Approved January 24, 1991
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Larry Turnquist at
Chairperson

3:40 a.m./p.m. on Wednesday, January 23, 1991 in room 531-N of the Capitol.

All members were present except:

Representative Cribbs - Excused
Representative Sawyer - Absent
Representative Welshimer - Absent

Committee staff present:

Chris Courtwright - Research
Fred Carman - Revisor
Nikki Feuerborn - Secretary

Conferees appearing before the committee:

Mr. Ron Todd, Commissioner of Insurance

Others attending: See attached list

Representative Sprague moved that the minutes for the January 23, 1991, meeting be approved with the following corrections: Representatives Wells and Sawyer be listed as excused rather than absent and correct the spelling of Mr. Turnquist's name in the fourth paragraph. Motion seconded by Representative Ensminger. Motion carried.

Insurance Commissioner Ron Todd introduced his assistants, Mr. Terry Tiede and Mr. Dick Brock. He gave an overview of the insurance industry and expressed confidence in its continued solvency. He reviewed the solvency standards established and adopted by the NAIC. Florida and New York are the only states thus far who have received accreditation; Kansas is working on its accreditation.

Commissioner Todd stated support of the Insurance Interim Committee's recommendations which are included in HB 2001. They are: community rating, portability of coverage, rate regulation of all health insurers, exclusions for pre-existing conditions, exclusions from coverage, and a small employer health benefit plan.

Legislative Proposals (Attachment 1) from the Insurance Commissioner's office were distributed and explained to the Committee. Legislative Proposal 4A is based on the idea of establishing an availability mechanism for a health insurance plan to accommodate a catastrophic illness or accident for individual uninsureds. It contains no premium limitation as it has a very high ($5,000) deductible, is not totally self-sustaining, and does not include provisions for a premium tax offset or other means of subsidization by use of public funds.

Legislative Proposal 4B would be entered as a House Concurrent Resolution approving and directing the Commissioner of Insurance to implement a health risk pool with a smaller deductible but with coinsurance provisions for individual uninsureds. A premium cap of 150% of a calculated average premium for such coverage in the normal market and provisions for a subsidy through a premium tax offset is also provided. This plan addresses the affordability issue.

Legislative Proposal 6 addresses a certification problem encountered by some insurance agents who have successfully completed all paperwork and examinations for certification but due to no fault of their own have not received certification. This would allow the Commissioner of Insurance to waive an additional examination and not be limited to a two year period.

Legislative Proposal 7 would require the Commissioner of Insurance to establish a billing system for the collection of required certification fees when an insurer authorizes or continues an authorization of an agent to represent them.

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 3:40 ~~a.m.~~/p.m. on Wednesday, January 23, 1991

Legislative Proposal 8 is a revision of the statutory provisions regulating businesses involved solely in financing insurance premiums.

Legislative Proposal 11 related to the minimum education requirements applicable to insurance brokers. It adds provisions which would permit life and health courses and professional designation courses equivalent to 15 hours of college credit to qualify rather than limiting such courses to business and accounting only.

Representative Sprague moved that Proposals 4A, 4B, 6, 7, 8, and 11 as requested be introduced as bills in the House of Representatives. The motion was seconded by Representative Flower. Motion carried.

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

GUEST LIST

COMMITTEE: House Insurance

DATE: 1-23-91

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
JIM OLIVER	TOPEKA, KS	PIAK
Nancy Zogleman	Topeka	BC/BS
LISA Getz	Wichita	Wichita Hospitals
TERRY TIEDE	Topeka	Ks. Ins. Dept.
LEWJENE SCHNEIDER	TOPEKA	STATE FARM
Lee Wright	Overland Park	Farmers Ins. Group
Leland Smith	Wichita	WIBA
Terry Scholl?	Topeka	KMS
Dick Brock	Topeka	Ins Dept.
Bill Curtis	Topeka	Ks. Assoc. of School Bds.
HARRY SPRING	KC	PRIME HEALTH
Wendell STROM	TOPEKA	CCTF - AARP
TRUDY ARON	"	Amer Inst of ARCHITECTS
David Hanzlick	Topeka	KS Dental Ass'n
John Peterson	Topeka	Kaiser Permanente
Ron Todd	"	Comm of Ins
[illegible]	TOPEKA	PRUDENTIAL
Bev Bradley	Topeka	KS Assoc of Counties
Whitney Damron	Topeka	Pete McGill & Assoc.

