Approved January 23, 1990
Date

MINUTES OF THE House COMMITTEE ON Insurance

The meeting was called to order by Dale Sprague
Chairperson

3:30 xx.m./p.m. on January 16, 1990 in room 531-n of the Capitol.

All members were present except: Representative Marvin Littlejohn
Representative Kent Campbell
Representative Theo Cribbs
Representative Rex Hoy

Committee staff present: Chris Courtwright, Research Department
Emalene Correll, Research Department
Bill Edds, Revisor of Statutes
Patti Kruggel, Committee Secretary

Conferees appearing before the committee:

see attached list

The meeting was called to order by the Chairman at 3:40 p.m.

The Chairman took the opportunity to welcome Representative Henry Helgerson as a new member of the Committee.

The Chairman announced that the Committee will meet together with the Senate Financial and Commercial Insurance Committee in a joint hearing to discuss Costs of Health Care Insurance tentatively scheduled for January 30, 1990. He also asked that the Insurance Department be prepared to present testimony at that hearing.

Request for introduction of committee bills were heard at this time.

Dick Brock, Insurance Department, provided copies (Attachment 1) of the Insurance Departments Proposals and asked that the Committee make introduction of Legislative Proposals 1, 2, 4, 6, 7, and 10.

Legislative Proposal No. 1 -- Relating to rate filings; prospective loss costs, rating organizations, regulations.

Legislative Proposal No. 2 -- Relating to agents; continuing education requirements; insurance companies; independent study entities; limitations.

Legislative Proposal No. 4 -- Relating to health maintenance organizations; amending K.S.A. 1988 Supp. 40-3209 and repealing the existing section; also repealing K.S.A. 1988 Supp. 40-3209a.

Legislative Proposal No. 6 -- Relating to health maintenance organizations; deposit requirements; amending K.S.A. 1988 Supp. 40-3227 and repealing the existing sections.

Legislative Proposal No. 7 -- Relating to agents; agencies; certification; reports to commissioner; penalty; amending Sec. 2., 1988 House Bill No. 3055 and repealing the existing section.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE House COMMITTEE ON Insurance,

room 531-N, Statehouse, at 3:30 ~~a.m.~~/p.m. on January 16, 19~~89~~.

Legislative Proposal No. 10 -- Relating to firefighters relief associations; calculation of tax distribution; excluding effects of reappraisal; amending K.S.A. 40-1706 and repealing the existing section.

Representative Helgerson made a motion to introduce Legislative Proposals 1, 2, 4, 6, 7, and 10. Representative Brown seconded. The motion carried.

The Chairman announced the next meeting of the Committee would be January 23, 1990.

The meeting was adjourned at 3:55 p.m.

GUEST LIST

COMMITTEE: ______________________ DATE: 1/16/90

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Dick Brock	Topeka	Ins Dept
Jeff Rockett	Topeka	Ks Assn of P&C Ins Co
Lee WRIGHT	Overland Park	Farmers Ins Group
Terry Leatherman	Topeka	K.C.C.I.
JACK ROBERTS	TOPEKA	BC-BS
Kay Coles	Topeka	K-NEA
Bill Curtis	Topeka	Ks. Assoc. of School Bds
Tom Bell	"	Ks. Hosp. Assn.

Explanatory Memorandum For

Legislative Proposal No. 1

This recommendation would permit the Commissioner of Insurance to require rating organizations who develop and file rates for various kinds and classes of insurance on behalf of member and subscriber companies to develop and file only that portion of the total rate that is estimated to be necessary to cover losses. Individual insurance companies would have to supplement the so-called "loss cost rate" with the amount necessary to reflect their expenses, profit and the effect of their individual investment results.

While competition has produced overall rate levels that generally reach the same goals, the mandatory application of this technique on those kinds and classes of insurance where it is appropriate, will assure a more universal use of rates that are reflective of individual company management performance. It will also produce a more accurate public perception of the role of rating organizations while continuing to permit the absolutely essential use of loss data reflective of the experience of the industry as a whole.

Enabling legislation is the necessary vehicle because the orderly transition to loss cost rate filings will require great flexibility with regard to the kinds and classes of insurance to be affected and the time frames to be used. The use of administrative regulations to implement the process provides the necessary flexibility while continuing to allow legislative oversight on such implementation.

Attachment 1

LEGISLATIVE PROPOSAL NO. 1

AN ACT relating to insurance; rate filings, prospective loss costs, rating organizations, regulations.

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

Section 1. (a) Notwithstanding the provisions of K.S.A. 1988 Supp. 40-928(b), the commissioner may adopt regulations that require rating organizations to file rates which are only reflective of prospective loss costs. Any such regulations shall specify the kinds of insurance, coverages, or situations to which the requirements apply and shall clearly set forth the effective date and any procedures necessary to affect an orderly transition to the new system.

(b) For purposes of this act, "prospective loss costs" shall mean that portion of a rate which:

(1) Does not include provisions for expenses, other than loss adjustment expenses, or profit; and

(2) is based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time.

Sec. 2. Notwithstanding the provisions of K.S.A. 1988 Supp. 40-1113(b), the commissioner may adopt regulations that require rating organizations to file rates which are only reflective of prospective loss costs. Any such regulations shall specify the kinds of insurance, coverages, or situations to which the requirements apply and shall clearly set forth the effective date and any procedures necessary to affect an orderly transition to the new system.

(b) For purposes of this act, "prospective loss costs" shall mean that portion of a rate which:

(1) Does not include provisions for expenses, other than loss adjustment expenses, or profit; and

(2) is based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time.

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

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Explanatory Memorandum For

Legislative Proposal No. 2

Legislative Proposal No. 2 would codify an existing administrative regulation the authority for which has been questioned by the Joint Committee on Administrative Rules and Regulations.

