the provisions of this section shall be valid after one year from its date or after such further period, not exceeding one year, as may be authorized by the commissioner of insurance upon cause shown, unless the 500 applicants hereinafter required have been secured and the organization has been completed as herein provided. The articles of incorporation and all other proceedings thereunder shall become null and void in one year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as hereinafter provided.

(d) Upon receipt of a preliminary certificate of authority from the commissioner of insurance, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount so collected. No society shall incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow, any benefit to any person until:

(1) actual bona fide applications for benefits will have been secured on not less than 500 applicants, and any necessary evidence of insurability has been furnished to and approved by the society;

(2) at least 10 subordinate lodges have been established into which the 500 applicants have been admitted;

(3) there has been submitted to the commissioner of insurance, under oath of the president or secretary, or corresponding officer of the society, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted and premiums therefor; and

(4) it shall have been shown to the commissioner of insurance, by sworn statement of the treasurer, or corresponding officer of such society, that at least 500 applicants have paid in cash premiums which in the aggregate amount to at least $150,000. Said advance premiums shall be held in trust during the period or organization and if the society has not qualified for a certificate of authority within one year, as herein provided, such premiums shall be returned to said applicants.

(e) The commissioner of insurance may make such examination and require such further information as the commissioner deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the commissioner shall issue to the society a certificate of authority to that effect and that the society is authorized to transact business pursuant to the provisions of this article. The certificate of authority shall be prima facie evidence of the existence of the y shall be prima facie evidence of the existence of the society at the date of such certificate. The commissioner of insurance shall cause a record of such certificate of authority to be made. A certified copy of such record may be given in evidence with like effect as the original certificate of authority.

(f) Any incorporated society authorized to transact business in this state at the time this article becomes effective shall not be required to reincorporate.

New Sec. 28. (a) A domestic society may amend its laws in accordance with the provisions thereof by action of its supreme governing body at any regular or special meeting thereof or, if its laws so provide, by

referendum. Such referendum may be held in accordance with the provisions of its laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six months from the date of submission thereof, a majority of the members voting shall have signified their consent to such amendment by one of the methods herein specified.

(b) No amendment to the laws of any domestic society shall take effect unless approved by the commissioner of insurance who shall approve such amendment if the commissioner finds that it has been duly adopted and is not inconsistent with any requirement of the laws of this state or with the character, objects and purposes of the society. Unless the commissioner of insurance shall disapprove any such amendment within 30 days after the filing of same, such amendment shall be considered approved. The approval or disapproval of the commissioner of insurance shall be in writing and mailed to the secretary of corresponding officer of the society at its principal office. In case the commissioner disapproves such amendment, the reasons therefor shall be stated in such written notice.

(c) Within 90 days from the approval thereof by the commissioner of insurance, all such amendments, or a synopsis thereof, shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that same have been duly addressed and mailed, shall be prima facie evidence that such amendments or synopsis thereof, have been furnished the addressee.

(d) Every foreign or alien society authorized to do business in this state shall file with the commissioner of insurance a duly certified copy of all amendments of, or additions to, its laws within 60 days after the enactment of same.

(e) Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society shall be prima facie evidence of the legal adoption thereof.

New Sec. 29. A society may create, maintain and operate, or may establish organizations to operate, not for profit institutions to further

purposes permitted by New Sec. 5(a)(2). Such institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held or leased by the society for this purpose shall be reported in every annual statement.

New Sec. 30. (a) A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer (other than another fraternal benefit society) having the power to make such reinsurance and authorized to do business in this state, or if not so authorized, one which is approved by the commissioner of insurance, but no such society may reinsure substantially all of its insurance in force without the written permission of the commissioner of insurance. It may take credit for the reserves on such ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability, to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after the effective date of this article, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

(b) Notwithstanding the limitation in (a) a society may reinsure the risks of another society in a consolidation or merger approved by the commissioner of insurance under New Sec. 31.

New Sec. 31. (a) A domestic society may consolidate or merge with any other society by complying with the provisions of this section. It shall file with the commissioner of insurance:

(1) A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

(2) a sworn statement by the president and secretary or corresponding officers of each society showing the financial condition thereof on a date fixed by the commissioner of insurance but not earlier than December 31, next preceding the date of the contract;

(3) a certificate of such officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds vote of the supreme governing body of each society, such vote being conducted at a regular or special meeting of each such body, or, if the society's laws so permit, by mail; and

(4) evidence that at least 60 days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society.

(b) If the commissioner of insurance finds that the contract is in conformity with the provisions of this section, that the financial statements are correct and that the consolidation or merger is just and equitable to the members of each society, the commissioner shall approve the contract and issue a certificate to such effect. Upon such approval, the contract shall be in full force and effect unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In such event the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of such state or territory and a certificate of such approval filed with the commissioner of insurance of this state or, if the laws of such state or territory contain no such provision, then the consolidation or merger shall not become effective unless and until it has been approved by the commissioner of insurance of such state or territory and a certificate of such approval filed with the commissioner of insurance of this state.

(c) Upon the consolidation or merger becoming effective as herein provided, all the rights, franchises and interests of the consolidated or merged societies in and to every species of property, real, personal or mixed, and things in action thereunto belonging shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument, except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest therein, vested under the laws of this state in any of the societies consolidated or merged, shall not revert or be in any way impaired by reason of the consolidation or merger, but shall vest absolutely in the society resulting from or remaining after such consolidation or merger.

(d) The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that such notice or document has been duly addressed and mailed, shall be prima facie evidence that such notice or document has been furnished the addressees.

New Sec. 32. Any fraternal benefit society incorporated under the laws of the state of Kansas may reorganize and convert itself into a mutual life

insurance company or into a stock life insurance company by conforming with the provisions of New Secs. 33 through 39.

New Sec. 33. A proposal to make a conversion authorized hereby may be submitted to either a regular or a special meeting of supreme legislative body of any such fraternal benefit society by action of either the supreme legislative body or by the directors of such society. At least 40 days prior to the meeting of the supreme legislative body which is to consider such proposed conversion there shall be mailed to each member or policyholder of the society to the post office address shown by the records of the society, and to each subordinate lodge or branch of the society a written or printed notice of such proposed conversion. Such notice shall be given either personally or by mail, to each member or policyholder entitled to vote. If mailed, such notice shall be deemed to be delivered when deposited in the United States mail, at his address as it appears on the records of the company. Such notice, whether the meeting is annual, periodic or special, shall state the place, day, hour and purpose of the meeting, and a copy of the plan for such proposed conversion shall be included in or enclosed with such notice. Within 30 days after the delivery of such notice, each subordinate lodge or branch shall in regular or called meeting vote upon the proposal and may give instructions to its representative or delegate to such forthcoming meeting of either district or the supreme legislative body as provided by laws of such society. If any such subordinate lodge, branch or district shall fail to elect delegates to such supreme meeting, any vacancy thus occurring shall be filled as provided by the laws of such society. At such meeting of the supreme governing body of such society, in addition to the duly accredited delegates, any member of such society may attend and be heard on the subject of the proposed conversion. No such society shall convert itself into a mutual or stock life insurance company except upon such terms and conditions as in the opinion of the commissioner of insurance shall fully protect the rights and interests of its members and policyholders; and the plan of such proposed conversion shall be submitted to and approved by the commissioner of insurance before it shall be submitted to the members or policyholders and the subordinate lodges or branches as hereinbefore provided. Any plan for converting any fraternal benefit society into a stock company under the

provisions hereof shall offer to each member or policyholder the following three options:

First: Any member not desiring to participate in the new organization shall be entitled to surrender his or her policy or certificate and receive thereon its net cash surrender value plus his share of the divisible free surplus, such share being determined by dividing the amount of said divisible free surplus by the proportion that such member's cash value bears to total cash values of all policies and certificates in force, said values being computed as of the end of the year preceding the date of conversion.

Second: Any member desiring to do so may permit his policy or certificate to be taken over by the new organization without surrendering any rights or being subject to any additional payments or penalties other than those called for in his contract.

Third: Each member or policyholder in the new organization may retain his insurance as provided in the second option hereinabove stated and in addition shall be entitled to purchase his proportionate share of the capital stock in the new company, as hereinafter set forth. Each of these options shall be submitted to the members at the same time. In the event of the failure of any member or policyholder to elect any of such options within 90 days as specified within the plan, he shall be deemed to have elected the second of such options.