Final Legislative Proposals

1. Recommend enactment of an insurers liquidation and rehabilitation law patterned after NAIC model. -- Senate

2. Adopt December 1990 model law on examinations or incorporate relevant provisions in existing law. -- Senate

3. Amend Holding Company Act to bring it into conformance with current NAIC model (except with regard to investment provisions). -- Senate

4. A. Propose alternative health risk pool mechanisms
   A new proposal creating a traditional residual market mechanism for catastrophic coverage ($5,000/$7,500 deductible) -- House
   B. A resolution approving the Department's 1988 recommendation pursuant to the enabling legislation already in effect -- House

5. Amend investment statutes to incorporate "new" NAIC designations "1" or "2" with respect to bonds. -- Senate

6. Add a provision to the agents licensing statutes permitting the Commissioner to waive the examination for persons who have successfully completed the exam but, due to clerical error within the certifying company, have never been certified. -- House

7. Amend K.S.A. 40-241i to permit the Department to establish a billing system for agents certification fees. -- House

8. Propose housekeeping amendments to the premium finance company act. -- House

9. Amend HMO law to require specific notice of conversion rights. -- Senate

10. Amend conversion and continuation law relating to Blue Cross and Blue Shield and commercial carriers to clarify areas that have caused administrative difficulties. -- Senate

11. Amend minimum education requirements in current brokers law to produce greater practicality. -- House

12. Amend K.S.A. 40-223 to provide sick leave for examiners. -- Senate

Jan 23, 1991
House
Ins. Committee
Attachment 1

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Explanatory Memorandum For

Legislative Proposal Nos. 4A & 4B

This proposal consists of two possible alternatives for consideration by the 1991 Kansas legislature each of which would authorize the creation of a mechanism that would make health insurance coverage available to some individuals who cannot obtain such coverage in the normal market.

We have identified these alternatives as Legislative Proposal No. 4A and Legislative Proposal No. 4B and two different proposals are presented because of their significantly different characteristics.

Legislative Proposal No. 4A is based on the idea of establishing an availability mechanism for a health insurance plan to accommodate a catastrophic illness or accident. Because of the catastrophic approach, the proposal contains no premium limitation since a very high front-end deductible coupled with other characteristics of catastrophic coverage such as exemption from mandated benefits and equality requirements and non-duplication provisions can conceivably produce a viable availability mechanism on a self-sustaining basis without a premium subsidy. Even if the plan is not totally self-sustaining, any required subsidy would be more modest. Therefore, Legislative Proposal No. 4A does not include provisions for a premium tax offset or other means of subsidization by use of public funds. This, of course, means any required subsidy would be provided by policyholders in the voluntary market. Obviously, this result would not be desirable but, at least theoretically, the fact that any such subsidy would affect insurance premiums in the competitive market should itself encourage the development of adequate rates and premiums for the catastrophic coverage.

To some people, a $5,000 deductible is so high that the insurance provided would be of little or no value. While it is true that $5,000 is a significant amount of money to most people and a seemingly impossible amount to some, few people would see it as totally and forever unobtainable. On the other hand, many persons in comfortable financial circumstances would suffer significant hardship if faced with the expense of a serious and/or

long-term illness without insurance protection. In other words, a person facing open heart surgery or a similar medical condition with insurance coverage that would pay all but $5,000 of the expenses would be far better off than the person with no coverage at all.

Legislative Proposal No. 4B takes a different approach. It provides for a plan with a smaller (though still significant) deductible but with coinsurance provisions that could subject covered persons to a maximum out-of-pocket expenditure of $5,000 per individual and $7,500 per family annually. However, a premium cap of 150% of a calculated average premium for such coverage in the normal market and provisions for a subsidy through a premium tax offset, is also provided. Therefore, this proposal provides more basic coverage and, to some extent, addresses the affordability issue.

In addition to the alternative proposals, there are two interim legislative committee reports attached to this memorandum. In reviewing these reports, you will note the legislature has previously considered and rejected Legislative Proposals No. 4A and 4B. Proposal 4A is changed in some respects from its original form but not enough to affect the 1979 interim committee's findings.

