Approved 2/14/90
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by SENATOR RICHARD L. BOND at
Chairperson

9:00 a.m./p.m. on MONDAY, FEBRUARY 12, 1990 in room 529-S of the Capitol.

All members were present ~~except:~~

Committee staff present:

Bill Edds, Revisors Office
Bill Wolff, Research Department
Louise Bobo, Committee Secretary

Conferees appearing before the committee:

Ron Todd, Assistant Commissioner of Insurance
Larry Magill, Kansas Independent Insurors
L. M. Cornish, Kansas Life Association

Chairman Bond called the meeting to order at 9:10 a.m.

SB 445 - Eligibility for group sickness and accident insurance.

Chairman Bond reopened the hearing on SB 445, continued from February 6, 1990. Ron Todd, Assistant Commissioner of Insurance, addressed the committee in support of this measure. He approved the amendment proposed by Bill Pitsenberger which requires contracts issued outside of the state, under the multiple employer trusts, to cover employees who are residents of the state. (Attachment 1)

Larry Magill, Kansas Independent Insurors, rose in opposition to SB 445. He stressed to the committee that passage of this bill would "dry up" the market for small insurors. According to Mr. Magill, if small group insurors are allowed or forced to accept anyone regardless of the condition of his health, the rates will go up and the healthy, younger firms will then seek coverage elsewhere at a lower rate. Under this bill, provisions preventing this "adverse selection" would be eliminated. (Attachment 2)

L. M. Cornish, Kansas Life Association, spoke briefly in opposition to this bill. He advised that this bill would increase the cost of health insurance for small employers. He also advised that this bill should be carefully considered and perhaps held for additional study. (Attachment 3)

Chairman Bond pronounced the hearing on SB 445 closed. Considerable discussion followed with committee members concerned about mandates and different reasons for rising costs, including advanced technical care. The consensus of the committee appeared to be that this issue should be targeted for further study by an interim committee, including but not limited to mandates, and that very careful perimeters should be drawn. In the meantime, SB 445 will rest in committee.

SB 547 - adverse underwriting decisions.

Bill Edds enlightened the committee regarding the ballooned version of this bill containing amendments which cleaned up language in the bill making it more clearly understood. (Attachment 4)

Senator Reilly made a motion to accept the amendments to this bill. Senator Salisbury seconded the motion. The motion passed.

Senator Salisbury then made a motion to move the bill out of committee favorably as amended. Senator Reilly seconded the motion. The motion passed.

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE,

room 529-S, Statehouse, at 9:00 a.m./~~p.m.~~ on MONDAY, FEBRUARY 12, 1990.

SB 532 - interstate banking

Bill Wolff presented an overview of this bill before the committee. (Attachment 5) Dr. Wolff continued by informing the committee that 47 states had some form of interstate banking. He also expressed concern that there is nothing in this bill that gives any authority to the Kansas Bank Commissioner that would allow him to obtain financial records of banks or bank holding companies from other states. Mr. Wolff advised that, under this bill, the Bank Commissioner has no specific authority. Mr. Wolff also informed the committee that tax ramifications were not addressed in this bill, for example, how do you treat the assets of a company not headquartered in your state?

Minutes of February 6, 7, and 8, were approved on a motion by Senator McClure with Senator Reilly seconding the motion. The motion passed.

Chairman Bond adjourned the meeting at 10:05 a.m.

GUEST LIST

COMMITTEE: FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE DATE: Mon. Feb 12, 1990

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
LM CORNISH	TOPEKA	KS LIFE INS ASSN
Terry Bunka	Manhattan	Ks Farm Bureau Life Ins Co.
CRAIG Weigel	Manhattan	KS Farm Bureau Life Ins
Jim Ling	Topeka	KBA
Brad Smoot	"	Fourth Financial
CHUCK STUART	Topeka	United Federal Cdn
Kathy Taylor	Topeka	KBA
Chuck Stones	"	"
M. Hauver	"	Capitol-Journal

TESTIMONY ON SENATE BILL 445
Senate Financial Institutions and Insurance Committee
February 6, 1990

Testimony of William Pitsenberger
Member, Governor's Commission on Access to Services
for the Medically Indigent and the Homeless

The Commission on Access to Services for the Medically Indigent and the Homeless was created by the Legislature in 1987, and its existence was extended in 1989.

Among its charges were to determine what problems existed in accessing medical care financing, and what solutions might exist to problems identified.

We considered persons to be medically indigent not if they were poor -- having Medicaid, for example, means that one is not medically indigent for many purposes -- but rather if one did not have resources for health care financing.

One group of the medically indigent we identified were working men and women who have no health insurance coverage. In some cases, this occurs because the employer does not offer group coverage. In others, it occurs because the amount of contribution required of the employee is unaffordable. In still others, it occurs because, while the employer offers group health insurance coverage, the insurance carrier refuses to cover persons with a history of past or current health conditions.

Two years ago, the legislature addressed this latter problem in part. Senate Bill 445 is designed to extend the remedy adopted then to other forms of group health insurance coverage.

Before talking about how Senate Bill 445 works, I want to explain the nature of the problem a little bit.

In insurance industry terminology, the problem is called "churning". It may be done by the employer seeking a lower rate and indifferent to the impact on some of his employees, or it may be done by an insurer seeking to increase profits.

Here is what happens.

Suppose an employer has four employees, who have had a consistent history of yearly health expenses like this:

Attachment 1
FI & I
2/12/90

Employee A -- $0.00

Employee B -- $200.00

Employee C -- $400.00

Employee D -- $2,400.00

Total -- $3,000.00

The average cost per employee, then, would be $750.00 per year. To this, an insurer would add its retentions to develop the premium.

The employer, seeking to lower the cost of health insurance, starts shopping among insurance companies. Along comes an insurance company that tells the employer that if he will drop Employee D from the policy, the rate will go down to $250.00 or $300.00 per employee per year. Let's say the employer is paying half the cost. If he goes along with this, he cuts his costs by almost $300.00 per employee, gives Employee D $125.00 or $150.00 -- the same as he is contributing towards the coverage for other employees -- and lets Employee D fend for himself.

Simply put, insurance companies find it easier and more profitable, and employers find it cheaper, to insure those who need insurance least, and to abandon the ones who need it most to conversion insurance pools of the sickest persons or to whatever coverage they can get in the non-group market.

That did not seem to the Commission to be what group health insurance should be about. Instead, it is more like non-group health insurance.