The intent of the current regulation and Legislative Proposal No. 2 is to enhance the effectiveness of the continuing education requirements applicable to insurance agents by limiting the amount of continuing education credit agents can receive from a single, self-interested source. Conversely, these limitations will result in agents being exposed to at least two sources of continuing education programs which, in turn, will result in the completion of a more diverse continuing education experience.

Specifically, the proposal provides that agents can accumulate no more than 9 of the 12 hours required of an agent licensed for one class of insurance or 18 hours of the 24 hour requirement for multiple line agents from courses sponsored by any insurance company. Similarly, the proposal would place 3 hour and 6 hour limitations on the credit that could be given for independent study courses e.g. correspondence courses.

Because of the minimal continuing education requirements that apply to pre-need funeral plans, crop insurance and title insurance, these limitations would not apply. Also, since current law permits the commissioner to unilaterally approve specific courses that lead to a nationally recognized designation or are otherwise deemed to be meritorious, the limitations suggested by this proposal are not applicable to these programs.

LEGISLATIVE PROPOSAL NO. 2

AN ACT relating to insurance; agents; continuing education requirements; insurance companies; independent study entities; limitations.

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

Section 1. No agent to whom Section 1 (b)(1) or (2) or both of 1988 House Bill No. 3126 applies shall receive more than nine hours of continuing education credit in any one class specified in section 1(g) of 1988 House Bill No. 3126 in any one biennium for approved subjects or courses sponsored by any insurance company.

Sec. 2. No agent to whom Section 1 (b)(1) or (2) or both of 1988 House Bill No. 3126 applies shall receive more than three hours of continuing education credit in any one class specified in section 1(g) of 1988 House Bill No. 3126 in any one biennium for approved subjects or courses taken or completed by independent study but this restriction shall not apply to programs of study approved by the commissioner pursuant to section 1(g)(7) of 1988 House Bill No. 3126.

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. 3

This is a model act recently adopted by the National Association of Insurance Commissioners. It is designed to address solvency problems and regulatory concerns that have become increasingly troublesome as a result of arrangements some insurers have entered into with independent entities known as managing general agents. In some of these arrangements, significant managerial decisions have been made without the exercise of any or insufficient oversight by the insurer itself. As a result, some insurers have been forced into liquidation because of a lack of knowledge and/or a lack of control with respect to the risks it had assumed, the reinsurance it had or had not secured, the inadequate reserves it had established and undisclosed liabilities for which it was responsible.

This proposal is intended to assure that management deficiencies of this kind are eliminated or significantly reduced by requiring all such arrangements between an insurer and a managing general agent to be governed by a written contract meeting certain minimum standards; by imposing certain prohibitions on the activities of managing general agents; by requiring insurers to exercise certain management responsibilities and obtain periodic reports of essential information; subject the managing general agent to the same Insurance Department examinations as apply to the insurer; and, authorizing the assessment of specific penalties for violations.

LEGISLATIVE PROPOSAL NO. 3

AN ACT relating to insurance; managing general agents; definitions, licensure; requirements.

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

Section 1. This act may be cited as the managing general agents act.

Sec. 2. As used in this act:

(a) "Actuary" means a person who is a member in good standing of the American academy of actuaries.

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

(c) "Insurer" means any person, firm, association or corporation duly licensed in this state as an insurance company.

(d) "Managing general agent" (MGA) means any person, firm, association or corporation who manages all or part of the insurance business of an insurer (including the management of a separate division, department or underwriting office) and acts as an agent for such insurer whether known as a managing general agent, manager or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross written premium equal to or more than 5% of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year together with one or more of the following: (1) adjusts or pays claims in excess of an amount determined by the commissioner, or (2) negotiates reinsurance on behalf of the insurer.

(e) Notwithstanding the above, the following persons shall not be considered as MGAs for the purposes of this act:

(1) An employee of the insurer;

(2) a U.S. manager of the United States branch of an alien insurer; and

(3) an underwriting manager which, pursuant to contract, manages all the insurance operations of the insurer, is under common control with the insurer, subject to the holding company regulatory act, and whose compensation is not based on the volume of premiums written.

(f) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

Sec. 3. (a) No person, firm, association or corporation shall act in the capacity of an MGA with respect to risks located in this state for an insurer licensed in this state unless such person is a licensed agent or broker in this state.

(b) No person, firm, association, or corporation shall act in the capacity of an MGA representing an insurer domiciled in this state with respect to risks located outside this state unless such person is licensed as an agent or broker in this state pursuant to the provisions of this act.

(c) The commissioner may require a bond in an amount acceptable to him for the protection of the insurer.

(d) The commissioner may require the MGA to maintain an errors and omissions policy.

Sec. 4. No person, firm, association, or corporation acting in the capacity of an MGA shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party and where both parties share responsibility for a particular function, specifies the division of such responsibilities and which contains the following minimum provisions:

(a) The insurer may terminate the contract for cause upon written notice to the MGA. The insurer may suspend the underwriting authority of the MGA during the pendency of any dispute regarding the cause for termination.

(b) The MGA will render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis.

(c) All funds collected for the account of an insurer will be held by the MGA in a fiduciary capacity in a bank which is a member of the federal reserve system. This account shall be used for all payments on behalf of the insurer. The MGA may retain no more than three months estimated claim payments and allocated loss adjustment expenses.

(d) Separate records of business written by the MGA will be maintained. The insurer shall have access and right to copy all accounts and records related to its business in a form usable by the insurer and the commissioner shall have access to all books, bank accounts and records of

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the MGA in a form usable to the commissioner. Such records shall be retained until the insurer and business to which they pertain has been the subject of an examination pursuant to the provisions of K.S.A. 40-222.