New Sec. 34. If, pursuant to said notice and convening of the regular or special meeting of the supreme legislative body, there shall be adopted a resolution by delegates representing lodges which comprise not less than 60 percent of the total membership of the society, authorizing the conversion of the said fraternal benefit society into a mutual or stock life insurance company, the directors of such society shall file with the commissioner of insurance and the secretary of state a certificate setting forth the following:

(a) The name of the society, and the new name of the corporation by which it shall thereafter be known: Provided, That if the new name of the corporation shall change from the former name of the society, it shall not adopt the same name as that of any other society or life insurance company doing business in this state nor a name similar to that of any other such society or life insurance company doing business in this state.

(b) The objection of the corporation.

(c) The location of its principal offices, which must be within the state of Kansas, and the names of the principal officers of such corporation, who shall serve until their successors are elected and qualified.

(d) The period, if any, for the duration of the corporation.

(e) The amount of the capital stock authorized, if any, and the number of shares into which it is divided, and the amount of capital stock to be immediately paid in, which shall not be less than $100,000 and generally comply with the laws of the state of Kansas governing the organization of insurance companies.

(f) Any other provisions which the supreme or governing body may choose to insert to protect the membership of the retiring society and insure the business and the conduct of the affairs of the new corporation.

New Sec. 35. A report of such meeting of the supreme legislative body certified to be the presiding officers under the corporate seal of such society shall also be filed with the commissioner of insurance.

New Sec. 36. If such fraternal benefit society be converting into a stock life insurance company, it shall be the duty of such fraternal benefit society to advise every member or policyholder of his right to subscribe for and purchase the stock of such stock life insurance company and of the amount of such stock for which he is entitled to subscribe and all other terms and conditions. The amount of such capital stock available to each member or policyholder shall be determined as set forth in the plan of proposed conversion. Exercise of such right shall be limited to 90 days after notice. Notice of such right shall be written or printed on a firm approved by the commissioner of insurance and shall be given either personally or by mail. If mailed, such notice shall be deemed to be delivered when deposited in the United States mail, with postage prepaid, addressed to the member or policyholder at his address as it appears on the records of the society.

No portion of the stock shall be offered for public sale until the membership of the society shall have had preference in the purchase thereof: Provided, That no one member shall be allowed to subscribe for or purchase more than 25 percent of the capital stock of the new company if there be other members applying in writing for the purchase of stock whose subscriptions are not filled. If the membership shall not have subscribed

for the total capital stock authorized, then others who were not members of the society at the time of the conversion may be permitted to subscribe for stock and be allowed equal rights in the ownership thereof with all other stockholders.

New Sec. 37. When any such fraternal benefit society shall have complied with the provisions of this article and the other laws of this state regulating the incorporation of life insurance companies, and shall have received from the commissioner of insurance its charter or certificate of authority to transact business as a life insurance company, its reorganization and conversion into such company shall be complete. Such reorganized and converted corporation shall be deemed in law to have all the rights, privileges, powers, and authority of any other corporation organized for doing a life insurance business in the state of Kansas, and controlled by the laws applying thereof: Provided, however, Such reorganized and converted corporation shall be obligated to maintain reserves attributable to policies or certificates of insurance issued prior to such conversion on the respective bases provided in such policies or certificates of insurance or in the laws applicable at their respective dates of issue, but in no event on a basis providing lower reserves than the national fraternal congress table of mortality with interest assumed at the rate of four percent per annum.

The new corporation shall be deemed in law to be a continuation of the business of the fraternal benefit society when the reorganization and conversion shall have been accomplished by the formation of a new company or by amendment to its former charter, and such reorganized corporation shall succeed to and become invested with all and singular the rights, privileges, franchises, and all property, real, personal, or mixed, of the former society, and all debts due on any account and all other things and choses in action, theretofore belonging to such fraternal benefit society, and all property rights, privileges, franchises, and all other interest shall thereafter be as effectually the property of such organized and converted corporation as they were the property of the former fraternal benefit society, and the title to any real estate by deed or otherwise vested in the former fraternal benefit society shall forthwith vest in such organized converted corporation, and the title thereto shall not in any way be impaired by reason of such change or reincorporation. The commissioner of

insurance shall have the power and authority to require such converted company to dispose of or revalue any security, investment, or asset regarded as ineligible for the converted company upon reasonable notice and terms to such converted company.

New Sec. 38. The rights of all members, policyholders, creditors, and the standing of all claims under the former fraternal benefit society shall be preserved unimpaired under the new corporation, and all debts, liabilities, and duties of the former fraternal benefit society shall thenceforth attach to the reorganized corporation, and may be enforced against it to the same extent as if said debts and liabilities, had been incurred or contracted by the new corporation, and all outstanding benefit certificates or policies issued by the said fraternal benefit society shall be valid obligations of the new corporation, without the issuance of new policies. There shall be filed an instrument appointing the commissioner of insurance and his successor or successors in office the true and lawful attorney of such company for service of process, containing the same provisions and having the same effect as the instrument required by New Sec. 40.

New Sec. 39. Such organized and converted corporation shall be obliged to carry out and perform all of the obligations of every kind and character owing by the former fraternal benefit society to the holders of its policies or beneficial certificates, and the same may be enforced against it to the extent as if said policies and benefit certificates had been issued by it after conversion. Any pending actions at law wherein the former fraternal benefit society was a party shall be unaffected by the conversion thereof and shall be prosecuted by or against such reorganized and converted corporation the same as if the conversion had not taken place.

New Sec. 40. Every society authorized to do business in this state shall appoint in writing the commissioner of insurance as agent for service of process as provided in K.S.A. 40-218. No such service shall require a society to file its answer, pleading or defense in less than 30 days from the date of mailing the copy of the service to a society. Legal process shall not be served upon a society except in the manner herein provided.

New Sec. 41. All decisions and findings of the commissioner of insurance made under the provisions of this article shall be subject to

review by proper proceedings in any court of competent jurisdiction in this state.

New Sec. 42. (a) A person who knowingly makes any false or fraudulent statement or representation in or with reference to any application for membership or for the purpose of obtaining money from or a benefit in any society, shall upon conviction be fined not less than $100 nor more than $500, or imprisonment in the county jail not less than 30 days nor more than one year, or both.

(b) Any person who willfully makes a false or fraudulent statement in any verified report or declaration under oath required or authorized by this article, or of any material fact or thing contained in a sworn statement concerning the death or disability of an insured for the purpose of procuring payment of a benefit named in the certificate, shall be guilty of perjury and shall be subject to the penalties therefor prescribed by law.

(c) Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in this state shall upon conviction be fined not less than $50 nor more than $200.

(d) Any person guilty of a willful violation of, or neglect or refusal to comply with, the provisions of this article for which a penalty is not otherwise prescribed, shall upon conviction, be subject to a fine not exceeding $200.

New Sec. 43. (a) Nothing contained in this article shall be so construed as to affect or apply to societies and organizations exempted by K.S.A. 40-202.

(b) The commissioner of insurance may require from any society or association, by examination or otherwise, such information as will enable the commissioner to determine whether such society or association is exempt from the provisions of this article.

New Sec. 44. The Commissioner of insurance may make and promulgate rules and regulations reasonable, necessary, and incidental to the enforcement and administration of the provisions of this act.

New Sec. 45. If any section, paragraph, sentence or phrase of this act shall be declared unconstitutional or void for any reason, such fact shall not in any way affect the remaining sections, paragraphs, sentences or phrases of this act, but the same shall continue in full force and effect.

Sec. 46. K.S.A. 40-701 through 40-736 are hereby repealed.

Sec. 47. This act shall take effect and be in force from and after January 1, 1989, and its publication in the statute book.

Explanatory Memorandum For
Legislative Proposal No. 2

Legislative Proposal No. 2 is the result of an Agent's Licensing Study Group. This study group began a comprehensive study of Kansas laws, regulations and procedures relating to agents licensing last spring and concluded its work in November of 1987. The proposal suggests some rather significant changes which can be summarized as follows:

(1) Introduces a "single license" concept whereby licensed agents would be authorized to act either as the agent of an insurance company or as an agent for an insured. Currently, this can be done but two licenses are required i.e. an agent's license and a broker's license. (Under this proposal, the broker's law, Article 37 of Chapter 40, Kansas Statutes Annotated, would be repealed.)