Now, you need to know that Kansas law on group health insurance is a little bit complicated. It stipulates the kinds of entities to whom a group insurance policy may be issued. It provides that, among others, a policy may be issued to:

(1) An employer, insuring employees of the employer.

(2) A trust established by two or more employers, covering employees of the employers.

(3) An association, covering members of the association or employees of members of the association.

Two years ago, the legislature amended the provisions dealing with group policies issued directly to employers, but did not address group insurance policies which cover employers as a member of a trust or a member of an association. Those changes that were made two years ago are identified in Senate Bill 445 beginning on line 43 of page 1 and continuing through line 18 on page 2.

The intent of Senate Bill 445 is to apply generally similar changes to the other forms of issuance identified above -- contracts covering employees of employers who obtain coverage through a multiple employer trust, and contracts covering employees of employers who obtain coverage through an association.

In particular, Senate Bill 445 prohibits the exclusion of individual employees from eligibility or coverage under a policy issued to a group, except at the option of the employees, or except when employees are enrolling at other than an open enrollment opportunity -- if they are enrolling in the coverage at a time other than their first opportunity to do so, for example, merely in anticipation of health expense. The idea here is to preclude group insurers from refusing coverage to persons merely because of past health conditions under a group insurance policy. If they want to pick and choose among the healthy, they are free to do so in the non-group market, not in group insurance.

It appears to me that one change is necessary in Senate Bill 445 to make it more effective in assuring access to health insurance for employees under contracts issued to trusts or associations. Most multiple employer trusts covering employees of Kansas employers have their situs outside Kansas -- in Illinois, say, or California. As a result, this Bill would not affect the contracts issued to those trusts. To remedy this, I would suggest that the language I have noted relating to contracts issued outside the state covering employees who are residents of the state be included.

I think all of you received copies of the General Accounting Office report on problems of access to health insurance in small businesses. The underwriting activities Senate Bill 445 seeks to prohibit are specifically identified as one of the problems in that report.

The Commission recommends passage of this Bill.

Session of 1990

SENATE BILL No. 445

By Senators Ehrlich and Anderson

1-8

AN ACT relating to insurance; concerning eligibility for coverage under group sickness and accident insurance; amending K.S.A. 1989 Supp. 40-2209 and repealing the existing section.

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

Section 1. K.S.A. 1989 Supp. 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. No policy providing benefits for hos-

within this state or issued outside this state covering persons who are residents of this state

Blue Cross
Blue Shield
of Kansas, Inc.

Legal Department

William H. Pitsenberger
General Counsel

Jane Chandler-Holt
Staff Counsel

February 8, 1990

Representative Henry Helgerson
State Capitol
Topeka, Kansas 66612

Dear Representative Helgerson:

At the joint meeting of the House Insurance Committee and the Senate Financial Institutions and Insurance Committee on January 30, Representative Lucas described several areas of concern to him:

1. The nature of Blue Cross and Blue Shield of Kansas under K.S.A. 40-19c01 et seq.

2. Whether Blue Cross and Blue Shield are treated more favorably than other insurers.

3. The impact of K.S.A. 40-2222 on the health insurance market.

4. Whether Blue Cross and Blue Shield of Kansas is an "insurance company".

5. Whether losses on a given line of business by Blue Cross and Blue Shield of Kansas result in the rates for other lines of business increasing.

At the meeting of the House Insurance Committee on February 7, you asked that we respond in writing to those questions.

These questions are addressed sequentially in this letter. Realizing the complexity of the health care financing market, however, these responses, although both lengthy and technical, are brief compared to the breadth and depth of the subject matter.

Attachment 1-5
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1133 Topeka Boulevard • Topeka, KS 66629 • 913-291-7509

Blue Cross and Blue Shield Plans around the nation are autonomous, self-governing organizations which share the names and symbols and trace themselves to a common origin in the Depression years. The first Blue Cross Plans were highly localized in nature, resembling modern health maintenance organizations more than insurance companies. The plan commonly regarded as the beginning of the Blue Cross movement was started at Baylor University Hospital under a program designed to allow a group of Texas school teachers to pay a small amount per month in order to purchase a guarantee of health care from the hospital. From this beginning, designed to provide protection for working men and women against the financial ruin of ill health, Blue Cross (designed to pay for hospital care) and similar Blue Shield (designed to pay for medical care) Plans grew rapidly across the country.

In the late 1930's Blue Cross and Blue Shield Plans were legally challenged by physicians as constituting the corporate practice of medicine, which was prohibited under then-existing medical ethics codes. Moreover, since these plans provided benefits in the form of services from contracting doctors and hospitals, instead of cash benefits, insurance regulators were not certain what kind of entity they were seeing -- whether it was insurance, or some other kind of activity altogether. To clarify both issues, states began passing special "enabling acts" to describe, permit, and regulate operation of these programs in the late 1930's. By the time Blue Cross and Blue Shield was organized in Kansas in 1941, this "enabling act" pattern had been well-established, and the Kansas Legislature followed suit. A Blue Shield enabling act was passed in 1945. These survive today in K.S.A. 40-1801 et seq. and K.S.A. 40-1901 et seq. Blue Cross and Blue Shield merged and is now governed by K.S.A. 40-19c01 et seq.

History is a useful tool in the law as well as in life. It helps give us a sense of perspective about where we are, it helps us understand how we got there, and it gives us intimations of where we may be going.

The concept that all persons should have access to health insurance is a relatively new one. While we rightly decry the 12% or more of Americans without some source of third-party health care financing resource, that 85% of Americans have some sort of health benefit program is close to a high water mark. The number of persons covered by insurance did not peak until 1978, and there has been some decline since. However, on the eve of World War II, fewer than 7% of us were covered by health insurance, and almost all of that was from Blue Cross and Blue Shield Plans.

Blue Cross and Blue Shield Plans understood themselves as a social movement well into the 1960's, at least. Their mission was to help working men and women afford health care. In Kansas, into the 1950's, enrollment drives were conducted on a county-by-county basis, much of the work coming from volunteers. All persons were accepted, and all paid the same rate for the same benefit. It was with the later entry into the field of health care financing of commercial insurance companies that the seeds of the problems we are reaping today were sown. These insurance companies saw that by isolating a segment of the market -- by selling a policy to a single employer group rated on that group's own experience -- they would be insuring a segment of the population healthier than average, and could charge lower rates than a community plan like Blue Cross and make a profit.