(e) The contract may not be assigned in whole or part by the MGA.

(f) Appropriate underwriting guidelines including:

(1) The maximum annual premium volume;

(2) the basis of the rates to be charged;

(3) the types of risks which may be written;

(4) maximum limits of liability;

(5) applicable exclusions;

(6) territorial limitations;

(7) policy cancellation provisions; and

(8) the maximum policy period.

The insurer shall have the right to cancel or non-renew any policy of insurance subject to the applicable laws and regulations relating to the cancellation and non-renewal of insurance policies.

(g) If the contract permits the MGA to settle claims on behalf of the insurer:

(1) All claims must be reported to the company in a timely manner.

(2) A copy of the claim file will be sent to the insurer at its request or as soon as it becomes known that the claim:

(A) Has the potential to exceed an amount determined by the commissioner or exceeds the limit set by the company; whichever is less;

(B) involves a coverage dispute;

(C) may exceed the MGAs claims settlement authority;

(D) is open for more than six months; or

(E) is closed by payment of an amount set by the commissioner or an amount set by the company, whichever is less.

(3) All claim files will be the joint property of the insurer and MGA. However, upon an order of liquidation of the insurer such files shall become the sole property of the insurer or its estate, the MGA shall have reasonable access to and the right to copy the files on a timely basis.

(4) Any settlement authority granted to the MGA may be terminated for cause upon the insurer's written notice to the MGA or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

(h) Where electronic claims files are in existence, the contract must address the timely transmission of the data.

(i) If the contract provides for a sharing of interim profits by MGA and the MGA has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments or in any other manner, interim profits will not be paid to the MGA until one year after they are earned for property insurance business and five years after they are earned on casualty business and not until the profits have been verified pursuant to section 5 of this act.

(j) The MGA shall not:

(1) Bind reinsurance or retrocessions on behalf of the insurer, except that the MGA may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules;

(2) commit the insurer to participate in insurance or reinsurance syndicates;

(3) appoint any agent or broker without assuring that the agent or broker is lawfully licensed to transact the type of insurance for which he or she is appointed;

(4) without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed one percent of the insurer's policyholder's surplus as of December 31 of the last completed calendar year;

(5) collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer; without prior approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer; or

(6) permit its subagent or broker to serve on its board of directors; or

(7) jointly employ an individual who is employed with the insurer;

(8) appoint a sub-MGA.

Sec. 5. Duties of insurers.

(a) No insurer may utilize or continue to utilize the services of an MGA on and after the effective date of this act unless such utilization is in compliance with this act.

(b) The insurer shall have on file an independent financial examination in a form acceptable to the commissioner of each MGA with which it has done business.

(c) If an MGA establishes loss reserves the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA. This is in addition to any other required loss reserve certification.

(d) The insurer shall periodically, but not less frequently than semi-annually, conduct an on-site review of the underwriting and claims processing operations of the MGA.

(e) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who shall not be affiliated with the MGA.

(f) Within 30 days of entering into or termination of a contract with an MGA, the insurer shall provide written notification of such appointment or termination to the commissioner. Notices of appointment of an MGA shall include a statement of duties which the applicant is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act, and any other information the commissioner may request.

(g) An insurer shall each quarter review its books and records to determine if any producer as defined by subsection 2d has become, by operation of subsection 2d, a MGA as defined in that subsection. If the insurer determines that a producer has become a MGA pursuant to the above, the insurer shall promptly notify the agent or broker and the commissioner of such determination and the insurer and agent or broker must fully comply with the provisions of this act within 30 days.

(h) An insurer shall not appoint to its board of directors an officer, director, employee or controlling shareholder of its MGAs. This subsection shall not apply to relationships governed by the applicable provisions of chapter 40, article 33, Kansas Statutes Annotated.

Sec. 6. The acts of the MGA are considered to be the acts of the insurer on whose behalf it is acting. An MGA may be examined pursuant to K.S.A. 40-222 and 40-223 as if it were the insurer.

Sec. 7. (a) If the commissioner finds after a hearing conducted in accordance with the provisions of the Kansas administrative procedure act that any person has violated any provision of this act, the commissioner may order:

(1) For each separate violation, a penalty in an amount of $5,000;

(2) revocation or suspension of the producer's license; and

(3) the MGA to reimburse the insurer, the rehabilitator or liquidator of the insurer for any losses incurred by the insurer caused by a violation of this act committed by the MGA.

(b) Nothing contained in this act is intended to or shall in any manner limit or restrict the rights of policyholders, claimants and auditors.

Sec. 8. The commissioner may adopt reasonable rules and regulations for the implementation and administration of this act.

Sec. 9. This act shall take effect on and after January 1, 1991 and its publication in the statute book.

Explanatory Memorandum For

Legislative Proposal No. 4

The additional language included in Section 1(b) of this proposal is intended to make it very clear that the failure of a health maintenance organization to pay a contracting or employed health care provider for covered services performed for a subscriber is not and shall not be a liability of the subscriber.

In addition, this proposal makes several editorial amendments necessary to merge the provisions of K.S.A. 1989 Supp. 40-3209a and K.S.A. 1989 Supp. 40-3209.

LEGISLATIVE PROPOSAL NO. 4

AN ACT relating to health maintenance organizations; amending K.S.A. 1988 Supp. 40-3209 and repealing the existing section; also repealing K.S.A. 1988 Supp. 40-3209a.