In view of this previous legislative action, the reasons for again advancing these proposals is probably not clear. However, if the issue of the uninsured population is considered and of concern, the Department's purpose in bringing these proposals and this material to your attention makes more sense. There simply is no magic formula, any brilliant administrative action, or spontaneous outpouring of generosity from the medical community that is going to finance the costs of health care for those people who are not eligible for public assistance or are not financially capable of self-insuring and have no insurance. The only way any state has addressed this problem so far is through a residual risk mechanism of the nature proposed, through some employer mandate coupled with a state funded plan or other definitive action.

Needless to say, enactment of either of the alternatives currently proposed would not solve the problem. Other actions such as an expansion of medicaid

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eligibility, a strengthening of public health services and other initiatives would still be necessary. But these are all incremental decisions and currently no action is being taken or proposed to make a health care financing mechanism available to individuals who cannot qualify for medicaid or obtain health insurance coverage.

Most of the initiatives now being explored, including House Bill No. 2001, relate to group coverage. While that bill addresses rates and underwriting and even though that bill will, if enacted, assist some uninsureds by making coverage available under a group program, it will not address the problem of individual uninsureds. Legislative Proposals 4A and 4B provide a vehicle to again explore the issue.

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LEGISLATIVE PROPOSAL NO. 4A

AN ACT relating to insurance; requiring certain insurers to offer catastrophic health insurance to eligible persons; prescribing the coverage of such insurance; establishing the Kansas health insurance association; and providing for the filing and approving of forms and rates.

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

Section 1. As used in this act, unless the context otherwise requires, the following words and phrases shall have the meaning ascribed to them in this section:

(a) "Association" means the Kansas health insurance association as established under section 4 of this act.

(b) "Basic coverage" means any policy of accident and health insurance or nonprofit hospital, medical or surgical service plan.

(c) "Carrier" means an insurer or fraternal benefit society providing medical, hospital or surgical expense incurred health insurance policies, mutual nonprofit hospital and medical service corporations and health maintenance organizations.

(d) "Catastrophic health insurance" means that coverage specified in section 3(a) and (b) of this act.

(e) "Eligible person" means any individual, family, corporation, association, partnership and any other legal entity which has established permanent or principal residence in this state and has secured or evidences an interest in securing health insurance coverage for itself, dependents, employees, members or other lawful interests.

(f) "Health care services" means any services or products included in the furnishing to any individual of medical or dental care, or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any other services or products for the purpose of preventing, alleviating, curing or healing human illness or injury.

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(g) "Health maintenance organization" means any organization granted a certificate of authority under the provisions of the health maintenance organization act.

(h) "insured" means those individuals covered under a plan of insurance, the individual's spouse, and the individual's dependent, unmarried children.

(i) "physician" means any person duly licensed or qualified to practice pursuant to the provisions of the Kansas healing arts act, and shall also mean any duly licensed dentist, optometrist, podiatrist or any duly licensed psychologist with respect to any services performed within the lawful scope of their license.

Sec. 2. (a) As a condition of doing business in this state and with respect to basic coverage delivered or issued for delivery in this state including all such policies in force on the effective date of this act, each carrier shall offer, either individually or in combination with other carriers in accordance with section 4 of this act, catastrophic health insurance to any eligible person as defined herein. The obligation to offer catastrophic health insurance shall not apply with respect to short term travel accident policies, automobile medical payments and incidental coverages issued with or as a supplement to liability insurance.

(b) The obligation of a carrier to offer the catastrophic health insurance coverage shall become effective no earlier than the date the market mechanism established pursuant to section 4 of this act becomes effective and operative.

Sec. 3. (a) Catastrophic health insurance required by this act shall provide coverage for all reasonable and customary charges for the necessary care and treatment of any sickness or injury incurred during any calendar year, subject to the exclusions allowed by section 6 of this act, which exceed five thousand dollars ($5,000) in the case of an individual insured, or an aggregate amount of seven thousand five hundred dollars ($7,500) in the case of an insured family for the benefits prescribed in subsection (c) of this section. Family coverage need not be made available for family members who are neither residing with nor dependent on the family for financial support. Unpaid expenses incurred during the last three (3) months of a calendar year may be applied to satisfy the threshold amount in the following calen ar year. For purposes of this section, where benefits

are provided in the form of services rather than cash payments, their value shall be determined on the basis of their monetary equivalency.