Initially, this was not a particular problem -- the market for health insurance was still immature and open to substantial growth. However, the market is now mature, and is faced with many problems.

Ultimately, to avoid being saddled with only poor health risks and rates which are unaffordable, Blue Cross, too, turned to group rating in self defense. As was described in the January 30 hearing, the newer practices adopted by commercial insurers -- excluding unhealthy people from groups, or rating such persons within the group based on individual claims experience -- is creating a deteriorating market in which insurers are scrambling to insure the healthiest risks only and to leave the less healthy with other insurers slower to adopt to such practices, such as Blue Cross.

There was some irony for those of us at Blue Cross in your suggestion that the enabling act under which Blue Cross and Blue Shield operates confers a special status on us. A few years ago, we seriously considered seeking an amendment to that act that would allow us to become a mutual insurance company. The reason for this was to allow us to be regulated under the more favorable laws which apply to commercial insurers (stock companies and mutual companies):

- Blue Cross and Blue Shield rates, both group and non-group, must be approved in advance of use by the Commissioner of Insurance. Commercial insurers group rates are not regulated at all, and non-group rates are regulated only indirectly, through approval authority over non-group contracts.

- °Blue Cross and Blue Shield has specific statutory limits on amounts of premiums which can be used for administrative expense, including solicitation; commercial insurers are free to use as much for administrative expense as they wish.

- °Blue Cross and Blue Shield are statutorily obligated to devote reasonable efforts to control of costs charged to them by providers of health care; commercial insurers have no such responsibilities.

The point I make above is that Blue Cross and Blue Shield of Kansas is the most heavily regulated private health care financing mechanism in Kansas.

By contrast, in the absence of K.S.A. 40-2222, so-called "self-insured multiple employer trusts" used as health care financing vehicles would be entirely unregulated. This lack of regulation -- the fact that they engage in insurance functions without proper funding -- has lead Raymond Maria, the Inspector General of the Department of Labor, to warn employers about such self-funded multiple employer arrangements (see attached articles).

Blue Cross and Blue Shield did not request or testify on K.S.A. 40-2222. It is an enforcement tool of the Insurance Commissioner. We believe, however, that we can shed some useful light on its background and purpose.

The federal Employee Retirement Income Security Act of 1974 (ERISA) contained a provision that said, in essence, that a state could not apply insurance laws to a self-insured arrangement. This created the stage for the rapid growth of a new industry, so-called self-insured multiple employer trusts. The "self-insured" aspect seems to mean only that they are not insurance companies. In an ordinary self-insurance arrangement, an employer pays all his own claims. However, if two employers pool together, it is highly unlikely that the per-employee costs for each will be exactly the same as the amount each has allocated. Employer A will be paying for some of the claims of Employer B, or vice-versa. In other words, they are sharing risk. If they pay these per-employee rates into a trust, the trust is assuming the risk. That, of course, is exactly what an insurance company does.

An insurance company, however, is regulated by a state official. Its finances are scrutinized annually. Its books are audited every three years. It is probably required by law to be a part of a guaranty association, which pays the claims if an insurance company goes broke.

What happens, however, in the case of a self-insured multiple employer trust arrangement? Suppose Employer A goes bankrupt, and Employer B's claims were higher than the amounts Employer B paid into the trust. Who pays for the claims of A's employees? Who pays for the additional costs of B's employees? Presumably, the "trust", but what if it has no money? That -- the trust going bankrupt, or the creators of the MET's absconding with the employer payments -- was what was happening in the late 1970's and early 1980's. Employees were left without coverage, and insurance commissioners were helpless to aid them.

It was with this background that in 1983, ERISA was amended to provide that states could, if they wished, subject multiple employer welfare arrangements which were self-insured in whole or in part to state insurance regulation. The Kansas Legislature, in response, in 1983 passed K.S.A. 40-2222, which in essence provides that any entity which undertakes to provide health benefits must obtain a certificate of authority and take other actions consistent with being an insurance company.

This seems to be good social policy -- to try to assure that the entities Kansans are dealing with are fiscally sound -- as well as fair -- to treat an entity which is engaged in the acceptance and transference of risk (the business of insurance) as other companies engaged in that business are treated.

The business of insurance -- accepting and transferring risk -- is the primary business of Blue Cross and Blue Shield of Kansas. Although the term "prepaid medical and hospital service corporation" is used in the title of its enabling act, it is for most purposes an insurance company. The phrase referred to in the state bid request -- the bids were requested from insurance companies -- was meant to distinguish the program requested, in which the risk of loss is transferred to someone else, from the state self-insuring and using a third-party administrator to pay claims.

Finally, you expressed concern that Blue Cross and Blue Shield losing money on the state group or lowering rates in a bidding situation meant that small groups were paying more than their fair share.

On a very fundamental basis, if the premiums of each group were enough to pay for the losses of each group individually -- if an insurer was not losing money on any group -- there would be no reason for insurance. The concept of insurance, of spreading risk of loss among insureds, requires that some pay less than their claims costs and some pay more.

Nevertheless, Blue Cross and Blue Shield of Kansas seeks to make each line of business (general categories like large groups, groups of 10-25, groups of 1-9 and non-group) self-sustaining, to assure that within these classes, rates are neither excessive nor inadequate. In the very small group area, however, for employers of 1-9 employees, we expect substantial losses in 1990 in spite of the increases we have obtained. That market has deteriorated, because of the practices of underwriting within a group and because of the failure of all persons within the group to participate in the insurance, to the point that we could not raise our rates high enough to break even in 1990 for groups of 1 to 9 in size.

As a matter of general financial history, we have lost money on small groups consistently, and the large groups are the ones which have contributed to our reserves.

Regarding the lowering of prices in a bid situation, each circumstance Representative Lucas cited requires separate review. I can tell you that there are many reasons this may have occurred. First, the lower price may have been associated with a higher deductible or a different shared payment program, a lower benefit level, than the original bid. Second, we may have obtained additional data from the other carrier or the group or from our own claims history which caused us to reevaluate the projected claims expense. Third, something in the underwriting may have changed -- the group may have had two programs and agreed to combine them into one. Whatever the reasons, there is no factual basis for suggesting that such changes, if they occurred, represent any shifting of costs to smaller groups, especially given the claims histories for the smaller groups.

As I said at the beginning, as lengthy as this letter is, it merely touches on the complexities of the issues present in health care financing. We are more than willing to share with you not only details of our own operation, but information about the health insurance market place in general.