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

Section 1. K.S.A. 1988 Supp. 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, and, 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; 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 enrollee or enrollees 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, mutual nonprofit hospital and medical service corporation or insurer for the policy form and plan selected, except that the insurer, mutual nonprofit hospital and medical service corporation or health maintenance organization shall require premium payments at least quarterly. The coverage shall be available to all enrollees of any 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 when:

(A) Such person was terminated for cause as permitted by the group contract approved by the commissioner;

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

(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. 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. <u>Further, any contract between a health maintenance organization and a provider shall provide that if the health maintenance organization fails to pay for covered health care</u>

services as set forth in the contract between the health maintenance organization and its enrollee, the enrollee or covered dependents shall not be liable to any provider for any amounts owed by the health maintenance organization. If there is no written contract between the health maintenance organization and the provider or if the written contract fails to include the above provision, the enrollee and dependents are not liable to any provider for any amounts owed by 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 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 apart of the contract and shall be stated in individual contracts by endorsement or certificate of coverage issued to enrollees.

Sec. 2. K.S.A. 1988 Supp. 40-3209 and 40-3209a are 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

The 1989 legislature enacted Senate Bill No. 398 which created a petroleum storage tank release fund to assist owners and operators in complying with the cleanup cost requirements of the Environmental Protection Agency (EPA) in the event of leakage or other necessary corrective action. However, the EPA requirements are actually twofold. First is the cleanup cost requirement previously mentioned. The other is a requirement that owners and operators of underground storage tanks be financially responsible for legal obligations they may incur as a result of leakage.

Senate Bill No. 398 did not address this second responsibility. Consequently, some, perhaps many, tank owners and operators in Kansas are still unable to comply with the EPA requirements because of an inability to secure necessary insurance coverage or take advantage of one of the other alternatives recognized by the EPA to comply with the minimum financial responsibility requirements.

Legislative Proposal No. 5 suggests a means of making the necessary liability insurance available to those who cannot obtain such coverage in the normal insurance market. It creates a residual market mechanism comprised of all insurers authorized to transact liability insurance in Kansas. This mechanism or pool would be obligated to provide coverage to needy tank owners and operators and presumably make it theoretically possible for all Kansas tank owners and operators to comply with the EPA requirements.

LEGISLATIVE PROPOSAL NO. 5

AN ACT relating to insurance; apportionment or assignment of risk of certain liability insurance; underground storage tanks; federal financial responsibility requirements.

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

Section 1. Every insurer undertaking to transact in the state of Kansas the kinds of insurance specified in subsections (b) or (c) of K.S.A. 40-1102 and every rating organization which files rates for such insurance shall cooperate in the preparation and submission to the commissioner of insurance of a plan or plans for the equitable apportionment among insurers of applicants for insurance who are in good faith, entitled to but who are unable to procure through ordinary methods, insurance necessary to achieve compliance with the financial responsibility requirements imposed by 40 CFR part 280, subpart H and part 281 adopted by the federal environmental protection agency. Such plan or plans shall provide:

(a) Reasonable rules governing the equitable distribution of risks by direct insurance, reinsurance or otherwise and their assignment to insurers, including provisions requiring, at the request of the applicant, an immediate assumption of the risk by an insurer or insurers upon completion of an application, payment of the specified premium and deposit the application and the premium in the United States mail, postage prepaid and addressed to the plan's office;

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

(c) the limits of liability which the insurer shall be required to assume;

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

(e) for every such plan or plans, there shall be a governing board to be appointed by the commissioner of insurance which shall meet at least annually to review and prescribe operating rules, and which shall consist of the following members:

(1) Seven (7) members who shall be appointed as follows: Three (3) of such members shall be representatives of foreign insurance companies, two (2) members shall be representatives of domestic insurance companies and two (2) members shall be licensed independent insurance agents. Said members shall be appointed for a term of three (3) years, except that the initial appointment shall include two (2) members appointed for a two-year term and two (2) members appointed for a one-year term as designated by the commissioner; and

(2) Two (2) members representative of the general public interest with said members to be appointed for a term of two (2) years.

The commissioner shall review the plan as soon as reasonably possible after filing in order to determine whether it meets the requirements set forth in (a), (b), (c) and (d) above. As soon as reasonably possible after the plan has been filed the commissioner shall in writing approve or disapprove the same. Any plan shall be deemed approved unless disapproved within forty-five (45) days. Subsequent to the waiting period the commissioner may disapprove any plan on the ground that it does not meet the requirements set forth in (a), (b), (c) and (d) above, but only after a hearing held upon not less than ten (10) days' written notice to every insurer and rating organization affected specifying the matter to be considered at such hearing, and only by an order specifying in what respect the commissioner finds that such plan fails to meet such requirements, and stating when within a reasonable period thereafter such plan shall be deemed no longer effective. Such order shall not affect any assignment made or policy issued or made prior to the expiration of the period set forth in said order. Amendments to such plan or plans shall be prepared, and filed and reviewed in the same manner as herein provided with respect to the original plan or plans.

If no plan meeting the standards set forth in (a), (b), (c) and (d) is submitted to the commissioner within the period stated in any order disapproving an existing plan the commissioner shall, if necessary to carry out the purpose of this section after hearing, prepare and promulgate a plan meeting such requirements. If, after a hearing the commissioner finds that any activity or practice of any insurer or rating organization in connection with the operation of such plan or plans is unfair or unreasonable or otherwise inconsistent with the provisions of this subsection the

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commissioner may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this subsection and requiring discontinuance of such activity or practice.

Sec. 2. An insurer participating in the plan approved by the commissioner may pay a commission with respect to insurance assigned under the plan to an agent licensed for any other insurer participating in the plan or to any insurer participating in the plan.

Sec. 3. If any clause, paragraph, subsection or section of this act shall be held invalid or unconstitutional, it shall be conclusively presumed that the legislature would have enacted the remainder of this act without such invalid or unconstitutional clause, paragraph, subsection or section.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.

Explanatory Memorandum For

Legislative Proposal No. 6

Legislative Proposal No. 6 suggests a significant increase in the deposit requirements applicable to health maintenance organizations.