(2) Require the licensing of insurance agencies as well as individual insurance agents.

(3) Permit insurance companies to certify insurance agencies to represent them and, by so doing, automatically authorize each agent to act as their representative.

(4) Permit new agents or agencies to transact business immediately upon appointment by an insurance company rather than await confirmation of certification from the Insurance Department.

(5) Initiate an annual continuing education requirement for all insurance agents. These provisions would require each agent to complete eight hours of approved educational activities to retain a property/casualty license and/or a separate eight hours to retain authority to transact life/A&H and/or variable contracts business. Agents authorized only for crop insurance would be subject to a one hour annual continuing education requirement.

(6) Authorize the commissioner to delegate responsibility for the development and conduct of agent's licensing examinations to outside firms and establish an examination fee commensurate with the cost.

Enactment of this proposal should add to the professional stature and competence of Kansas insurance agents.

EXHIBIT 2

LEGISLATIVE PROPOSAL NO. 2

AN ACT relating to insurance; insurance agents; licensing; qualifications; examination; certification; continuing education; amending K.S.A. 40-239, 40-240, 40-241 and 40-241i and repealing the existing sections; also repealing K.S.A. 40-240a, 40-240b, 40-240c, 40-240d, 40-240e and 40-3701 through 40-3713.

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

Section 1. K.S.A. 40-239 is hereby amended to read as follows: 40-239. An insurance agent is hereby defined to be an individual, corporation, association, partnership or other legal entity authorized in writing, by any insurance company lawfully qualified to transact the business of insurance, suretyship or indemnity in this state, to negotiate or effect contracts of insurance, suretyship or indemnity on behalf of any such insurance company; or any member of a ~~copartnership~~ partnership or association, or any stockholder, officer or agent of a corporation, permitted by law to negotiate or effect such contracts, where said ~~copartnership~~ partnership, association or corporation holds a direct agency appointment from any insurance company. All such agents shall thereby become liable to all the duties, requirements, liabilities and penalties as provided in this code.

Sec. 2. K.S.A. 40-240 is hereby amended to read as follows: 40-240. (a) Any person desiring as agent to engage in the insurance business, as herein set out, shall first apply to the commissioner of insurance of this state, in the manner hereinafter prescribed, for an insurance agent's license, authorizing such agent to engage in and transact such business. The applicant for such license shall file with the commissioner of insurance such applicant's written application for a license authorizing the applicant to engage in the insurance business and the applicant shall make sworn answers to such interrogatories as the commissioner of insurance may require on uniform forms and supplements prepared by the commissioner. A nonrefundable fee in the amount of $ shall accompany such application. Such applicant if an individual shall establish:

~~(a)~~ (1) That the applicant is a graduate of an accredited four-year high school or its equivalent. This requirement shall not apply to any person holding a valid agent's license as of July 1, 1971, or a full-time student enrolled in an accredited high school in this state while and to the extent such student is participating in an insurance project sponsored by a bona fide junior achievement program;

~~(b)~~ (2) that the applicant is of good business reputation and is worthy of a license.

(b) Corporations, associations, partnerships, sole proprietorships and other legal entities acting as insurance agents and holding a direct agency appointment from an insurance company or companies are required to obtain an insurance agent's license. Application for such license shall be made to the commissioner on a form prescribed by him or her. Before granting the license, the commissioner shall determine that:

(1) Each officer, director, partner and employee of the applicant who is acting as an insurance agent is licensed as an insurance agent;

(2) has disclosed to the insurance department all officers, directors and partners whether or not they are licensed as insurance agents;

(3) has disclosed to the insurance department all officers, directors, partners and employees who are licensed as insurance agents; and

(4) has designated a licensed officer or partner responsible for the organization's compliance with the insurance laws and rules and regulations of this state.

(c) The insurance department may require any documents reasonably necessary to verify the information contained in the application.

(d)(1) Agents licensed pursuant to section 2(b) of this act shall advise the commissioner of any officers, directors, partners or employees who are licensed as individual insurance agents and are not disclosed at the time application is made for a license within fifteen working days of their affiliation with the licensee. Failure to provide the commissioner with such information shall subject the licensee to a monetary penalty of $10 per day for each working day the required information is late subject to a maximum of $300 per person per licensing year.

(2) Officers, directors, partners or employees disclosed at the time of the original application or reported thereafter whose affiliation with the licensee is terminated shall be reported to the commissioner within 30 days

of the effective date of termination. Failure to report such termination shall subject the licensee to the penalty prescribed in paragraph (1) of this subsection.

Sec. 3. K.S.A. 40-241 is hereby amended to read as follows: 40-241. If the commissioner of insurance is satisfied that the applicant for an agent's license is of good business reputation and is otherwise qualified in the line of business, the applicant if an individual shall be given ~~a written~~ an examination by the commissioner or his or her designee to determine whether such applicant possesses the competence and knowledge of the kinds of insurance and transactions under the license applied for, of the duties and responsibilities of such a license and of the pertinent provisions of the laws of this state. The applicant shall be tested on each class or subclassification of insurance which may be written. An examination fee prescribed in rules and regulations adopted by the commissioner ~~in an amount not to exceed $25~~ shall be paid by the applicant and shall be required for each class of insurance for each attempt to pass the examination. Such examination fee shall be in addition to the certification fee required under K.S.A. 40-252, and amendments thereto. There shall be ~~three~~ five classes of insurance for the purposes of this act:

(1) Life~~, including~~;

(2) health and accident;

~~(2)~~ (3) casualty and allied lines;

~~(3)~~ (4) ~~fire~~ property and allied lines~~.~~ ;

(5) variable contracts.

The commissioner of insurance shall establish rules and regulations with respect to the scope, subclassification, type and conduct of such written examination. Examinations shall be given to applicants ~~as follows: Class one examinations~~ at least twice a month in Topeka, Kansas, and at least quarterly in other convenient locations in the state of Kansas~~; class two and three examinations not more frequently than twice a month in Topeka, Kansas, and concurrently in other convenient locations in the state of Kansas~~. The commissioner shall publish or arrange for the publication of information and material which applicants can use to prepare for such written examination. One or more rating organizations, advisory organizations or other associations may be designated by the commissioner to assist in, or assume responsibility for, distribution of the study manuals

to applicants and other interested parties. Persons purchasing the study manual shall be charged a reasonable fee established or approved by the commissioner. In the event the publication and distribution of the study material or the development and conduct of examinations is delegated to private firms, organizations or associations and the state incurs no expense or obligation, the provisions of K.S.A. 75-3738 to 75-3744, inclusive, and amendments thereto, shall not apply. If the commissioner of insurance finds that the individual applicant is trustworthy, competent and has satisfactorily completed the written examination, the commissioner shall forthwith issue to the applicant a license as an insurance agent but the issuance of such license shall confer no authority to transact business in this state until the agent has been certified by a company pursuant to K.S.A. 40-241i and amendments thereto. If ~~the~~ such applicant fails to satisfactorily complete the written examination, ~~such~~ the examination may be retaken following a waiting period of not less than ~~14~~ seven days from the date of the last attempt. If the applicant again fails to satisfactorily complete the written examination, it may be retaken following another waiting period of not less than seven days from the date of the most recent attempt. Thereafter, the examination may be retaken following a waiting period of not less than six months from the date of the most recent attempt. The certification and examination fee shall not be returned for any reason and the examination fee shall be forfeited if the applicant fails to appear for the examination or fails to notify the commissioner or his or her designee by certified mail of their inability to appear at least three working days prior to the scheduled examination date. ~~No insurance agent shall be required to take an examination for continuation of the agent's license for any class or subclassification of business which the agent was certified to write prior to May 1, 1963, or for which the agent has previously been examined by the commissioner of insurance.~~ The commissioner of insurance shall keep a permanent record of all agents' licenses issued and the insurance companies that the respective agents were certified to represent under such licenses for a period of 10 years.