Sincerely,

William H. Pitsenberger
General Counsel

c: Representative Dale Sprague, Chairman
House Insurance Committee

Members of House Insurance Committee

Senator Richard Bond, Chairman
Senate Financial Institutions and Insurance Committee

Members of Senate Financial Institutions &
Insurance Committee

Representative Artie Lucas

Litigation

EASTERN AGREES TO COMPLY WITH COBRA, LETTING STRIKERS BUY HEALTH INSURANCE

Eastern Airlines and the Labor Department entered into a consent decree last week under which the airline agreed to comply with the Consolidated Omnibus Budget Reconciliation Act of 1986 by letting striking and laid-off employees pay for continued health insurance coverage at group rates (*Dole v. Eastern Air Lines Inc.*, DC SFla, No. 89-279-CIV, Dec. 8, 1989).

The consent order, approved by the U.S. District Court for the Southern District of Florida, followed an investigation by the departments's Pension and Welfare Benefits Administration of charges by striking and laid-off Eastern employees who had paid the insurance premiums but were denied coverage by Eastern's health insurance carriers.

According to David George Ball, assistant secretary of labor for pension and welfare benefits, the complainants sought to obtain the continued health benefits available under COBRA, which amended the Employee Retirement Income Security Act to require that health plan sponsors provide terminated employees and beneficiaries with the opportunity to receive continued health benefits at group rates. As part of its investigation into Eastern's possible violations of COBRA's notification and insurance claims processing provisions, PWBA reviewed files on every individual who elected continued coverage to determine compliance, Ball said.

Eastern did not admit to any of the allegations in PWBA's complaint other than those concerning its role as sponsor and administrator of the Eastern Air Lines Group Life and Medical Insurance Benefit Plan and the court's jurisdiction. As part of the consent decree, however, Eastern agreed to notify its plan administrator which employees qualify for continued coverage under COBRA within 30 days of eligibility and inform qualifying beneficiaries of their right to continued coverage within 45 days of eligibility.

Eastern also agreed to record all payments for continued health care coverage under COBRA and notify a beneficiary's insurer of such payments in a timely manner. The consent decree required that Eastern provide the Labor Department with detailed quarterly reports documenting its compliance with the court order for a period of five years and enjoined Eastern from violating COBRA.

Following issuance of the consent order, Labor Secretary Elizabeth Dole said in a statement that employers "must know the Labor Department is serious about protecting the right of working Americans to continued health coverage in cases like Eastern."

Enforcement

FRAUD IN HEALTH CARE ARRANGEMENTS UNCHECKED BY LABOR DEPARTMENT, MARIA SAYS

More aggressive Labor Department enforcement in the area of Employee Retirement Income Security Act health care plans is needed to address the problem of fraudulent multiple employer welfare arrangements (MEWAs), acting Labor Department Inspector General Raymond Maria told a House panel Dec. 13.

Speaking before a hearing of the House Government Operations Subcommittee on Legislation and National Security, Maria said the potential for fraud in MEWAs is greater than in traditional types of pension and employee benefit plans.

According to Maria, these arrangements masquerade as non-profit, self-insured medical plans and solicit small employers seeking health care coverage for their employees. In the case of fraudulent MEWAs, premium revenue is embezzled by the perpetrators, often in the form of premium payments to a reinsurer who is a "shell company" located in a separate country.

Through delays in paying claims, the trusts, which are insolvent and unable to meet reimbursement liability, can continue to operate for three or four years, Maria stated. In a recent case, 3,000 MEWA participants in one state were defrauded and now are personally liable for nearly $3.2 million in medical costs they thought were insured, he stated.

Unlike insurance companies, MEWAs are not licensed by state insurance regulators and generally do not maintain reserves to pay claims, Maria noted. State enforcement agencies have been ineffective in their attempts to address fraudulent MEWAs because of multi-state schemes, limited resources, and unresponsiveness by the Labor Department, Maria stated.

Ineffective Enforcement

The Labor Department's existing enforcement strategy, which relies on civil penalties, is inadequate to address the problem of fraud in health care arrangements, Maria told the subcommittee.

"Civil fines and penalties are a cost of doing business and a way of business for unscrupulous benefit plans operators, administrators, service providers, and others," he stated. "The criminal sanctions of imprisonment, forfeiture of assets, and disqualification are needed to deter criminal actions."

Despite promises of increased criminal enforcement, the Pension and Welfare Benefit Administration lacks sufficient resources to conduct investigations, Maria stated. PWBA has no trained criminal investigators and no capability to conduct sophisticated investigations using electronic surveillance and other techniques, he stated. In addition, PWBA has no experience in recognizing or conceptualizing the use of non-ERISA criminal provisions, such as the mail fraud, false statements, and Racketeer Influenced and Corrupt Organizations statutes, Maria said.

Congress needs to address the issue of investigative authority of the inspector general's office, Maria stated. The Inspector General Act should be amended specifically to allow the inspectors general to conduct criminal investigations of all programs regulated or administered by their respective agencies, he stated.

Currently, the Labor Department inspector general is restricted to program related investigations as the result of a Justice Department legal analysis of the scope of the Inspector General Act, Maria noted.

"Who can object to another 20 convictions per year for benefit plan abuse," he said.

Criminal Sanctions

Echoing Maria's comments, Joseph M. Fioravanti, an attorney with Curren, Winning and Fioravanti in Philadelphia, told the subcommittee that the Labor Department should use criminal sanctions in prosecuting employee benefit plan cases.

Fioravanti, former assistant U.S. attorney, said restitution is not an effective sanction against plan administrators that intentionally defraud employers and employees. In cases relating to employee plans, the same conduct that is made the subject of civil restitution could have greater impact if prosecuted under criminal statutes, Fioravanti stated.

Fioravanti suggested setting up a policy whereby the PWBA would routinely refer pension and employee benefit cases to the U.S. attorney for possible criminal prosecution. Under this system, the U.S. attorney would be given, in effect, the right of first refusal to prosecute cases. Successful prosecution under criminal law would allow the government to seek restitution and would send a powerful message to the community, Fioravanti told the subcommittee.

The Labor Department's inadequate enforcement of MEWAs has resulted in unnecessary losses to employers and plan participants, according to Patricia Petersen, deputy insurance commissioner for the state of Washington.

Petersen testified that most states consider MEWAs to be subject to the primary jurisdiction of the Labor Department since the arrangements are authorized under ERISA. However, the Labor Department engages in very little monitoring of MEWAs either before a MEWA is formed or during operation, Petersen stated.