The initial legislation which governed the creation of health maintenance organizations (HMO's) imposed no financial requirements on HMO's. This was understandable and acceptable public policy at this point in the HMO history because the idea of preventive medicine, the competition fostered between HMO's and traditional insurance or prepaid service plans, and the efficiencies fostered by a managed care environment all suggested that HMO's should not be restricted by the imposition of other than absolutely essential requirements during their formative years.

The HMO concept is now a mature means of financing health care -- so mature in fact that insolvencies are becoming more frequent and the National Association of Insurance Commissioners has now incorporated some specific insolvency provisions in its model act.

The HMO environment in Kansas does not require this kind of action but obviously a $25,000 deposit is inadequate in relation to the financial obligations HMO's now incur. Accordingly, Legislative Proposal No. 6 recommends an increase in the deposit requirement from the current $25,000 to $100,000. This increase would be effective for all HMO's becoming licensed in Kansas after the effective date of the amended law. However, existing HMO's would continue to be subject to the $25,000 requirement until April 1, 1991 and would then be required to increase their deposit by $25,000 annually until the $100,000 requirement is reached.

LEGISLATIVE PROPOSAL NO. 6

AN ACT relating to health maintenance organizations; deposit requirements; amending K.S.A. 1988 Supp. 40-3227 and repealing the existing section.

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

Section 1. K.S.A. 1988 Supp. 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 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) ~~$25,000~~ $100,000.

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~~ 1991, $25,000. On and after April 1, ~~1989~~ 1991, organizations making deposits under this paragraph shall increase the amount of such deposit by an amount of not less than ~~$1,500~~ $25,000 per year until the deposit totals ~~$25,000~~ $100,000.

In the second fiscal year, if applicable, the amount of the additional deposit shall be equal to 2% of its estimated annual uncovered

expenditures. In the third fiscal year, if applicable, the additional deposit shall be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth fiscal 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 organization related 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.

The annual deposit requirement shall not apply to an organization if the total amount of the accumulated deposit is equal to 25% of its estimated annual uncovered expenditures for the next calendar year, or the capital and surplus requirements for the formation for admittance of an accident and health insurer in this state, whichever is less.

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 $1,000,00 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. 2. K.S.A. 1988 Supp. 40-3227 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after April 1, 1991, and its publication in the statute book.

Explanatory Memorandum For

Legislative Proposal No. 7

When the procedures for obtaining an insurance agent's license and the insurance company certification were changed by 1988 House Bill No. 3055, the penalty amounts inserted for the late reporting of certain information to the Commissioner were simply estimates of the penalty that would encourage timely submission of required information. Current familiarity with the requirements and actual experience of agents and companies now indicates that the maximum penalty which applies to the reporting of new agent employees of insurance agencies is unnecessarily severe. Accordingly, enactment of this proposal would reduce the maximum penalty applicable to agents from $300 to $50.

LEGISLATIVE PROPOSAL NO. 7

AN ACT relating to insurance; agents; agencies; certification; reports to commissioner; penalty; amending Sec. 2., 1988 House Bill No. 3055 and repealing the existing section.

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

Section 1. ~~From and after May 1, 1989,~~ 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 $20 shall accompany such application. Such applicant, if an individual, shall establish:

(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; and

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

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

(4) the applicant has designated a licensed officer, employee, partner or other person to be 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 subsection (b) 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 15 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~~ $50 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. 2. Section 2 of 1988 House Bill No. 3055 is hereby repealed.

Sec. 3. This act shall take effect and be in force on and after May 1, 1990 and its publication in the Kansas register.

Explanatory Memorandum For

Legislative Proposal No. 8

Enactment of Legislative Proposal No. 8 would correct two unintended results of 1989 Senate Bill No. 107. As currently structured, the 1989 enactment could permit death benefits under a life insurance application to be denied if coverage was made effective when the application was taken; the insurer determined it would not issue the policy on the basis applied for but would issue a policy of some kind; and, the covered person or persons died before the company's counter-offer was accepted. The first amendment suggested in Section 1 of this proposal would preclude the occurrence of situations such as this by providing that coverage would remain in effect until the potential consumer had an opportunity, 10 days, to respond to the counter-offer.

The second amendment concerns erroneous information on the application. The applicant is or should be in a position to know whether or not the information on the application is accurate. Therefore, it is not appropriate or in keeping with the original intent of 1989 Senate Bill No. 107 to require the delay both the insurer and applicant would experience if, in such situations, the company was required to return the premium and the application to obtain corrections that were already evident to the insurer.

LEGISLATIVE PROPOSAL NO. 8

AN ACT relating to insurance; adverse underwriting decisions; amending K.S.A. 40-2,112 as amended by 1989 Senate Bill No. 107 and repealing the existing section.

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

Section 1. K.S.A. 40-2,112 as amended by 1989 Senate Bill No. 107 is hereby amended to read as follows: 40-2,112. (a) In the event of an adverse underwriting decision the insurance company or agent responsible for the decision shall either provide the applicant, policyholder or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing or advise such persons that upon written request they may receive the specific reason or reasons in writing.

(b) Upon receipt of a written request within 60 business days from the date of the mailing of notice or other communication of an adverse underwriting decision to an applicant, policyholder or individual proposed for coverage, the insurance company or agent shall furnish to such person within 21 business days of the receipt of such written request;

(1) The specific reason or reasons for the adverse underwriting decision, in writing, if such information was not initially furnished in writing pursuant to subsection (a); or

(2) if specific items of medical-record information are supplied by a health care institution or health care provider it shall be disclosed either directly to the individual about whom the information relates or to a health care provider designated by the individual and licensed to provide health care with respect to the condition to which the information relates, whichever the insurance company or agent prefers; and

(3) the names and addresses of the institutional sources that supplied the specific items of information given pursuant to subsection (b)(2) if the identity of any health care provider o health care institution is disclosed either directly to the individual or to the designated health care provider, whichever the insurance company or agent prefers.