(b) Notwithstanding the provisions of subsection (a) of this section, the fixed threshold limits in individual policies providing individual or family catastrophic health insurance coverage may be stated as the dollar amount prescribed in subsection (a) of this section or the amount of benefits payable under other existing basic coverage, whichever is higher.

(c) The coverage required by subsections (a) or (b) of this section shall include coverage for all reasonable and customary medical or health care charges incurred by the insured or on the insured's behalf for treatment furnished or prescribed by a physician for injury or sickness, subject to the exclusions permitted in section 6 of this act. Minimum required coverage where room accommodations are necessary for treatment shall include semiprivate room accommodations unless other intensive or private accommodations are medically necessary.

(d) Notwithstanding the provisions of subsection (a) of this section, references made to the calendar year basis for determining entitlement to catastrophic benefits shall not preclude the use in appropriate contracts of a twelve-month period not based upon a calendar year. If such an alternate twelve-month period is selected, the three-month period immediately preceding the alternate twelve-month period shall be used in determining eligible expenses which shall be added to the twelve-month period expenses as required by subsection (a) of this section.

(e) The requirements of this act may be met by offering on an individual or group basis the catastrophic health insurance as part of a comprehensive policy form, or as a rider or endorsement to other existing forms. However, this provision shall not be construed to relieve the carrier of the obligation to make available separate catastrophic health insurance if desired by eligible persons.

(f) Coinsurance provisions are prohibited in catastrophic insurance plans within the scope of this act, except as provided for in section 6(k) of this act.

(g) The maximum benefit payable for each covered person under a policy issued pursuant to this act shall be limited to a lifetime aggregate of $1,000,000.

Sec. 4. (a) There is hereby created a nonprofit legal entity to be known as the Kansas health insurance association which must assure that catastrophic health insurance is made available throughout the year to every person applying for coverage who is a resident of this state. All carriers, health maintenance organizations and group funded pools providing health insurance or health care services in this state shall be members of the association. Each carrier, in meeting its obligation under section 2 of this act, may elect to issue a catastrophic health insurance policy in its own name, may reinsure the policy with the association or refer the risk to the association which will provide the catastrophic health insurance in the name of the association. The association shall operate under a plan of operation established and approved under subsection (b) of this section and shall exercise its powers through a board of directors established under this section.

(b)(1) The board of directors of the association shall be selected by members of the association subject to the approval of the commissioner of insurance. To select the initial board of directors, and to initially organize the association, the commissioner of insurance shall give notice to all members in this state of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member shall be entitled to one (1) vote in person or proxy. If the board of directors is not selected within sixty (60) days after the organizational meeting, the commissioner of insurance shall appoint the initial board. In approving or selecting members of the board, the commissioner of insurance shall consider, among other things, whether all members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members of the board of directors, but shall not otherwise be compensated by the association for their services.

(2) The association shall submit to the commissioner of insurance a plan of operation for the association and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation shall become effective upon approval in writing by the commissioner of insurance consistent with the date on which the coverage under this act must be made available. The commissioner of insurance shall, after notice and hearing, approve the plan of operation

provided such plan is determined to be suitable to assure the fair, reasonable and equitable administration of the association, and provides for the sharing of association losses on an equitable proportionate basis among the member carriers, health maintenance organizations and group-funded pools. If the association fails to submit a suitable plan of operation within one hundred eighty (180) days after the appointment of the board of directors, or at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner of insurance shall, after notice and hearing, adopt and promulgate such reasonable rules and regulations as are necessary or advisable to effectuate the provisions of this section. Such rules and regulations shall continue in force until modified by the commissioner of insurance or superseded by a plan submitted by the association and approved by the commissioner of insurance. The plan of operation shall, in addition to requirements enumerated elsewhere in this act:

(i) Establish procedures for the handling and accounting of assets and moneys of the association;

(ii) establish the amount and method of reimbursing members of the board;

(iii) establish regular times and places for meetings of the board of directors;

(iv) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner of insurance;

(v) establish procedures whereby selections for the board of directors will be made and submitted to the commissioner of insurance for his or her approval;

(vi) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and

(vii) establish procedures for the periodic advertising on behalf of all member carriers of the general availability of the health insurance coverages from individual carriers and the association.