In particular, Petersen faulted the department for its lack of support in state activities concerning MEWAs. Even when states uncover evidence of fraud and other crimes DOL rarely, if at all, takes criminal, civil or other action against those affected MEWAs or the perpetrators, she stated.

Litigation

CRESTAR PAYS U.S. NEWS PLAN $2 MILLION TO SETTLE INVESTMENT MANAGEMENT DISPUTE

U.S. News & World Report pension plan participants will receive about $2 million from Crestar Bank, settling a dispute over Crestar's administration of a terminated real estate investment fund, under an agreement filed in the U.S. District Court for the Eastern District of Virginia (*U.S. News & World Report v. Crestar Bank*, DC EVa, Civil Action No. 89-1563-A, Dec. 6, 1989).

The payment to the U.S. News plan is part of a $19.6 million payout Crestar will make by year end to 130 trusts that participated in its real estate fund. Crestar was trustee of the U.S. News plan from 1985 through October 1989.

According to a complaint filed Nov. 13, U.S. News alleged that Crestar violated its fiduciary and disclosure obligations under the Employee Retirement Income Security Act and federal securities laws by failing to disclose liquidity problems preventing it from honoring investment elections and loan or withdrawal requests from the real estate fund.

In a prepared statement, counsel for U.S. News termed the settlement "exceptional." "Defendants do not usually pay plaintiffs 100 percent of what the plaintiffs are asking for, particularly not at so early a stage in the proceeding. And plaintiffs do not usually obtain such direct and immediate benefits for third parties. Crestar senior management deserves great credit for taking decisive and creative action to correct a serious but correctable problem," U.S. News counsel said.

Counsel for Crestar told BNA the bank had considered taking such action when it decided to terminate the real estate fund and that it was concerned about the impact of a protracted liquidation proceeding on the participating trusts in the fund. "U.S. News is being treated the same way as other participating trusts," Crestar counsel said, adding that the case was settled on terms that are in the best interests of all participating trusts.

The settlement calls for Crestar to advance monies to pay each participating trust its pro rata share in the real estate fund. U.S. News agreed to release Crestar from liability based on the allegations raised in the complaint. While it expressly reserved its claims under ERISA's fiduciary responsibility provisions, U.S. News agreed not to pursue such claims unless a complaint is filed by plan participants or the Labor Department. Crestar did not release or waive any defenses or claims it may have in response to such action.

Fund Asset Transfers

A health and welfare benefit plan may not retain funds attributable to contributions for employees whose union withdrew from participation in the plan after creation of a new, employer-sponsored plan, the U.S. Court of Appeals for the Second Circuit ruled (*Trapani v. Consolidated Edison Employees' Mutual Aid Society, Inc.*, CA 2, Docket No. 89-7389, Dec. 4, 1989).

A federal district court directed the plan to pay a proportionate share of plan assets to a class of affected employees (14 *BPR* 292, 8 *EBC* 1313). While agreeing that the plan could not retain the assets for employees who no longer were covered by the plan, the appeals court reversed the district court ruling to the extent it required payment to individual participants.

The Mutual Aid Society provided health and welfare benefits to employees of Consolidated Edison of New York Inc. under labor agreements with three local Electrical Workers unions. In 1983, members of one of the unions ceased participating in the Mutual Aid plan under a new contract in which the employer provided health and welfare benefits for those employees.

Members of the withdrawn union filed a class action to recover a share of the Mutual Aid Society plan's assets attributable to their members. The class ultimately received a judgment of more than $114,000.

ERISA requires that employee welfare benefit plan assets be held for the exclusive purpose of providing benefits to participants and their beneficiaries. Since the Mutual Aid Society plan included both employer and employee contributions and the change in funds was initiated by the employer rather than by the employees, equitable considerations concerning unjust enrichment support the conclusion that Mutual Aid may not retain the funds in question, the appeals court held.

However, the appeals court said it would be inconsistent with ERISA's purpose of establishing plans to provide health and welfare benefits if the disputed funds were paid out to class members. It reasoned that allowing individual members to receive a cash rebate from the former benefit plan would be a windfall to those employees, and that the monies instead should be deposited in the employees' new benefit plan.

Qualified Domestic Relations Orders

A state trial court erred in holding that it did not have

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1-13

Human Services Task Force of which Wilensky will serve as vice-chair, and a Senate bipartisan group.

While admitting that it is astounding to have so many different groups looking at the same issue, Wilensky declined to elaborate on her views, or the position of the departmental task force regarding the uninsured. She said that she would do so this summer. However, in response to questioning from Riegle, Wilensky agreed that the issue cannot be addressed solely through private insurance provisions, but would require a public/private partnership.

In other areas, Wilensky said she would look into having HCFA facilitate the states to act as prudent purchasers of drugs under the Medicare program; that the department is reviewing, and will report to Congress by Oct. 1 regarding the severity of illness adjustment; and that she would pass on to the department the committee's pressing concern over the scheduled Feb. 1 change in the payment scheme under the end stage renal disease program.

Health Insurance

GRANDY TO OFFER INCENTIVE PLAN TO PROMOTE ACCESS TO CARE FOR UNINSURED

A bill aimed at expanding access to health care coverage and making insurance more affordable is being developed, Rep. Fred Grandy (R-Iowa) announced Jan. 25.

Grandy said the bill is an alternative to legislative proposals that would require most employers to provide a minimum package of health care benefits to their employees, such as that offered by Sen. Edward Kennedy (D-Mass) and Rep. Henry Waxman (D-Calif) (S 768/HR 1845).

Stressing that his proposal is still in draft form, Grandy told a legislative meeting of the Self-Insurance Institute of America, held Jan. 24-25, that the bill first puts into effect various affordability and health care cost control measures to avoid the initial "demand-push inflation" inherent under other proposals.

According to a description of the bill, a "carrot and stick" approach is used to induce the development and implementation of private sector mechanisms to provide for universal availability of health care coverage. The "carrots" include instituting 100 percent health care deductions for self-employed individuals and their employees, preemption under the Employee Retirement Income Security Act of state health benefit mandates, and incentives provided under ERISA Section 501(c)(9) to encourage soundly financed, multiple employer basic group health plans. In addition, the bill would remove state barriers to managed care options to promote competition, innovative cost-control approaches, and quality review.