(c) The obligations imposed by this section upon an insurance company or agent may be satisfied by another insurance company or agent authorized to act on its behalf.

(d) The company or the agent, whichever is in possession of the money, shall refund to the applicant or individual proposed for coverage, the difference between the payment and the earned premium, if any, in the event of a declination of insurance coverage, termination of insurance coverage, or any other adverse underwriting decision.

(1) If coverage is in effect, such refund shall accompany the notice of the adverse underwriting decision, except in the case of life insurance where, along with the notice of the adverse underwriting decision, an insurer includes an offer of coverage to the insured under a different policy or at an increased premium. If such a counter-offer is made by the insurer, the insured or the insured's legal representative shall have ten business days in which to notify the company of acceptance of the counter-offer, during which time coverage will be deemed to be in effect. The insurer shall promptly refund the premium upon notice of the insured's refusal to accept the counter-offer.

(2) If coverage is not in effect and payment therefor is in the possession of the company or the agent, the underwriting decision shall be made within 20 business days from receipt of the application by the agent unless the underwriting decision is dependent upon substantive information available only from an independent source. In such cases, the underwriting decision shall be made within 10 business days from receipt of the external information by the party that makes the decision. The refund shall accompany the notice of an adverse underwriting decision.

(e) The obligation imposed by subsection (d)(1) shall not apply if material underwriting information requested by the application for coverage is clearly misstated or omitted.

Sec. 2. K.S.A. 40-2,112 as amended by 1989 Senate Bill No. 107 is hereby repealed.

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

Explanatory Memorandum For

Legislative Proposal No. 9

This is a proposal recommended by the Committee on Surety Bonds and Insurance which, by statute, the Commissioner of Insurance chairs. Recently, the Committee encountered a situation where property insurance not expressly authorized to be purchased or carried by a state agency could be added to an insurance policy the state was purchasing without additional cost to the state. In one case, the successful bidder was simply willing to include certain property under the blanket policy without additional premium charge and in another case an endowment fund was willing to pay the premium. In these two situations, the Committee was able to develop a rational connection between the property to be insured and the authority cited in K.S.A. 74-4702. However, the prohibition against a state carrying insurance not so authorized raises a question we believe the legislature should address. The opportunity to do so is provided by Legislative Proposal No. 9.

LEGISLATIVE PROPOSAL NO. 9

AN ACT relating to state agencies; property insurance; purchasers; amending K.S.A. 1988 Supp. 74-4702 and repealing the existing section.

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

Section 1. K.S.A. 1988 Supp. 74-4702 is hereby amended to read as follows: 74-4702. No state agency shall purchase ~~or carry~~ insurance on any property owned by the state agency or the state except as expressly and specifically authorized by K.S.A. 74-4703, 74-4705 and 75-2728 and K.S.A. 1986 Supp. 72-4342, 76-391, 76-747, 76-748 and 76-749 and as required by K.S.A. 74-4707 and amendments to these sections.

Sec. 2. K.S.A. 1988 Supp. 74-4702 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. 10

In 1984 the legislature substantially revised the method by which firefighters relief taxes are apportioned to individual firefighters relief associations. The firefighters relief tax is a tax paid on fire insurance premiums which is collected by the Commissioner of Insurance for distribution to qualified firefighters relief associations in accordance with a formula prescribed by statute. The funds paid to such associations are for the relief and benefit of firefighters and their dependents when a firefighter is injured, disabled or killed in the discharge of their duties as a firefighter.

Prior to 1984 and the establishment of the statutory formula, insurance policies providing fire and lightning coverage were coded by the insurers so that the tax on the fire premiums could be specifically and directly assigned to the firefighters relief association where the covered property was located. This was an effective method of distribution but it was very expensive to administer and the rapid growth in urban areas was creating an increasing number of erroneous codings which was adding to the difficulties. Consequently, the 1984 legislative action was designed to modernize the method by which firefighters relief taxes were distributed and by doing so, make it more efficient without adversely affecting and in fact improving the end result.

There were a number of changes incorporated in the 1984 legislation but the one relevant to Legislative Proposal No. 10 consisted of abrogating the old system of individual policy coding and replacing it with a system that uses population and assessed property valuation to measure the relative difference in fire protection responsibilities between fire districts and, in turn, firefighters relief associations. This new system is working well and has seemingly produced equitable distributions of the subject tax. However, statewide reappraisal presents a real problem because, if nothing is done, it will almost certainly result in significant changes in what some associations receive in relation to others even though the new assessed

valuations do not change the number or size of the property protected by the fire district. As a result, Legislative Proposal No. 10 suggests a change in the law which would nullify the effect of statewide reappraisal on the distribution of firefighters relief taxes.

LEGISLATIVE PROPOSAL NO. 10

AN ACT relating to firefighters relief associations; calculation of tax distribution; excluding effects of reappraisal; amending K.S.A. 40-1706 and repealing the existing section.

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

Section 1. K.S.A. 40-1706 is hereby amended to read as follows: 40-1706. (a) On or before April 1 of each year, every firefighters relief association which holds funds received under the firefighters relief act shall submit to the commissioner of insurance a verified account showing in full the receipts and disbursements and general condition of such funds for the year ending on the preceding December 31. If such account or other information shows such funds are not being expended for the purposes authorized by the firefighters relief act, the commissioner of insurance shall notify the county attorney of the county in which any such firefighters relief association is located and the county attorney shall institute proceedings to recover for the use of the firefighters relief association all moneys expended for purposes not in accordance with the provisions of the firefighters relief act. The commissioner of insurance shall hold any funds of such firefighters relief association until the commissioner is notified by the county attorney that such condition has been corrected.