(3) The plan of operation may provide that any or all powers and duties of the association are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this association, or its equivalent in two (2) or more states. A delegation

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under this section shall take effect only with the approval of both the board of directors and the commissioner. The commissioner of insurance shall not approve a delegation unless the protections afforded to the insured are substantially equivalent or greater than those provided under this act. In the event the commissioner of insurance, at any time, determines that participation of association members doing business in this state in a multi-state organization is not in the best interests of the citizens of this state, the commissioner of insurance may require such members to establish and operate a state health insurance association solely in this state in accordance with this section.

(c) The association shall have the general powers and authority enumerated by this subsection in accordance with the plan of operation approved by the commissioner of insurance under subsection (b). The association shall have the general powers and authority granted under the laws of this state to carriers licensed to transact the kinds of health service or insurance included under section 3(d) of this act, and in addition thereto, the specific authority and duty to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this act;

(2) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers;

(3) take such legal action as necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association;

(4) establish appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not be unreasonable in relation to the coverage provided and the reasonable operational expenses of the association;

(5) administer any type of reinsurance program for or on behalf of members;

(6) pool risks among members;

(7) issue policies of insurance on an indemnity or provision of service basis providing the coverage required by this act in its own name or on behalf of members including the provision of conversion policies for persons covered under group health insurance policies, health maintenance organization plans and group-funded pool plans;

(8) administer separate pools, separate accounts, or other plans or arrangements as deemed appropriate for separate members or groups of members;

(9) operate and administer any combination of plans, pools, reinsurance arrangements or other mechanisms as deemed appropriate to best accomplish the fair and equitable operation of the association; and

(10) appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association.

(d) Every member shall participate in the Kansas health insurance association in accordance with the provisions of this subsection.

(1) A member shall determine the particular risks it elects to reinsure in the association or have coverage issued by the association on its behalf. The election of particular risks shall be made from the following risk classes the member underwrites in the state:

(i) Individual, excluding group conversions;

(ii) group conversions; and

(iii) groups with fewer than fifty (50) employees or members.

(2) No member nor group policyholder shall be permitted to select out individual eligible lives from a group and reinsure them in the association. Members electing to administer risks which are reinsured in the association shall comply with the benefit determination guidelines and the accounting procedures established by the association. A risk reinsured by the association cannot be withdrawn by the participating carrier except in accordance with the rules established by the association.

(3) Rates for coverages issued by the association or reinsured through the association shall not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage. Separate scales of premium rates may apply for individual risks and group risks, consisting of one (1) rate for each of a number of age brackets of insured individuals and one (1) rate for all eligible dependents. Rates may be adjusted for area variations in health care provider costs. Premium rates shall take into consideration the extra morbidity and administrative expenses, if any, for risks reinsured in the association, reasonable expense allowances to members reinsuring risks, and the level of rates charged by carriers for groups of fifty (50) or fewer

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lives. All rates promulgated by the association shall be submitted for approval to the commissioner of insurance.

(e)(1) Following the close of each fiscal year, the association shall determine the net premiums (reinsurance premiums less administrative expense allowance), the expenses of administration pertaining to the reinsurance operations of the association and the incurred losses for the year. Any net loss shall be assessed to all members in proportion to their respective shares of total health insurance premiums received in this state during the calendar year (or with paid losses in the year) coinciding with or ending during the fiscal year of the association or any other equitable basis as may be provided in the plan of operation. For health maintenance organization members of the association, the proportionate share of losses shall be determined through application of an equitable formula based upon claims paid or the value of services provided. In sharing losses, the association may abate or defer in whole or in part the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. Net gains, if any, shall be held at interest to offset future losses or allocated to reduce future premiums.

(2) Expense allowances referred to in subsection (1) of this section shall also apply to risks for which particular members do not elect to administer one or more classes of risks reinsured in the association. Any net loss to the association represented by the excess of its actual expenses of administering policies issued by the association over the applicable expense allowance shall be separately assessed to the members. All assessments shall be on an equitable formula established by the association.

(3) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association, and the association shall have an annual audit of its operations by an independent certified public accountant.

(4) The association shall be subject to examination by the commissioner in accordance with K.S.A. 40-222. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

(f) All policy forms issued by the association or reinsured through the association shall conform in substance to prototype forms developed by the

association, shall in all other respects conform to the requirements of this act, and shall be filed with and approved by the commissioner of insurance prior to use.