Sec. 4. K.S.A. 40-240i is hereby amended to read as follows: 40-241i. (a) Any company authorized to transact business in this state may, upon determining that the agent is of good business reputation and, if an individual, has had experience in insurance or will immediately receive a

course of instruction in insurance and on the policies and policy forms of such company, certify such agent as the agent of the company under the license in effect for the agent. The certification shall be made to the commissioner on a form prescribed by the commissioner ~~immediately upon~~ within 15 days of appointment of the agent by the company, and shall be accompanied by the certification fees set forth in K.S.A. 40-252, and amendments thereto~~;~~ . Such appointment shall be effective immediately and shall remain in effect until May 1, unless the commissioner is notified to the contrary or the license of the certified agent is terminated. The certification fee shall not be returned for any reason and failure of the company to certify an agent within 15 working days of his or her appointment shall subject the company to a penalty of not less than $25 per calendar day from the date of appointment to the date proper certification is recorded by the insurance department.

(b) Certification of other than an individual agent will automatically include each licensed insurance agent who is an officer, director, partner, employee or otherwise legally associated with the corporation, association, partnership or other legal entity appointed by the company. The required annual certification fee shall be paid for each licensed agent certified by the company at the time of the original certification of the agency and any continuation thereof.

~~(b)~~ (c) With respect to insurance on growing crops, evidence satisfactory to the commissioner that the agent is qualified to transact insurance in accordance with standards or procedures established by any branch of the federal government shall be deemed to be the equivalent of certification by a company.

New Sec. 5. Any resident of this state holding a valid insurance agent's license shall be authorized to negotiate contracts of insurance, place risks, solicit, countersign or effect contracts of insurance as an agent for an insured other than himself or herself and not as an agent of an insurance company or any other type of insurance carrier. When acting as an agent for an insured, the insurance agent may transact business with admitted insurers and a fee may be charged for the services provided separate and apart from any commission paid by an insurer if a written contract describing or setting forth the agreement between the insured and the insurance agent is in effect. Any person who is certified to represent

the insurance company whose policy is being negotiated shall be deemed to be acting as an agent for the company unless a written agreement otherwise describing the relationship between the insured and the agent is in effect.

New Sec. 6. (a) For purposes of this section, the following terms shall mean:

(1) "Annual due date" means March 31, 1989 and March 31 of each year thereafter.

(2) "Approved subject" or "approved course" means any educational presentation involving insurance fundamentals, insurance law, insurance policies and coverage, insurance needs, insurance risk management, or other areas, which is offered in a class, seminar or other similar form of instruction, and which has been approved by the commissioner under this chapter as expanding skills and knowledge obtained prior to initial licensure or developing new and relevant skills and knowledge.

(3) "C.E.C." means continuing education credit. One C.E.C. is 50 to 60 minutes of each clock hour of instruction or the C.E.C. value assigned by the commissioner. The C.E.C. values will be assigned in whole units. The commissioner will assign a C.E.C. value to each approved subject on a case-by-case basis.

(b)(1) Every licensed agent who is an individual and holds a property casualty qualification shall annually obtain a minimum of eight C.E.C.'s in courses certified as property/casualty.

(2) Every licensed agent who is an individual and holds a life, accident/health, or variable contracts qualification shall annually complete eight C.E.C.'s in courses certified as life, accident and health, or variable contracts.

(3) Every licensed agent who is an individual and holds a crop only qualification shall annually obtain a minimum of one C.E.C. in courses certified as crop under the property and casualty category.

(c) Individual agents who hold licenses with both a property/casualty qualification and a life, accident and health, or variable contracts qualification and who earn C.E.C.'s from courses certified by the commissioner as qualifying for credit in any class, may apply those C.E.C.'s toward either the property/casualty continuing education requirement or to the life, A/H, and variable contracts continuing education requirement. However, a C.E.C. applied to satisfy the annual property/casualty

requirement may not also be applied to satisfy the annual requirement for life, accident and health, or variable contracts, and vice versa.

(d) An instructor of an approved subject is entitled to the same credit as a student completing the study.

(e) If an individual agent completes more than the annual requirement of accredited continuing education courses in a single year by passing an examination part leading to a recognized professional designation, the agent may accumulate and carry-over to the next year up to the equivalent of the annual requirement for the type of license qualification held.

(f)(1) All individual agents who have been licensed for more than one year must, on or before the annual due date, file a report with the commissioner that they have met the continuing education requirements for the previous calendar year. Every individual agent shall maintain a record of all courses attended along with a certificate of attendance, for three years after the date of attendance.

(2) A newly licensed individual agent shall have the remainder of the calendar year in which he or she is initially licensed plus the next calendar year to comply with the C.E.C. requirements.

(3) If the required report showing proof of continuing education completion is not furnished by the annual due date, then the individual agent's qualification and corresponding license(s) will not be renewed by the commissioner.

(4) An applicant for an individual agent's license who previously held a license which terminated because of failure to meet continuing education requirements and who seeks to be relicensed must pass the examination required for issuance of the new qualification and license and provide evidence that appropriate C.E.C.'s have been completed for the prior year.

(5) Upon written application by an individual agent, the commissioner may, in cases involving medical hardship or military service, extend the time within which to fulfill the minimum continuing educational requirements, not to exceed 180 days.

(g)(1) A course, program of study, or subject must be submitted to and certified by the commissioner in order to qualify for purposes of continuing education.

(2) The following information shall be furnished with each request for certification:

(A) Name of provider or sponsoring organization;

(B) course title;

(C) date course will be offered;

(D) location where course will be offered;

(E) outline of the course including a schedule of times when subjects will be presented;

(F) names and qualifications of instructors;

(G) number of C.E.C.'s requested; and

(H) a nonrefundable fee in the amount of $50 per course or a nonrefundable fee in the amount of $250 per year for all courses.

(3) Upon receipt of such information, the commissioner will grant or deny certification as an approved subject and will indicate the number of C.E.C.'s that will be recognized for the subject. Each approved subject or course will be assigned by the commissioner to one or both of the following classes:

(A) Property and casualty insurance contracts or

(B) life insurance contracts (including annuity and variable contracts) and accident/health insurance contracts.

(4) A course or subject must have a value of at least one C.E.C.

(5) A provider seeking approval of a course for continuing education credit shall provide for the issuance of a certificate of attendance to each person who attends a course offered by it. The certificate shall be signed by either the course instructor or the provider's authorized representative. Providers shall also maintain a list of all persons who attend courses offered by them for continuing education credit for at least seven years from the date the courses are offered.

(6) A course may be approved after a program of study has been held if the required material is furnished within 60 days after the program was completed and prior to the annual due date.

(7) The commissioner may grant approval to specific programs of study that have appropriate merit, such as programs with broad national or regional recognition, notwithstanding the lack of a request for certification. The fee prescribed by subsection (g)(2)(H) of this section shall not apply to approvals granted hereunder.

(h) The commissioner will provide, upon request, a list of all approved continuing education courses currently available to the public.

(i) Independent study. An individual agent who studies independently for an insurance examination, other than an agent's examination, approved by the commissioner and who passes an independently monitored examination, will receive credit for the C.E.C.'s assigned by the commissioner as recognition for the approved subject. No other credit will be given for independent study.

New Sec. 7. The commissioner is hereby authorized to adopt such rules and regulations as may be necessary to carry out the provisions of this act.

Sec. 8. K.S.A. 40-239, 40-240, 40-240a, 40-240b, 40-240c, 40-240d, 40-240e, 40-241, 40-241i and 40-3701 through 40-3713 are hereby repealed.

Sec. 9. Sections 3 and 5 of this act shall take effect and be in force from and after their publication in the statute book. The remaining sections shall take effect and be in force from and after May 1, 1989.

Explanatory Memorandum For
Legislative Proposal No. 3

The statutes governing the formation, operation and regulation of health maintenance organizations (HMO's) were first enacted in 1974 and are found in Article 32 of Chapter 40, Kansas Statutes Annotated. With few exceptions, these statutes have not been materially changed since their enactment even though HMO's have evolved so they have different organizational structures, different backgrounds, different profit motives and so forth. Legislative Proposal No. 3 was primarily developed by the Kansas HMO Association to clarify provisions of existing law that are lacking in specificity such as documentation of fiscal solidity. Also such clarification will result in the removal of inconsistencies that result from differing HMO organizational structures, specifically staff or group model as opposed to independent practice associations. In addition, the minimum deposit requirements for new and existing HMO's has been increased from $10,000 to $150,000 with a transition period provided to facilitate compliance.