(b)(1) All moneys received by the commissioner of insurance from the tax imposed by K.S.A. 40-1703 and amendments thereto shall be remitted to the state treasurer. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount thereof in the state treasury and shall be credited to the state firefighters relief fund which is hereby created in the state treasury.

(2) The state firefighters relief fund shall be administered by the commissioner of insurance. An amount equal to not more than the amount authorized for expenditure during the current fiscal year by appropriations enacted by the legislature may be set aside in the state firefighters relief fund and expended by the commissioner of insurance for the administrative

expenses of the department of insurance under the firefighters relief act, subject to the provisions of appropriations acts.

(c) Prior to August 1, 1987, and each August 1 thereafter, except as provided in subsections (b) and (d), of the total amount of moneys credited to the state firefighters relief fund as of July 1 of the same year the amounts determined as prescribed in subsections (c)(1) through (c)(6) shall be paid as provided therein.

(1) An amount equal to 3% of such total amount shall be paid by the commissioner of insurance to the treasurer of the Kansas state firefighters association, inc., for fire prevention and fire extinguishment education and study.

(2) An amount equal to 5% of such total amount shall be paid by the commissioner of insurance to the Kansas state firefighters association, inc., which shall be set aside as a death benefit fund to provide such benefits as determined by the association in accordance with the constitution and bylaws thereof, except the amount paid under this subsection (c)(2) shall not be more than the lesser of $100,000 or the result obtained by subtracting the balance in the death benefit fund of the association on July 1 from $100,000.

(3) The amount of $500 shall be paid by the commissioner of insurance to each firefighters relief association.

(4) The remaining amount of the moneys credited to the state firefighters relief fund, after the amounts are reserved or paid for the purposes authorized by subsections (b)(2), (c)(1), (c)(2) and (c)(3), shall be paid by the commissioner of insurance to firefighters relief associations so that the amount received by each firefighters relief association bears the same proportion to the total amount to be paid as the amount such firefighters relief association received from the amounts collected from the tax imposed by K.S.A. 40-1703 and amendments thereto for all of calendar year 1983, bears to the total amount paid to all firefighters relief associations from the taxes collected for all of calendar year 1983, subject to adjustments made to correct for errors in the payments distributed and as otherwise provided pursuant to this subsection (c)(4), adjustments made pursuant to subsection (c)(5) for firefighters relief associations that did not receive a payment from taxes paid for all of calendar year 1983 and adjustments pursuant to subsection (c)(6) for redeterminations based upon

changed circumstances. The commissioner of insurance may make adjustments in the amounts of payments for the current year made under this subsection (c)(4) for errors in the payments distributed for the prior year, except that adjustments may be made in the payments to be distributed by August 1, 1987, for any errors in the payments distributed during the period from July 1, 1984, through June 30, 1987, and an adjustment shall be made in the payment to be distributed by August 1, 1987, for each firefighters relief association which was in existence for only part of calendar year 1983 and which received a payment for calendar year 1983 based on the taxes received for only part of calendar year 1983, to reflect the total of the payments that would most probably have been received by such firefighters relief association during the period from August 1, 1984, through June 30, 1987, if such firefighters relief association had been in existence for all of calendar year 1983, reduced by the payments actually received by such firefighters relief association during the period from August 1, 1984 through June 30, 1987. For purposes of all payments under subsection (c)(4) after the adjusted payment distributed by August 1, 1987, such firefighters relief association shall be considered to have received for calendar year 1983, the amount it most probably would have received if it had been in existence for all of calendar year 1983, which shall be the amount having the same proportional relationship to 365 days as the amount actually received for calendar year 1983 has to the number of days that such firefighters relief association was in existence during calendar year 1983, subject to adjustments pursuant to subsection (c)(6) for redeterminations based upon changed circumstances.

(5) Whenever a firefighters relief association is to receive a payment under subsection (c)(4) but did not receive a payment from any of the taxes collected for calendar year 1983, the commissioner of insurance shall determine for the nonreceiving association, from such information as is made available to the commissioner by the nonreceiving association, the amount the nonreceiving association would most probably have received if it had actually received such a payment from the taxes collected for all of calendar year 1983, with appropriate adjustments based on payments to firefighters relief associations of fire departments providing fire protection services within geographic areas having similar populations and assessed tangible property valuation as the geographic area provided fire

protection services by the fire department of each such nonreceiving association. The commissioner shall make such determination as follows:

(A) One-half of the amount due shall be determined based upon the population figure provided by the association pursuant to administrative rules and regulations adopted by the commissioner. The determination of this 1/2 of the amount due shall be made in accordance with the following formula:

(i) An association which received a payment from the taxes collected for all of calendar year 1983 and which has a population similar to that of the nonreceiving association shall be ascertained;

(ii) the payment the comparable association received from taxes collected for all of calendar year 1983 shall be divided by two;

(iii) the population of the area served by the nonreceiving association shall be divided by the population of the area served by the association to which the nonreceiving association is being compared, to produce an adjustment factor reflecting the variance in population size; and

(iv) the amount received from taxes collected for all of calendar year 1983 by the association with the comparable population shall be multiplied by the population adjustment factor obtained in paragraph (iii) of this subsection (c)(5)(A).