(g) The association shall not issue nor reinsure catastrophic health insurance plan coverage to any individual or group, that on the effective date of coverage applied for or reinsured, already has or would have qualified for comprehensive health insurance coverage as an insured or covered dependent.

Sec. 5. With respect to catastrophic health insurance, there shall be no exclusion permitted for pre-existing conditions. However, a six-month waiting period may be used for any specific conditions that has been diagnosed or treated within a six-month period preceding the application. Eligible expenses incurred after expiration of the six-month waiting period are payable.

Sec. 6. The following are permissible exclusions to coverage required of any catastrophic health insurance plan within the scope of this act:

(a) Services for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay;

(b) services and charges made for benefits provided pursuant to the laws of the United States including, but not limited to military service-connected disabilities, medical services provided for members of the armed forces and their dependents or for employees of the armed forces of the United States, medical services financed by medicare and medicaid and medical services which may be financed in the future on behalf of all citizens by the United States;

(c) injuries or sicknesses to the extent that coverage is provided under a worker's compensation or occupational disease law, or any similar law;

(d) care which is primarily for custodial or domiciliary purposes;

(e) cosmetic surgery unless provided as a result of an injury or medically necessary surgical procedure;

(f) dentistry and other orthodontia; optometry; hearing aids; and routine foot care;

(g) travel or transportation for medical purposes, except local professional ambulance service to a local health facility qualified to treat injury or sickness;

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(h) injuries or sickness resulting from declared or undeclared war or act of war;

(i) care required as a result of intentionally self-inflicted injuries;

(j) corrective appliances and artificial aids unless such appliances and aids are medically necessary for the purpose of rehabilitation;

(k) mental illness benefits up to a fifty percent (50%) coinsurance factor while confined and outpatient mental illness visits in excess of twenty (20) visits during any twelve (12) months or calendar year benefit period;

(l) the provisions of K.S.A. 40-2,100 to 40-2,105, inclusive, 40-2,114 and subsection (D) of K.S.A. 40-2209 and K.S.A. 1988 Supp. 40-2229 and 40-2230, and amendments thereto, shall not be mandatory with respect to any catastrophic health insurance plan under this act; and

(m) any other exclusions which are approved by the commissioner.

Sec. 7. (a) No policy of catastrophic health insurance shall be delivered or issued for delivery in this state nor shall any application, rider, or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto have been filed with the commissioner of insurance.

(b) No such policy shall be issued, nor shall any application, rider, endorsement, premium rate or classification of risks be used in connection therewith until the expiration of thirty (30) days after it has been so filed unless the commissioner shall sooner give written approval thereto.

(c) The commissioner may, within thirty (30) days after the filing is made, disapprove any such form, premium rate or classification of risks: (1) If the benefits provided therein are unreasonable in relation to the premium charged, or (2) if the form contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of such policy. The commissioner shall, in writing, specify the reasons for any such disapproval and state that a hearing will be granted within twenty (20) days after request in writing by the carrier.

(d) The commissioner may at any time, after a hearing of which not less than twenty (20) days written notice shall have been given to the carrier, withdraw approval of any such filing on any of the grounds stated in this section. It shall be unlawful for the carrier to issue or use any such form, premium rate or classification of risks after the effective date of

such withdrawal of approval. The notice of any hearing called under this subsection shall specify the matters to be considered at such hearing and any decision affirming disapproval or directing withdrawal of approval under this section shall be in writing and shall specify the reasons therefor.

(e) Any order or decision of the commissioner under this section shall be subject to review in accordance with the provisions of K.S.A. 40-251.

Sec. 8. (a) Coordination of benefit provisions as approved by the commissioner may be included in a group catastrophic health insurance plan.

(b)(1) No persons shall be eligible for catastrophic health insurance on an individual basis who have such catastrophic health coverage as required by this act through another source either individually or as a dependent.

(2) No carrier shall sell catastrophic health insurance on an individual basis to any person who is ineligible for such coverage pursuant to subsection (b)(1) of this section.

Sec. 9. No group catastrophic health insurance plan shall exclude any individual member who would otherwise be eligible for coverage during regular enrollment periods, solely on the basis that such individual is deemed to be uninsurable according to individually underwriting health standards.

