Approved February 2, 1988
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

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

9:00 a.m./~~p.m.~~ on January 27, 1988 in room 529-S of the Capitol.

All members were present except:

Senators Kerr and Burke - Excused

Committee staff present:

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

Conferees appearing before the committee:

Ron Todd, Kansas Insurance Department
David Douglas, Savings and Loan Commissioner
Jim Turner, Kansas League of Savings Institutions

The minutes of January 26 were approved.

The meeting continued with the testimony of Ron Todd of the Insurance Department requesting the introduction of four bills. (See Attachments I through IV.)

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

The hearing began on SB 506 dealing with guarantee stock. Jim Turner, Kansas League of Savings Institutions, testified in support of the bill. (See Attachment V.)

David Douglas, Savings and Loan Commissioner, stood in support of SB 506.

Sen. Harder made a motion to amend line 48 as suggested by Mr. Turner, Sen. Reilly seconded, and the motion carried.

Sen. Harder made a motion to report SB 506 favorable for passage as amended, Sen. Reilly seconded, and the motion carried.

The meeting was adjourned.

SENATE COMMITTEE

ON

FINANCIAL INSTITUTIONS AND INSURANCE

OBSERVERS
(Please print)

DATE	NAME	ADDRESS	REPRESENTING
	Gerald L Goodell	Topeka	Ks League of Savings
	David Dongan	Topeka	Savings & Loan Dept
	Jan Turner	Topeka	KLSI
	Joe D. Morris	TOPEKA	KCSI

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.

Attachment I

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.

~~(c) 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.

Attachment II

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. 6

BC/85

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.

Attachment III

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.

Attachment IV

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.

KLSI Kansas League of Savings Institutions

JAMES R. TURNER, President • Suite 512 • 700 Kansas Ave. • Topeka, KS 66603 • 913/232-8215

January 27, 1988

TO: SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

FROM: JIM TURNER, KANSAS LEAGUE OF SAVINGS INSTITUTIONS

RE: S.B. 506 (COMMISSIONS-GUARANTEE STOCK)

The Kansas League of Savings Institutions appreciates the opportunity to appear before the Senate Committee on Financial Institutions and Insurance in support of S.B. 506 which would allow the payment of commissions in connection with the sale of guarantee stock.

This proposal amends a 1943 statute which restricted the payment of commission in connection with the sale of stock of state-chartered savings and loan associations. There is no such restriction to impair the sale of stock of federally-chartered associations and this measure would create parity in this area. The bill was introduced by KLSI at the request of the State Savings and Loan Commissioner.

Further, we would request that the bill be amended to become effective upon publication in the Kansas Register. Currently several state-chartered associations have stock sales under consideration and enactment in the Register would avoid the need for a "Special Order."

We would appreciate the committee's earliest action in reporting S.B. 506 favorably for passage.

James R. Turner
President

JRT:bw

Attachment V