(B) The remaining 1/2 of the amount due shall be determined based upon the assessed tangible property valuation figure provided by the nonreceiving association pursuant to administrative rules and regulations adopted by the commissioner. The determination of the remaining 1/2 of the amount due shall be made in accordance with the following formula:

(i) An association which received a payment from the taxes collected for all of calendar year 1983 and which has an assessed tangible property valuation <u>as of November 1, 1989</u> similar to that of the nonreceiving association shall be ascertained;

(ii) the payment the comparable association received from taxes collected for all of calendar year 1983 shall be divided by two;

(iii) the assessed tangible property valuation of the area served by the nonreceiving association shall be divided by the assessed tangible property valuation of the area served by the association to which the nonreceiving association is being compared, to produce an adjustment factor reflecting the variance in assessed tangible property valuation; and

(iv) the amount received from taxes collected for all of calendar year 1983 by the association with the comparable assessed tangible property valuation shall be multiplied by the valuation adjustment factor obtained in paragraph (iii) of this subsection (c)(5)(B).

(C) The amount obtained in paragraph (iv) of subsection (c)(5)(A) shall be added to the amount obtained in paragraph (iv) of subsection (c)(5)(B) to determine the total amount the nonreceiving association most probably would have received if it had actually received a payment from the taxes collected for all of calendar year 1983. The amount a nonreceiving association most probably would have received if it had actually received a payment from taxes collected for all of calendar year 1983 shall be divided by the total amount paid to all firefighters relief associations from the taxes collected for all of calendar year 1983 to determine the proportionate amount due the nonreceiving association for the current and succeeding years and thereafter such association shall not be considered to be a nonreceiving association. The commissioner of insurance shall include the amount so determined within the computations prescribed by subsection (c)(4) for payments thereunder.

(6) One or more firefighters relief associations may apply, prior to October 1 of any year, to the commissioner of insurance for a redetermination of the proportionate amounts payable to all firefighters relief associations under subsection (c)(4) and, upon receipt of such application, the commissioner of insurance shall hold one joint hearing in accordance with the provisions of the Kansas administrative procedure act prior to December 1 of such year, at which all applicants shall be heard and may present information. The commissioner of insurance may redetermine such proportionate amounts based upon such information as is presented to or otherwise made available by the applicants to the commissioner and may make a finding of changed circumstances. However, increases in the assessed tangible property valuation resulting from a statewide reappraisal conducted pursuant to K.S.A. 1988 Supp. 79-1476 shall not constitute a changed circumstance. Upon making such finding, the commissioner of insurance may include such redetermination within the computations prescribed by subsection (c)(4) for payments in subsequent years. Any increase or reduction in the amounts to be distributed as a result of a finding of changed circumstances by the commissioner shall be proportionately distributed among all firefighters relief associations. An application for

redetermination shall not be made by any firefighters relief association more often than once every three years <u>but this restriction shall not apply with respect to applications for redetermination submitted in calendar year 1989 that were based in whole or in part on an increase in the assessed tangible property valuation resulting from statewide reappraisal</u>.

(d) Except as otherwise provided in this section, whenever any firefighters relief association fails to qualify for funds, as provided in the firefighters relief act, for a period of two consecutive years, the funds on deposit with such association shall be returned by the county attorney to the commissioner of insurance. The commissioner of insurance shall remit all such funds to the state treasurer. Upon receipt of any such remittance, the state treasurer shall deposit the entire amount thereof in the state treasury to the credit of the state firefighters relief fund. The commissioner of insurance shall pay such amount of funds to the Kansas state firefighters association, inc., for fire prevention and fire extinguishment education and study.

(e) When a firefighters relief association fails to qualify for payments under the firefighters relief act as a result of the territory which it serves being consolidated, merged or annexed with another governmental unit having a qualified firefighters relief association, the funds and obligations of such disqualified association shall be transferred to the surviving firefighters relief association and the disqualified association shall dissolve forthwith under the existing laws of this state.

(f) When any firefighter, the spouse of such firefighter or those dependent upon any member of a disqualified association is receiving reasonable benefits from such association at the time of disqualification, the benefits shall be continued in accordance with the resolution of such disqualified association and shall be paid by the surviving association if the disqualification resulted from consolidation, merger or annexation and shall be paid by the county attorney if disqualification resulted from reasons other than consolidation, merger or annexation. Nothing in the firefighters relief act shall be construed as a bar to the lawful receipt of such benefits.

(g) The treasurer of a firefighters relief association shall give bond for the safekeeping of funds received under the firefighters relief act and for faithful performance in such sum with such sureties as may be approved

by the governing body of such city, township, county or fire district. All the moneys so received shall be set apart and used by the firefighters relief association of such cities, townships, counties or fire districts solely and entirely for the objects and purposes of the firefighters relief act and shall be paid to and distributed by the firefighters relief associations of such cities, townships, counties or fire districts under such provisions as shall be made by the governing body thereof. In all cases involving expenditures or payments in an amount of $500 or more prior certification shall be obtained from the attorney of the governing body that such expenditure or payment complies with the requirements of the firefighters relief act.

(h)(1) The officers of a firefighters relief association may invest any amount, not to exceed 90% of all such moneys, in investments authorized by K.S.A. 12-1675 and amendments thereto in the manner prescribed therein or in purchasing bonds of the city, township, county of fire district in which such firefighters relief association is located. When such investments are not obtainable, United States government bonds may be purchased or any municipal bonds of this state, except that such funds shall not be invested in any such municipal bonds where the bonded indebtedness of the municipality is more than 15% of its total assessed valuation, as shown by the last assessment preceding such investment.

(2) Such investment must be approved by the governing body of such city, township, county or fire district. It shall be the duty of the attorney of such governing body of such city, township, county or fire district to examine all such bonds as to their validity and report thereon in writing to the governing body and the firefighters relief association of such city, township, county of fire district, and no bonds shall be purchased by the firefighters relief association of such city, township, county or fire district until they have been approved and found valid by the attorney.

Sec. 2. K.S.A. 40-1706 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after August 1, 1990 and its publication in the statute book.