Senate

EXHIBIT 3

LEGISLATIVE PROPOSAL NO. 3

AN ACT relating to health maintenance organizations; certificate of authority; contracts; deposits; amending K.S.A. 40-3203, 40-3207, 40-3209, 40-3227 and repealing the existing sections.

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

Section 1. K.S.A. 40-3203 is hereby amended to read as follows: 40-3203. (a) Except as otherwise provided by this act, it shall be unlawful for any person to provide health care services in the manner prescribed in subsection (f) of K.S.A. 40-3202 and amendments thereto without first obtaining a certificate of authority from the commissioner.

(b) Applications for a certificate of authority shall be made in the form required by the commissioner and shall be verified by an officer or authorized representative of the applicant and shall set forth or be accompanied by:

(1) A copy of the basic organizational documents of the applicant such as articles of incorporation, partnership agreements, trust agreements or other applicable documents;

(2) a copy of the bylaws, regulations or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) a list of the names, addresses and official capacity with the organization of all the persons who are to be responsible for the conduct of its affairs, including all members of the governing body, the officers and directors in the case of a corporation and the partners or members in the case of a partnership or corporation;

(4) a statement generally describing the organization, its enrollment process, its operation, its quality assurance mechanism, its internal grievance procedures, the methods it proposes to use to offer its enrollees an opportunity to participate in matters of policy and operation, the geographic area or areas to be served, the location and hours of operation of the facilities at which health care services will be regularly available to enrollees <u>in the case of staff and group practices (in all other cases, a list of providers by specialty, with addresses and telephone numbers)</u>, the

type and specialty of health care personnel engaged to provide health care services, the number of personnel in each category and a records system providing documentation of utilization rates for enrollees;

(5) copies of all contract forms the organization proposes to offer enrollees together with a table of rates to be charged;

(6) ~~a statement of the financial condition of the organization, balance sheet and projected sources and uses of funds;~~ the following statements of the fiscal soundness of the organization:

(A) Descriptions of financing arrangements for operational deficits and for developmental costs if operational one year or less;

(B) copy of the most recent unaudited financial statements of the health maintenance organization;

(C) financial projections as follows:

(i) for a minimum of three years from the anticipated date of certification; on a monthly basis from the date of certification through one year;

(ii) if health maintenance organization is expected to incur a deficit, projections for each deficit year and for one year thereafter;

(iii) using accrual accounting system with generally accepted accounting principles.

(D) financial projections shall include:

(i) monthly statements of revenue and expense for first year on a gross dollar as well as per-member-per-month basis, with quarters consistent with standard calendar year quarters;

(ii) quarterly statements of revenue and expense for each subsequent year;

(iii) quarterly balance sheet; and

(iv) statement and justification of assumptions;

(7) a description of the procedure to be utilized by a health maintenance organization to provide for:

(A) Offering enrollees an opportunity to participate in matters of policy and operation of the health maintenance organization;

(B) monitoring of the quality of care provided by such organization including, as a minimum, peer review; and

(C) resolving complaints and grievances initiated by enrollees;

(8) a written irrevocable consent duly executed by such applicant, if the applicant is a nonresident, appointing the commissioner as the person upon whom lawful process in any legal action against such organization on any cause of action arising in this state may be served and that such service of process shall be valid and binding in the same extent as if personal service had been had and obtained upon said nonresident in this state;

(9) a plan in the case of group or staff practices, that will provide for maintaining a medical records system which is adequate to provide an accurate documentation of utilization by every enrollee, such system to identify clearly, at a minimum, each patient by name, age and sex and to indicate clearly the services provided, when, where, and by whom, the diagnosis, treatment and drug therapy; in all other cases, evidence that contracts with providers require that similar medical records systems be in place;

(10) evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of health care; and

(11) such other information as may be required by the commissioner to make the determinations required by K.S.A. 40-3204 and amendments thereto.

Sec. 2. K.S.A. 40-3207 is hereby amended to read as follows: 40-3207. (a) When the commissioner has reasonable cause to believe that grounds for the denial, suspension or revocation of a certificate exists or when the commissioner levies an administrative penalty, such commissioner shall notify the health maintenance organization in writing stating the grounds upon which the commissioner believes the certificate should be denied, suspended or revoked or the penalty levied. The applicant may, within 15 days from receipt of such notice, make written request to the commissioner for a hearing thereon. The commissioner shall hear such party or parties within 20 days after receipt of such request and shall give not less than 10 days' written notice of the time and place of the hearing. Within 15 days after such hearing the commissioner shall affirm, reverse or modify the previous action, specifying the reasons therefor. Pending such hearing and decision thereon the commissioner may suspend or postpone the effective date of the previous action.

Upon the request of the commissioner, a representative of the secretary of health and environment who is licensed to practice medicine and surgery shall be in attendance at the hearing and shall participate in the proceedings. Recommendations received pursuant to this subsection may be rejected or accepted in full or in part by the commissioner. Nothing in this subsection shall be construed to limit or modify in any way the authority given by the provisions of this act to the commissioner to deny, suspend or revoke a certificate or to levy an administrative penalty in lieu of suspension or revocation.

(b) Any person aggrieved by an order of the commissioner may apply within 30 days after the rendition of the order, to the district court of the county in which the order of the commissioner is to become effective for a review of such order or decision. If the order of the commissioner is to become effective in more than one county, the application must be to the district court of any one of such counties.

(c) Any party to any such review proceeding in a district court may appeal from the final decision rendered by such court in such proceedings to the supreme court as provided by K.S.A. 60-2103.

Sec. 3. K.S.A. 40-3209 is hereby amended to read as follows: 40-3209. (a) All forms of contracts issued by the organization to enrollees or other marketing documents purporting to describe the organization's health care services shall contain as a minimum:

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

(2) The locations of all facilities, the hours of operation and the services which are provided in each facility in the case of staff and group practices; in all other cases, a list of providers by specialty with a list of addresses and telephone numbers;

(3) ~~The predetermined periodic rate of payment which the enrollee is obliged to pay;~~ The financial responsibilities of the enrollee and the amount of any deductible, copayment or coinsurance required;

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

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

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

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

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

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

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

Sec. 4. K.S.A. 40-3227 is hereby amended to read as follows: 40-3227. (a) Unless otherwise provided below, each health maintenance organization doing business in this state shall deposit with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities or any combination of these or other measures that are acceptable in the amount set forth in this section for the payment of uncovered expenditures.

(b) The amount for an organization that is beginning operation shall be the greater of: (1) Five percent of its estimated <u>average monthly uncovered</u> expenditures for ~~health care services for~~ its first year of operation; or

(2) twice its estimated average monthly uncovered expenditures for its first year of operation; or

(3) ~~$10,000~~ <u>$150,000</u>.

At the beginning of each succeeding year, unless not applicable, the health maintenance organization shall deposit with the organization or trustee, cash, securities or any combination of these or other measures

acceptable to the commissioner, in an amount equal to 4% of its estimated annual uncovered expenditures for that year.

(c) Unless not applicable, an organization that is in operation on the effective date of this act shall make a deposit equal to the larger of: (1) One percent of the preceding 12 months' uncovered expenditures; or

(2) until April 1, 1989, $10,000. On and after April 1, 1989, organizations making deposits under this paragraph shall increase the amount of such deposit by an amount of not less than $14,000 per year until the deposit totals $150,000;

In the second year, if applicable, the amount of the additional deposit shall be equal to 2% of its estimated annual uncovered expenditures. In the third year, if applicable, the additional deposit shall be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth year and subsequent years, if applicable, the additional deposit shall be equal to 4% of its estimated annual uncovered expenditures for each year. Each year's estimate, after the first year of operation, shall reasonably reflect the prior year's operating experience and delivery arrangements.

(d) The commissioner may waive any of the deposit requirements set forth in subsections (b) and (c) whenever satisfied that: (1) The organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year; or (2) the organization's performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income; or (3) the assets of the organization or its contracts with insurers, hospital or medical service corporations, governments or other organizations are reasonably sufficient to assure the performance of its obligations.