Sec. 10. Participation in any market plan, the establishment of uniform policy forms, procedures or premium rates for insurance provided by the market or the conduct of any other joint act or procedure required by this act shall not be the basis for any legal action or criminal or civil liability against any market plans established pursuant to section 4 of this act or any participating carrier.

Sec. 11. The commissioner of insurance is hereby authorized to adopt such rules and regulations as may be necessary to carry out the provisions of this act.

Sec. 12. This act may be cited and shall be known as the Kansas catastrophic health insurance act.

Sec. 13. This act shall take effect and be in force from and after January 1, 1992, and its publication in the statute book.

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LEGISLATIVE PROPOSAL NO. 4B

A HOUSE CONCURRENT RESOLUTION approving and directing the commissioner of insurance to implement a health risk pool.

WHEREAS, K.S.A. 40-2111 authorizes the commissioner of insurance to establish a plan whereby applicants for accident and sickness insurance who cannot procure such insurance through ordinary methods shall be equitably apportioned among insurers; and

WHEREAS, Such statutory authority requires legislative approval of the plan established by the commissioner of insurance prior to implementation; and

WHEREAS, The commissioner of insurance presented a plan to the 1988 session of the Kansas legislature for approval and has otherwise met the requirements of K.S.A. 40-2111; and

WHEREAS, A study conducted by the commissioner of insurance revealed that of 79,230 applications for insurance submitted to insurers during the 12 month period ending June 30, 1987, 4,702 applicants were rejected entirely and 13,263 applicants were issued policies with coverage restrictions or at substandard rates because of an uninsurable or abnormal health condition; and

WHEREAS, even persons with the will and financial means to procure accident and health insurance cannot do so because coverage is not available to them in the voluntary market; and

WHEREAS, the rising costs of health care demands that access to accident and health insurance or some other financing mechanism be available to as many Kansas citizens as possible: Now, therefore,

Be it resolved by the House of Representatives of the State of Kansas, the Senate concurring therein:

That the Kansas Health Insurance Pooling Mechanism included in the "Accident and Health Risk Pool Report" submitted to the 1988 Kansas legislature by the Commissioner of Insurance and attached hereto is hereby approved; and,

Be it further resolved: That the Commissioner of Insurance is hereby directed to implement such Health Insurance Pooling Mechanism no later than January 1, 1992; and,

Be it further resolved: That the Commissioner of Insurance is authorized to make any incidental changes in the Health Insurance Pooling Mechanism as may become necessary during its implementation to improve its ability to attract and serve the needs of Kansas citizens; and,

Be it finally resolved: That the Chief Clerk of the House of Representatives be directed to send an enrolled copy of this resolution to the Commissioner of Insurance and (add any other appropriate persons).

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KANSAS HEALTH INSURANCE POOLING MECHANISM

Section 1. Definitions.

1. "Pool" means the Kansas Health Insurance Pool.

2. "Board" means the Board of Directors of the pool.

3. "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer as defined in this section.

4. "Insurer" means any insurance company, health maintenance organization, and non-profit hospital and medical service company authorized to transact business in this state.

5. "Insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or third party administrator, health care services or benefits other than through an insurer.

6. "Health insurance" means any hospital and medical expense incurred policy, and nonprofit health care service plan contract. The term does not include insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

7. "Medicare" means coverage under both part A and B of Title XVIII of the Social Security Act, 42 USC 1395, et seq as amended.

8. "Physician" may be defined by including the words "duly qualified physician" or "duly licensed physician". An insurer using these terms shall recognize and accept, to the extent of its obligation under the contract, all providers of medical care and treatment when these services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

9. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

a. be an institution operated pursuant to law; and

b. be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

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c. provide twenty-four (24) hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).

The definition of the term "hospital" may state that such term shall not be inclusive of:

a. convalescent homes, convalescent, rest, or nursing facilities; or

b. facilities primarily affording custodial, educational or rehabilitory care; or

c. facilities for the aged, drug addicts or alcoholics; or

d. any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

10. "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to §2 of this pooling mechanism.

11. "Benefits plan" means the coverages to be offered by the pool to eligible persons pursuant to §6 of this pooling mechanism.

12. "Department" means the Kansas Insurance Department.

13. "Commissioner" means the Kansas Insurance Commissioner.

14. "Member" means all insurers participating in the pool.

Section 2. Operation of the Pool.