To the extent the private sector "carrot" is not implemented within a fixed period of time, a "fallback" mechanism would be triggered whereby the availability of coverage would have to be provided by employers or, for certain individuals, by a federally imposed, state-based system, according to the description. Employers would be obligated to make insurance available to their employees, and would be encouraged—but not required—to contribute to the cost of the coverage, Grandy explained. "If this is a mandate, it is a market-wide mandate," he said. "If we're opposed to an upfront mandate, there have to be alternatives."

The government's ability to fund a new program such as the Kennedy/Waxman plan—which has an estimated price tag of $66 billion—is drastically reduced in the current era of the budget deficit, Grandy told the conference. Moreover, the proposal has created a rift between corporate employers, he said. Large companies maintain they pay for the health care of their employees and for spouses or dependents whose employers do not furnish coverage. Small businesses claim they cannot afford the cost of health insurance. Quoting a congressional colleague who said that the mandated benefits debate has become a battle between "big and little Republicans," Grandy added, "If you're going to do something substantive, you need consensus, not a battle."

A national health insurance program is the only other alternative being widely discussed, Grandy said. "This has enormous appeal," but would mean the virtual elimination of the U.S. employer-based insurance system, the conversion of all for-profit hospitals and health maintenance organizations to non-profit entities, and possible rationing of health care based on the government's ability to provide services at a low cost. "Even Canada is beginning to have to cut back on the number of services they can provide," he noted.

Grandy said his intention is to have the proposed legislation ready for use as a substitute or amendment to HR 1845 when it nears mark-up in the House in April. The Senate version of the plan was approved by the Senate Labor and Human Resources Committee July 12, 1989 (16 *BPR* 1320).

Grandy's bill will be introduced within a few weeks, he said, adding, "We do not have all the time in the world on this issue. Everyone acknowledges the magnitude of the problem, but no one accepts the consequences of the solutions."

MEWAs And METs

Self-insured multiple employer welfare trust arrangements and multiple employer trusts that are not well managed should be subject to immediate, vigorous regulation by state government agencies responsible for monitoring such arrangements, the Self-Insurance Institute of America said in a policy statement released Jan. 25 at the conference.

Self-insured MEWAs and METs are arrangements for funding benefit plans of small and medium-sized employers. The arrangements provide health care benefits to employees of unrelated firms who purchase coverage under the trust.

"Unfortunately some MEWAs/METs are too often formed by persons who lack the knowledge and skills to design and manage such programs on a sound, ongoing basis," the institute said in a press release. Enforcement action by state regulators to eliminate fraudulent or abusive practices of financially unsound trust arrangements is long overdue, the institute asserted.

The institute pointed out that state regulatory agencies have the authority to regulate MEWAs and METs, whether or not they are self-insured. "Legal authority for the states to regulate self-insured MEWAs or METs was granted by Congress in 1983 when the Employee Retirement Income Security Act of 1974 was amended," the institute stated. SIAA supports the current ERISA framework applicable to health benefit plans, and urges states to exercise more vigorously their responsibilities under the federal-state framework that delegates to states the responsibility of regulating MEWAs and METs under ERISA Section 514, according to the press release.

At a press conference, SIAA Executive Vice President James A. Kinder said the institute decided to release its policy statement on the issue because "the information carried back to us is [trust arrangement regulation] is a grey area . . . states are going to the [federal government] and saying, 'We need your help. This is your problem.' "

Asked whether a wave of MET failures is coming, Kinder said the institute has received several concerned calls from state regulators, and that several arrangements are experiencing financial problems.

2/7/90 To: Pitsenberger
Tom Miller
John Knack
Fy.
From: Mattox

Opinions

Crack down on benefit crooks

THIEVES CAUGHT burglarizing homes, stealing cars or robbing banks are arrested and prosecuted.

Is it too much to expect, then, that third-party administrators and others caught stealing from employee health care plans also face criminal prosecution?

We don't think so, and we applaud the recent announcement by the U.S. Justice Department and the U.S. Department of Labor that they are stepping up criminal investigations into the abuse of self-funded multiple employer welfare arrangements—also known as self-funded multiple employer trusts.

In announcing the indictment of an Atlanta TPA last month, federal authorities reported additional investigations are now under way in California, Florida, Texas, North Carolina, Pennsylvania and other states (*BI*, Jan. 29).

It's about time.

State regulators and law enforcement authorities have been stymied for too long in attempts to deal with unscrupulous MET operators.

A spate of self-funded MET scandals in the late 1970s and early 1980s produced amendments to the federal Employee Retirement Income Security Act of 1974, seeking to clarify the jurisdictional boundaries between ERISA and various state insurance laws.

However, state insurance departments attempting to regulate self-funded METs still routinely face claims by MET entrepreneurs that ERISA preempts state regulation.

Lacking resources and multistate jurisdiction, state authorities are also ill-equipped to pursue nationwide MET fraud investigations. Compounding the problem, the Department of Labor has historically offered little or no help to the states in their enforcement efforts.

This appears to be changing.

In congressional testimony last year, Raymond Maria, the Labor Department's acting inspector general, warned that unless MET fraud artists are stopped, thousands of workers will find themselves without health care benefits.

Mr. Maria described MET scams as "the classic Ponzi scheme," in which dishonest MET operators rake in benefit premiums as fast as they can while embezzling the funds in a variety of ways, including through offshore reinsurers they control. When premium income slows and the MET can't keep up with incoming claims, the plan collapses.

Mr. Maria offered several proposals for dealing with the problem, including more aggressive federal criminal enforcement efforts. Civil fines and penalties, long favored by the Department of Labor, are considered merely a "cost of doing business" for unscrupulous MET operators, he observed.

In addition, the Labor Department is preparing what it calls "plain English" materials to be given to state insurance departments explaining the department's and the states' roles in regulating self-funded METs. This should help states better understand that they indeed do have regulatory power to police METs.

The department also is considering requiring all METs to file reports or registration statements with the department. That would enable the Labor Department and the states to better regulate self-funded METs.

Following last month's indictment in Atlanta, Mr. Maria also said the Labor Department is questioning what he called an insurance industry practice of paying commissions to benefit plan fiduciaries for placement of stop-loss and other coverages.

All of these ideas are good ones, and can only reduce the risk that innocent working men and women might suddenly find themselves without health care coverage in the wake of a MET failure.

The best idea, though, is putting teeth into the threat of criminal sanctions.

"We want to send a strong signal to people who deal with employee benefit plans that we consider these funds to be sacred—inviolable," Mr. Maria said last month.