(e) When an organization has achieved a net worth not including land, buildings and equipment of at least $1,000,000 or has achieved a net worth including land, buildings and equipment of at least $5,000,000, the annual deposit requirement shall not apply.

If the organization has a guaranteeing organization which has been in operation for at least five years and has a net worth not including land, buildings and equipment of at least $1,000,000 or which has been in operation for at least 10 years and has a net worth including land, buildings and equipment of at least $5,000,000, the annual deposit requirement shall not apply. If the guaranteeing organization is sponsoring

more than one organization, the net worth requirement shall be increased by a multiple equal to the number of such organizations. This requirement to maintain a deposit in excess of the deposit required of an accident and health insurer shall not apply during any time that the guaranteeing organization maintains for each organization it sponsors a net worth at least equal to the capital and surplus requirements set forth in article 11 of chapter 40 of the Kansas Statutes Annotated for an accident and health insurer. The deposit requirements imposed by this act shall not apply to health maintenance organizations not organized under the laws of this state to the extent an amount equal to or exceeding that required by this act has been deposited with the commissioner or an organization or trustee acceptable to the department of insurance of its state of domicile for the benefit of Kansas enrollees.

(f) All income from deposits shall belong to the depositing organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner before being substituted.

(g) In any year in which an annual deposit is not required of an organization, at the organization's request the commissioner shall reduce the required, previously accumulated deposit by $100,000 for each $250,000 of net worth in excess of the amount that allows the organization not to make the annual deposit. If the amount of net worth no longer supports a reduction of its required deposit, the organization shall immediately redeposit $100,000 for each $250,000 of reduction in net worth, provided that its total deposit shall not exceed the maximum required under this section.

Sec. 5. K.S.A. 40-3203, 40-3207, 40-3209 and 40-3227 are hereby repealed.

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

Explanatory Memorandum For
Legislative Proposal No. 4

Legislative Proposal No. 4 relates to health maintenance organizations and would require such organizations to make a conversion contract available to persons who are terminated from a group but remain in the HMO's service area and for persons whose coverage in an HMO is terminated because the HMO is ceasing to do business in the service area. This proposal would provide HMO subscribers with essentially the same conversion options as are available from commercial health insurers and mutual nonprofit hospital and medical service corporations. Because of the unique nature of HMO's, the geographical area served by the conversion option is more limited than that required by other health care financing entities but will accommodate the needs of most people.

Senate

EXHIBIT 4

LEGISLATIVE PROPOSAL NO. 4

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

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

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

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

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

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

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

(5) all criteria by which an enrollee may be disenrolled or denied reenrollment; ~~and~~

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

(7) a provision that an enrollee or a covered dependent of an enrollee whose coverage under a health maintenance organization group contract has been terminated for any reason but who remains in the service area and who has been continuously covered by the health maintenance organization for at least three months shall be entitled to obtain a converted contract. The converted contract shall provide coverage at least equal to the conversion coverage options generally available from insurers or mutual nonprofit hospital and medical service corporations in the service area at the applicable premium cost. The group or group members shall be solely responsible for paying the premiums for the alternative coverage. The

frequency of premium payment shall be the frequency customarily required by the health maintenance organization or insurer for the policy form and plan selected except that the insurer or health maintenance organization shall not require premium payments less frequently than quarterly. The coverage shall be available to all members of the group without medical underwriting. The requirement imposed by this subsection shall not apply to a contract which provides benefits for specific diseases or for accidental injuries only nor shall it apply to any employee or member or such employee's or member's covered dependents whose termination of benefits under the contract occurred because: (1) Such person was terminated for cause as permitted by the group contract approved by the commissioner; (2) any discontinued group coverage was replaced by similar group coverage within 31 days; or (3) the employee or member is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. Written application for the converted contract shall be made and the first premium paid not later than 31 days after termination of the group coverage and shall become effective the day following the termination of coverage under the group contract. In addition, the converted contract shall be subject to the provisions contained in paragraphs (2), (4), (5), (6), (7), (8), (9), (13), (14), (15), (16), (18), (19), (20) and (21) of subsection (D) of K.S.A. 40-2209, and amendments thereto.

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

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

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

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

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

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

Explanatory Memorandum For
Legislative Proposal No. 5

Legislative Proposal No. 5 would permit the Commissioner of Insurance to require insurance companies and other insurance mechanisms doing business in Kansas to be audited annually by an independent certified public accountant. Despite the existence of insurance guaranty funds, the insolvency of an insurer places policyholders, claimants, agents, other insurers and others in a difficult and costly position. In addition, some insurance mechanisms such as HMO's and prepaid service plans are not subject to guaranty fund laws and the problems caused by insolvency are therefore even more acute.

Legislative Proposal No. 5 will not prevent insolvencies. It will, however, produce another review of an insurer's financial condition and serve as a valuable complement to the "early warning" system administered by the National Association of Insurance Commissioners and the financial condition examinations and internal auditing activities conducted by insurance departments.

House
Controversial

EXHIBIT 5

LEGISLATIVE PROPOSAL NO. 5

AN ACT relating to insurance; audited financial reports; rules and regulations; amending K.S.A. 40-225 and repealing the existing section.

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

Section 1. K.S.A. 40-225 is hereby amended to read as follows: 40-225. Every insurance company or fraternal benefit society doing business in this state shall, if the statement of condition required below is compatible, participate in the insurance regulatory information system administered by the national association of insurance commissioners and shall annually, on January 1 or within 60 days thereafter, file with the commissioner of insurance a statement of its condition as of the preceding December 31. The commissioner may upon request, and for good cause shown grant a reasonable extension of time within which such statement may be filed. Such statement shall be made upon the form prescribed and adopted from time to time by the national association of insurance commissioners with such additions or amendments thereto as shall seem to the commissioner of insurance best adapted to elicit from such companies a true exhibit of their condition.

The commissioner may require any insurer, fraternal benefit society, mutual nonprofit hospital and medical service corporation, health maintenance organization or any prepaid service plan operating under Articles 19a, 19b or 19d of Chapter 40 of the Kansas Statutes Annotated to have an annual audit by an independent certified public accountant and file an audited financial report in accordance with rules and regulations adopted to effectuate such requirement.

It shall be the duty of the commissioner of insurance, on or before December 1 of each year, to furnish, upon request, to each company required to make such report two or more printed forms as herein prescribed. The commissioner may also at any time address any proper inquiries to any such insurance company or fraternal benefit society or its officers in relation to its condition or any other matter connected with its transactions. Each company, society or officer addressed shall promptly and truthfully reply in

writing to all such inquiries, and such replies shall be verified if the commissioner of insurance requires. If the national association of insurance commissioners does not prescribe such a form as is herein contemplated for any insurance company or fraternal benefit society doing business in this state, the commissioner of insurance shall prescribe and adopt a form to be used by such companies. The statement of any insurance company organized under the laws of a country other than the United States may, in the discretion of the commissioner of insurance, include only its assets, liabilities and transactions in the United States.

Sec. 2. K.S.A. 40-225 is hereby repealed.

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

Explanatory Memorandum For
Legislative Proposal No. 6

This proposal would require all mutual nonprofit hospital and medical service corporations doing business in this state to offer an additional conversion option to persons who are terminated from a group accident and sickness contract. The conversion option presently required entitles terminated group members to adequate coverage but the cost is quite high. The additional option that would be required by enactment of Legislative Proposal No. 6 would still permit the terminated group members to obtain meaningful insurance protection but the deductible and copayment provisions would enable them to do so at a lower cost.

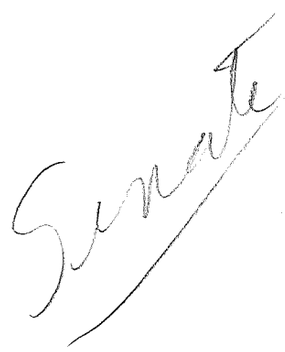


EXHIBIT 6

LEGISLATIVE PROPOSAL NO. 6

AN ACT relating to insurance; accident and sickness coverage; conversion rights; nonprofit medical and hospital service corporations; amending K.S.A. 40-19c06 and repealing the existing section.