Fair enough. Common thieves face the risk of arrest and imprisonment; so should white-collar thieves in the employee benefit field.

1-75

Testimony on SB 445
Before the Senate Financial Institutions and Insurance Committee
By: Larry W. Magill, Jr., Executive Vice President
Independent Insurance Agents of Kansas
February 6, 1990

Thank you very much, Mr. Chairman, and members of the committee for the opportunity to appear today. We are opposed to SB 445 because of grave concerns that it would dry up the market for small employer group insurance coverage, leaving even more employees without medical insurance. We know that is not the intent of the bill sponsors, but feel that would be the ultimate consequence of enacting the legislation.

Before explaining why we are concerned that SB 445 would dry up the market, we need to define what we mean by adverse selection. Adverse selection occurs when an "unhealthy" firm (one with employees who have serious medical problems) is able to join a group plan. If a number of unhealthy firms join, the experience of the plan is adversely affected relative to other plans. Ultimately, this will cause the plan's rates to exceed the "market" rate being charged by other competing multiple employer trusts. When that happens, the "healthy" younger firms leave to buy their insurance at a lower cost from a competing group. As they leave, they drive the rates even higher. Eventually, this leads to a residual market for only those firms that because of health problems cannot go elsewhere and the group plan collapses.

To avoid adverse selection and to protect the group's rates and experience, most multi-employer and association-sponsored plans medically underwrite firms with less than ten employees wishing to join the plan. If all employees of the firm are found acceptable, the firm is allowed to join the plan.

Attachment 2
FI&I
2/12/90

While it is not a "hard and fast" rule, most plans allow single employers with more than ten employees to join without medical evidence (medical underwriting). The theory is that there are enough employees in the over ten firms that the likelihood of joining the plan to insure one sick employee or dependent is less and the average experience of the ten new "lives" won't hurt the group's overall experience.

Newly hired employees of existing firms with less than ten lives and employees who rejected coverage initially, and decide they want it later must normally meet medical underwriting standards and provide medical evidence. Again, this is to protect the group's experience and avoid adverse selection.

In addition, most group plans include the following restrictions on eligibility or coverage, again to protect against adverse selection:

1. They contain a pre-existing conditions clause. The length varies from three months to one year. It places limitations on coverage for illnesses or injury existing before coverage went into effect.

2. Minimum participation requirements. Generally, the minimum participation requirement is 75% of the eligible employees of the firm. This protects from adverse selection and gives a good cross-section of employees.

3. Full-time employees defined. Generally a plan defines full-time employee as one working 30 hours or more per week. This avoids insuring unhealthy non employees such as retired owners who may work only a few hours a week, if at all.

4. The actively at work clause. At the time that a group is taken over by a new carrier, if an employee is disabled, sick or in the hospital when coverage would have taken effect, the employee must be well and back at work to come under the new group coverage. The previous carrier would have that employee's claim up to that point.

However, under the provisions of SB 445, all of the preceding restrictions designed to allow a group insurance plan to survive would be prohibited.

Over the past several years, the Independent Insurance Agents of Kansas have taken a number of steps to try to save our group insurance program for our members. All of these steps have moved us away from a single, group rate for everyone to a rate that more closely approximates the "risk" of claims each employee represents. All of these measures were forced on us by competition that would skim the cream (healthy, young firms) if we did not combat it. They were:

1. Age rating by brackets.
2. Territory rating: Kansas City, Wichita and the remainder of the state.
3. Tiered rating by loss ratio brackets.
4. Elimination of open enrollment (non medical) for new members of IIAK with fewer than ten employees.
5. Pre-hospitalization utilization review and approval.
6. A competitive "new business rate" <u>below</u> the rate charged the lowest tier currently in the group to attract new young, healthy firms.

Despite these changes, we were cancelled by our carrier, CNA, effective 10/31/88, because of a 119% loss ratio, declining participation and no hope of charging a high enough premium to cover claims without driving off the younger, healthier firms.

We could not find any carrier, including Blue Cross/Blue Shield, to take over the entire group (113 firms, 410 lives and over $1 million in premium) on a non medical basis. The best offer we could find was from IIAA's endorsed program that Kelsey National administers using Connecticut General Insurance Company. They took 76 firms non medically and eventually wrote an additional six firms with medical underwriting information.

<u>Had this bill passed in 1988 as was proposed then, we could not have</u>

offered those 76 firms coverage. Our association-sponsored group would have ended - probably permanently.

SB 445 seeks to eliminate all group medical underwriting, but it does nothing to guarantee group participation by individual firms or members. If all 580 of our member firms participated, our group could survive without medical underwriting - but they won't. There are too many other competitors willing to offer temporarily lower rates.

Participation is one of the key differences between a single employer plan and a multi-employer or association-sponsored plan for small firms. The large firm can absolutely control participation. The multi-employer trust or association-sponsored plan cannot.

SB 445 will eliminate competition and options for small employers. The group programs that survive - Blue Cross/Blue Shield, and a few others, will be stronger, but there will be far fewer choices for the consumer.

To our knowledge, no other state in the country has passed a law like this.

Nor, to our knowledge, does the Insurance Department have any statistics or quantitative information on what groups are operating in Kansas, what their coverage provisions are, what their rates are, how many small employers and employees they cover or what their reaction to this bill would likely be.

Nor does this measure affect self-insured plans, HMO's or PPO's. Like the fact that they are not required to provide mandated benefits and pay no premium taxes, this would be one more reason to self-insure.

The entire area of group insurance cost and availability is a major concern and an extremely complex problem. We urge the committee not to

pass SB 445 and continue to study the entire area of health insurance cost and availability before making any changes.

Kansas Life Association

L.M. Cornish
General Counsel
900 Merchants Natl. Bank Bldg.
Topeka, Kansas 66612

February 9, 1990

TO: Members, Senate Financial Institutions and Insurance Committee

RE: SB 445

We oppose SB 445 which will increase the cost of health insurance for Kansas small employers. This is particularly true for those small employers insured under a multiple employer trust arrangement.

The increase in cost is caused by the "adverse selection" which occurs when firms with high risk members are mandated into group plans with lower risk.

We join Farm Bureau Life Insurance Company and the Independent Insurance Agents of Kansas in opposing this bill and support the written statements made by them before the Committee.