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

Section 1. K.S.A. 40-19c06 is hereby amended to read as follows: 40-19c06. (1) No subscription agreement, except as provided in subsection (4) of this section, between a corporation organized under the nonprofit medical and hospital service corporation act and a subscriber, shall entitle more than one person to benefits, except that a "family subscription agreement" may be issued, at an established subscription charge, to a husband and wife, or husband, wife, and their dependent child or children and any other person dependent upon the subscriber. Only the subscriber must be named in the subscription agreement.

(2) Every subscription agreement entered into by any such corporation with any subscriber shall be in writing and a certificate stating the terms and conditions shall be furnished to the subscriber to be kept by the subscriber. No such certificate form shall be made, issued or delivered in this state unless it contains the following provisions: (a) A statement of the nature of the benefits to be furnished and the period during which they will be furnished, and if there are any benefits to be excepted, a detailed statement of such exceptions printed as hereinafter specified; (b) a statement of the terms and conditions, if any, upon which the subscription agreement may be canceled or otherwise terminated at the option of either party; (c) a statement that the subscription agreement includes the endorsements and attached papers, if any, and contains the entire contract; (d) a statement that no statement by the subscriber in the application for a subscription agreement shall avoid the subscription agreement or be used in any legal proceeding, unless such application or an exact copy is included in or attached to such subscription agreement, and that no agent or representative of such corporation, other than an officer or officers designated therein, is authorized to change the subscription agreement or

waive any of its provisions; (e) a statement that if the subscriber defaults in making any payments under the subscription agreement, the subsequent acceptance of a payment by the corporation or by one of its duly authorized agents shall reinstate the subscription agreement but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of such acceptance; (f) a statement of the period of grace which will be allowed the subscriber for making any payment due under the subscription agreement. Such period shall not be less than 10 days; and (g) if applicable, a statement of the kind of hospital in which the subscriber may receive benefits and the types of benefits to which the subscriber may be entitled to in such kinds of hospitals. The subscriber shall be entitled to benefits in any nonparticipating hospital in Kansas which is licensed by the secretary of health and environment and in which the average length of stay of patient is similar to the average length of stay in participating hospitals

(3) In every such subscription agreement made, issued or delivered in this state: (a) All printed portions shall be plainly printed; (b) the exceptions of the subscription agreement shall appear with the same prominence as the benefits to which they apply; (c) if the subscription agreement contains any provisions purporting to make any portion of the articles of incorporation or bylaws of the corporation a part of the subscription agreement, such portion shall be set forth in full; and (d) there shall be a brief description of the subscription agreement on the first page and on its filing back.

(4) Any such corporations may issue a group or blanket subscription agreement, provided the group of persons insured conforms to the requirements of law applicable to other companies writing group or blanket sickness and accident insurance policies and provided such subscription agreement and the individual certificates issued to members of the group shall comply in substance with this section. Any such subscription agreement may provide for the adjustment of the premiums based upon the experience at the end of the first year or of any subsequent year of insurance and such readjustment may be made retroactive in the form of a rate credit or a cash refund.

(5)(a) Any group subscription agreement issued pursuant to subsection (4) of this section shall provide that an employee or member or such

employee's or member's covered dependents whose insurance under the group subscription agreement has been terminated for any reason, including discontinuance of the group in its entirety or with respect to an insured class, and who has been continuously insured under the group subscription agreement or under any group policy or subscription agreement providing similar benefits which it replaces for at least three months immediately prior to termination, shall be entitled to have such coverage nonetheless continued under the group policy for a period of six months and at the end of such six-month period of continuation, such employee or member or such employee's or member's covered dependents shall be entitled to obtain, at the employee's, member's or dependent's option either, (1) a converted subscription agreement providing coverage equal to 80% of that afforded under the group subscription agreement for basic hospital, surgical and medical benefits. ~~Any person eligible for a converted subscription agreement~~ Persons selecting this option shall also be entitled to obtain major medical expense coverage which will provide hospital, medical and surgical expense benefits to an aggregate maximum of not less than $50,000. The major medical expense coverage ~~required~~ may be subject to a copayment by the covered person of not more than 20% of covered charges and a deductible stated on a per person, per family, per illness, per benefit period, or per year basis or a combination of such bases of not more than $500 per person subject to a maximum annual deductible of $750 per family; or, (2) a subscription agreement which imposes a deductible of not less than $1,000 per subscriber and not less than $2,000 per family and subjects the covered person to a copayment of not more than 20% of covered charges with a $1,000 maximum copayment per subscriber and $2,000 maximum copayment per family per contract year and providing a lifetime maximum benefit of not less than $1,000,000. The requirement imposed by this subsection shall not apply to a group subscription agreement which provides benefits for specific diseases or for accidental injuries only nor shall it apply to any employee or member or such employee's or member's covered dependents whose termination of insurance under the group subscription agreement occurred because:

~~(1)~~ (A) Such person failed to pay any required contribution after receiving reasonable notice of such required contribution from the insurer in accordance with rules and regulations adopted by the commissioner of insurance;

~~(2)~~ (B) any discontinued group coverage was replaced by similar group coverage within 31 days; or

~~(3)~~ (C) the employee or member is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. In the event the group policy is terminated and not replaced the employee or member, at the option of the employee or member or at the option of the insurer, may be issued a conversion policy or certificate which otherwise meets these provisions in lieu of the right to continue group coverage required herein.

(b) Written application for the converted subscription agreement shall be made and the first premium paid to the insurer not later than 31 days after termination of the group coverage and shall become effective the day following the termination of insurance under the group subscription agreement. In addition, the converted subscription agreement shall be subject to the provisions contained in paragraphs (2), (3), (4), (5), (6), (7), (8), (9), (13), (14), (15), (16), (18), (19), (20) and (21) of subsection (D) of K.S.A. 40-2209, and amendments thereto.

Sec. 2. K.S.A. 40-19c06 is hereby repealed.

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

Explanatory Memorandum For
Legislative Proposal No. 7

The intent of this proposal is to prevent accident and health insurance companies from accepting only the healthy members of a group (as determined by the insurer's underwriting standards) and rejecting those whose health condition or some other perceived infirmity does not meet the insurer's standards. The proposal does not prevent insurers from denying coverage to the group as a whole but it would prevent insurers from using the advantageous elements of the group concept while avoiding the disadvantages. In so doing, it will reduce the number of people who are treated as second class citizens by the insurance mechanism as well as reducing the number of people whose access to adequate health insurance is greatly impaired by an insurer's actions.

EXHIBIT 7

LEGISLATIVE PROPOSAL NO. 7

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

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

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

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

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

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

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

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

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

(B) Each such policy shall contain in substance: (1) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by

the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or the insured's beneficiary.

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

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

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

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

(D) A group policy of insurance delivered or issued for delivery or renewed which provides hospital, surgical or major medical expense insurance, or any combination of these coverages, on an expense incurred

basis, shall provide that an employee or member or such employee's or member's covered dependents whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy or under any group policy providing similar benefits which it replaces for at least three months immediately prior to termination, shall be entitled to have such coverage nonetheless continued under the group policy for a period of six months and have issued to the employee or member of such employee's or member's covered dependents by the insurer, at the end of such six-month period of continuation, a policy of health insurance which conforms to the applicable requirements specified in this subsection. This requirement shall not apply to a group policy which provides benefits for specific diseases or for accidental injuries only. An employee or member or such employee's or member's covered dependents shall not be entitled to have such coverage continued or a converted policy issued to the employee or member of such employee's or member's covered dependents if termination of the insurance under the group policy occurred because: (a) The employee or member or such employee's or member's covered dependents failed to pay any required contribution after receiving reasonable notice of such required contribution from the insurer in accordance with rules and regulations adopted by the commissioner of insurance; (b) any discontinued group coverage was replaced by similar group coverage within 31 days; (c) the employee or member is or could be covered by medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded); or (d) the employee or member is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. In the event the group policy is terminated and not replaced the employee or member, at the option of the employee or member or at the option of the insurer, may be issued a conversion policy or certificate which otherwise meets these provisions in lieu of the right to continue group coverage required herein. The continued coverage and the issuance of a converted policy shall be subject to the following conditions:

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

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

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

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

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

(6) The insurer shall not be required to issue a converted policy covering any person if such person is or could be covered by medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded). Furthermore, the insurer shall not be required to issue a converted policy covering any person if:

(a)(i) such person is covered for similar benefits by another hospital, surgical medical or major medical expense insurance policy or hospital or

medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program, or

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

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

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

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

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

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

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

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

(a) Either the benefits provided under the sources referred to in (i) and (ii) above for such person or benefits provided or available under the sources referred to in (iii) above for such person, together with the benefits provided by the converted policy, would result in over-insurance

according to the insurer's standards on file with the commissioner of insurance, or the converted policyholder fails to provide the requested information;

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

(c) eligibility of the insured person for coverage under medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded) or under any other state or federal law providing for benefits similar to those provided by the converted policy; or

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

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

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

(10) Subject to the provisions and conditions of this act, if the group insurance policy from which conversion is made insures the employee or member for basic hospital or surgical expense insurance, the employee or member shall be entitled to obtain a converted policy providing, at the insured's option, coverage on an expense incurred basis under any one of the plans meeting the following requirements:

Plan A

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

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

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

Plan B

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

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

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

Plan C

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

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

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

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

maximum dollar amounts in plans A, B and C shall be rounded to the nearest multiple of $10.

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

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

(i) the smaller of the following amounts:

1. The maximum benefit provided under the group policy.

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

(ii) The smaller of the following amounts:

1. The maximum benefit provided under the group policy.

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

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

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

If the maximum benefit is determined by (a)(ii) above, the insurer may require that the deductible be satisfied during a period of not less than

three months if the deductible is $100 or less, and not less than six months if the deductible exceeds $100.

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

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

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

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

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

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

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

security amendments of 1965 or as later amended or superseded) or under any other state or federal law providing for benefits similar to those provided by the converted policy.

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

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

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

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

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

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

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

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

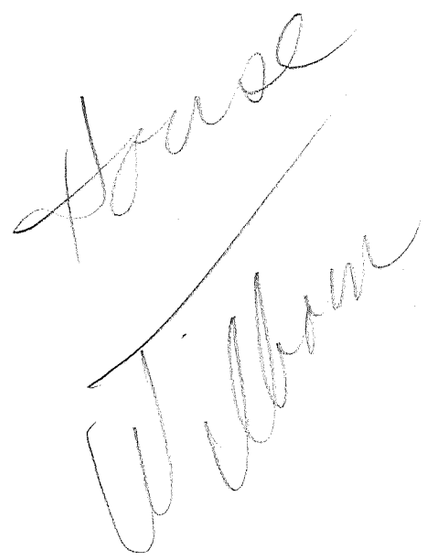
(21) The insurer shall give the employee or member and such employee's or member's covered dependents reasonable notice of the right to convert at least once during the six-month continuation period in accordance with rules and regulations adopted by the commissioner of insurance.

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

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

Explanatory Memorandum For
Legislative Proposal No. 8

Legislative Proposal No. 8 suggests several enhancements in the system governing examinations of insurance companies. First, it will permit the insurance commissioner to employ outside expertise, for example an independent actuary to evaluate loss reserves, and charge the costs for such services to the company being examined. Second, the proposal permits the Commissioner to impose an additional fee on examination costs to fund the purchase of personal computers and software to be used by examiners in conducting a more effective and efficient examination. In addition, the amount realized from this added charge can be used to pay maintenance fees associated with a software program purchased by the National Association of Insurance Commissioners for use by the several states as an improvement in the examination process. It should be noted that the proposal limits the amount that can be incurred by any company and its affiliates as a result of enactment of this proposal to $25,000 per examination. However, since the outside expertise will be rarely used the actual additional cost per examination will normally be much less (e.g. the amount now assessed for annual leave is approximately $6 per examiner, per examination day).



LEGISLATIVE PROPOSAL NO. 8

AN ACT relating to insurance; fees for examinations; compensation and expenses of examiners; amending K.S.A. 40-223 and repealing the existing section.

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

Section 1. K.S.A. 40-223 is hereby amended to read as follows: 40-223. Any person who makes any examination under the provisions of this act, except as provided in K.S.A. 40-110 and 40-253 and amendments thereto, may receive, as full compensation for such person's services, on a per diem basis an amount fixed by the commissioner, which shall not exceed the amount recommended by the national association of insurance commissioners, for such time necessarily and actually occupied in going to and returning from the place of such examination and for such time the examiner is necessarily and actually engaged in making such examination including any day within the regular workweek when the examiner would have been so engaged had the company or society been open for business, together with such necessary and actual expenses for traveling and subsistence as the examiner shall incur because of the performance of such services. For the purposes of this act, "necessary and actual expenses" shall be limited, whether for travel within the state or travel outside the state, to those limitations expressed in K.S.A. 75-3207 and amendments thereto which pertain to official travel outside the state. The daily charge shall be calculated by dividing the amount the examiner is authorized by the commissioner of insurance to charge per week by the number of days in the regular workweek of the company or society being examined.

All of such compensation, expenses, the employer's share of the federal insurance contributions act taxes, the employer's contribution to the Kansas public employees retirement system as provided in K.S.A. 74-4920 and amendments thereto, the self-insurance assessment for the workmen's compensation act as provided in K.S.A. 44-576 and amendments thereto, the employer's cost of the state health care benefits program under K.S.A. 75-6507, ~~and~~ a pro rata amount determined by the commissioner to provide

annual leave for the examiner not to exceed the number of days allowed state officers and employees in the classified service pursuant to regulations promulgated in accordance with the Kansas civil service act, all outside consulting and data processing fees necessary to perform any examination, and a sum equal to the amount charged for annual leave to fund the purchase, maintenance and enhancement of examination equipment and computer software shall be paid to the commissioner of insurance by the insurance company or society so examined, on demand of the commissioner. The amount paid for all outside consulting and data processing fees necessary to perform any examination, and the sum equal to the amount charged for annual leave to fund the purchase of examination equipment and computer software shall not collectively total more than $25,000 at any one company examination including examination of its subsidiaries, or combination thereof. Such demand shall be accompanied by the sworn statement of the person making such examination, setting forth in separate items the number of days necessarily and actually occupied in going to and returning from the place of such examination, the number of days the examiners were necessarily and actually engaged in making such examination including those days within the regular workweek while the examination was in progress and the company or society had closed for business, and the necessary and actual expenses for traveling and subsistence, incurred in and on account of such services. A duplicate of every such sworn statement shall be kept on file in the office of the commissioner of insurance. All moneys so paid to the commissioner of insurance shall be remitted to the state treasurer and the state treasurer shall issue duplicate receipts therefor, one to be delivered to the commissioner of insurance and the other to be filed with the director of accounts and reports.

Sec. 2. K.S.A. 40-223 is hereby repealed.

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

URANCE REFORM ACT OF 1988

The Insurance Reform Act of 1988 would enact specific criteria under which the Insurance Commissioner could reject rates for fire, marine, inland marine, allied lines (K.S.A. 1987 Supp. 40-927) and property and casualty insurance (K.S.A. 1987 Supp. 40-1112) as excessive, inadequate or unfairly discriminatory. The bill also would require that the Commissioner give due consideration to the companies' earnings or losses resulting from the investment of unearned premiums and loss reserves. Under current law, the Commissioner is authorized to promulgate reasonable rating standards for these classes of insurance through rules and regulations and is not required to take into account the companies' investment income.

The bill further would establish that when reviewing a filing, the Commissioner could require the insurers to provide, at the insurers' expense, all information necessary to evaluate the reasonableness of the filing, including an independent evaluation. Moreover, in any administrative proceeding, the insurers would be required to carry the burden of proof to show that rates were not excessive, inadequate or unfairly discriminatory.

When the Commissioner finds a rate or rate change to be excessive, inadequate, or unfairly discriminatory, he could require that a new rate schedule be filed within 30 days. He would be granted additional authority to retroactively adjust premiums to the effective date of the rate or rate change.

Finally, the bill would require any insurer attempting to cease the writing of insurance in Kansas or discontinue the renewal of certain property or casualty lines to submit a plan to the Commissioner outlining an orderly withdrawal from the market and providing for the minimization of the impact on the policyholders and the public. The proposed withdrawal or discontinuance could not take effect until such plan had been approved by the Commissioner.

EXHIBIT 9