Very truly yours,

L. M. CORNISH

LMC:sh

Attachment 3
FI+I
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Attachment 1
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2/12/90

Session of 1990

SENATE BILL No. 547

By Committee on Financial Institutions and Insurance

1-24

AN ACT relating to insurance; concerning adverse underwriting decisions with respect to life insurance coverage under certain circumstances; amending K.S.A. 1989 Supp. 40-2,112 and repealing the existing section.

| and premium refund obligations

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

Section 1. K.S.A. 1989 Supp. 40-2,112 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 or 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. 1989 Supp. 40-2,112 is hereby repealed.

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

such refund obligation shall not apply if:

(A) Material underwriting information requested by the application for coverage is clearly misstated or omitted and the company attempts to provide coverage based on the proper underwriting information; or

(B) the company includes with the notice of the adverse underwriting decision an offer of coverage to an applicant for life insurance 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 under the terms of the policy for which application has been made. The insurer shall promptly refund the premium upon notice of the insured's refusal to accept the counter-offer.

4-2

KEY PROVISIONS OF SB 532

(1) Amends the multi-bank holding company sections of the state banking code to allow interstate control of banks by bank holding companies.

(2) Provides for reciprocity with states contiguous to Kansas plus Iowa and Arkansas. Kansas banking holding companies would be allowed to purchase banks in those states and bank holding companies in those states would be allowed to purchase Kansas banks if the State Banking Board determined that the interstate laws of those states were compatible with Kansas law. **See Section 6(a)**

(3) Prohibits out-of-state bank holding companies from establishing a new bank in Kansas or from purchasing any Kansas bank which has been in operation for less than 5 years. Kansas bank holding companies would not be subject to such a restriction. **See Section 3(a)**

(4) Allows a bank holding company (either Kansas or out-of-state) to control no more than 12% of the total Kansas deposits of all banks and savings and loan associations. **See Section 2(a)**

(5) Provides that the home state of a bank holding company shall be that state where the deposits of the subsidiary banks of the holding company are largest at the time an acquisition application is filed with the State Banking Board. **See Section 6(b)**

(6) Provides that the interstate acquisition provisions of the act will become effective on July 1, 1992. **See Section 6(a)**

Interstate commissioner authority

Attachment 5
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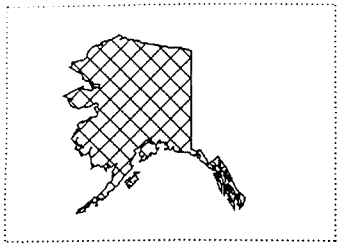
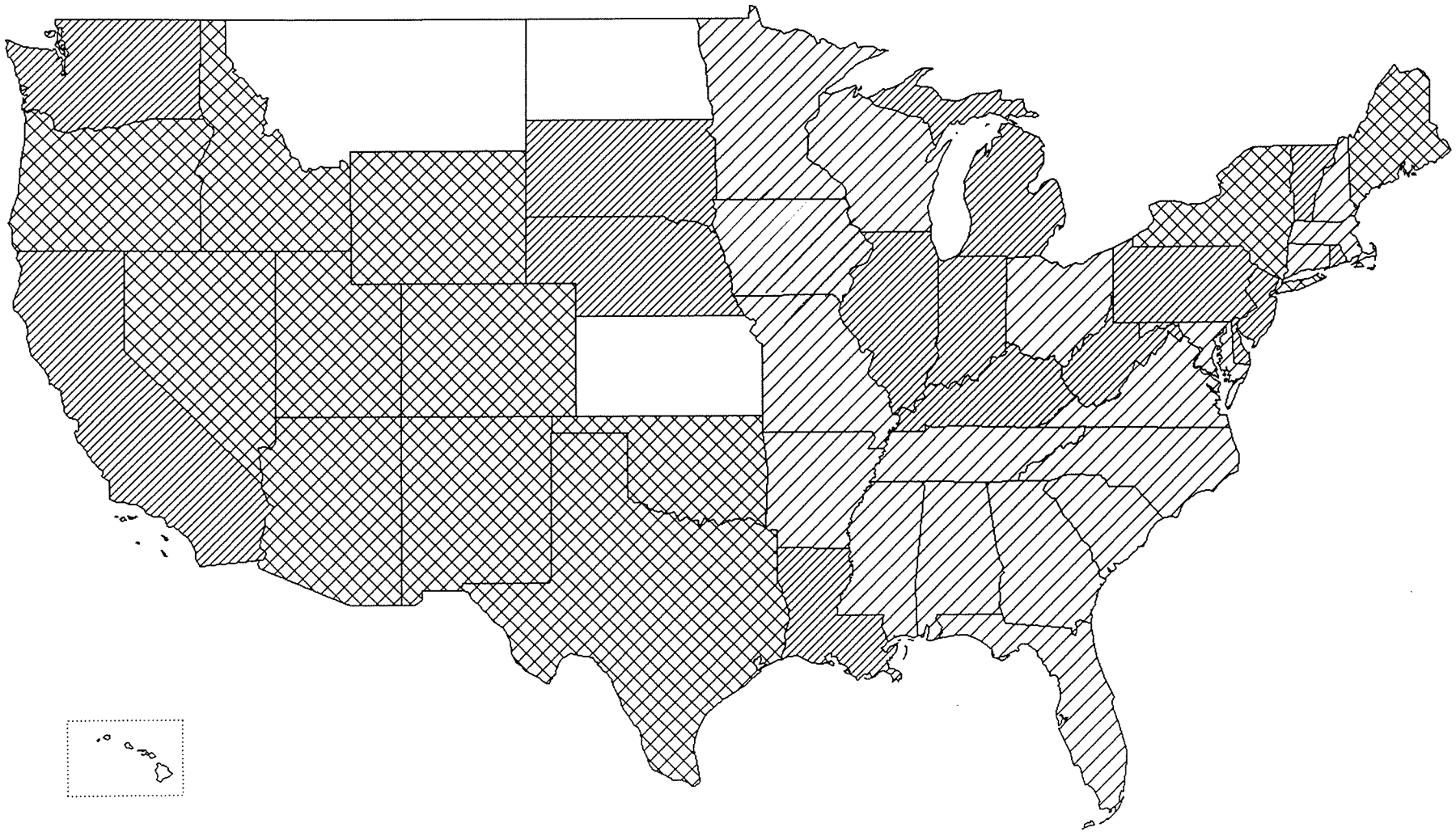
2/12/90



INTERSTATE BRANCH BANKING, 1990

- Nationwide
- Nationwide Reciprocal
- Regional Reciprocal
- Nationwide Branching Not Authorized



5-2

Kansas Legislative Research Department