1. A non-profit entity to be known as the Kansas Health Insurance Pool, will be established for the purposes of implementing this pooling mechanism. All insurers providing health plan benefits in this state on and after the effective date of this pooling mechanism shall be members of the pool.

2. The Commissioner shall appoint members of the governing board as specified in K.S.A. 40-2111. The Commissioner shall give notice to all insurers of the time and place for the initial organizational meeting.

3. If, within sixty (60) days of the organizational meeting, the administering insurer has not been appointed by the Board, the Commissioner shall appoint an administering insurer.

4. The Board shall submit to the Commissioner a plan of operation for the pool and any amendments thereto necessary or suitable to assure the

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fair, reasonable and equitable administration of the pool. The Commissioner shall, after notice and hearing, approve the plan of operation provided such is determined to be suitable to assure the fair, reasonable and equitable administration of the pool, and provides for the sharing of pool gains or losses on an equitable proportionate basis. The plan of operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this pool mechanism must be made available. If the pool fails to submit a suitable plan of operation within 180 days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the pool and approved by the Commissioner.

5. In its plan the Board shall,

a. Establish procedures for the handling and accounting of assets and monies of the pool.

b. Select an administering insurer in accordance with §4 of this pooling mechanism.

c. Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board, pursuant to §5 of this pooling mechanism. Assessment shall occur at the end of each calendar year. Assessments are due and payable within 30 days of receipt of the assessment notice.

d. Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan.

6. Powers and Authority of the pool. The pool shall have the specific authority to:

a. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this pooling mechanism, including the authority, with the approval of the Insurance Commissioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

b. Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against pool members;

c. Take such legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

d. Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claims costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices.

e. Assess members of the pool in accordance with the provisions of this section, and to make advance interim assessments as may be reasonable and necessary for the organizational and interim operating expenses. Any such interim assessments to be credited as offsets against any regular assessments due following the close of the fiscal year.

f. Issue policies of insurance in accordance with the requirements of this pooling mechanism.

g. Appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool.

h. Establish rules, conditions and procedures for reinsuring risks of pool members desiring to issue pool plan coverages in their own name. Such reinsurance facility shall not subject the pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

Section 3. Eligibility.

1. Any individual person, who is a resident of this state shall be eligible for pool coverage, except the following:

a. persons who have on the date of issue of coverage by the pool, coverage under health insurance or an insurance arrangement.

b. any person who is at the time of pool application eligible for health care benefits under any state Medicaid law.

c. any person having terminated coverage in the pool unless twelve months have lapsed since such termination.

d. any person on whose behalf the pool has paid out $1,000,000 in benefits.

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e. inmates of public institutions and persons eligible for public programs.

2. Any person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period.

3. Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium and who is not eligible for conversion, may apply for coverage under the plan. If such coverage is applied for within 60 days after the involuntary termination and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

Section 4. Administering Insurer.

1. The board shall select an insurer or insurers through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria established by the board which shall include:

   a. The insurer's proven ability to handle individual accident and health insurance.

   b. The efficiency of the insurer's claim paying procedures.

   c. An estimate of total charges for administering the plan.

   d. The insurer's ability to administer the pool in a cost efficient manner.

2. a. The administering insurer shall serve for a period of three (3) years subject to removal for cause.

   b. At least 1 year prior to the expiration of each 3 year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding 3 year period. Selection of the administering insurer for the succeeding period shall be made at least 6 months prior to the end of the current 3 year period.

3. a. The administering insurer shall perform all eligibility and administrative claims payment functions relating to the pool.

   b. The administering insurer shall establish a premium billing procedure for collection of premium from insured persons. Billings shall be made on a periodic basis as determined by the board.

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c. The administering insurer shall perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

1. Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made.

2. Evaluating the eligibility of each claim for payment by the pool.

d. The administering insurer shall submit regular reports to the board regarding the operation of the pool. The frequency, content, and form of the report shall be as determined by the board.

e. Following the close of each calendar year, the administering insurer shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the department on a form as prescribed by the Commissioner.

f. The administering insurer shall be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

Section 5. Assessments.

1. Following the close of each fiscal year, the pool administrator shall determine the net premiums (premiums less administrative expense allowances), the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.

a. Each insurer's assessment shall be determined by multiplying the total cost of operation by a fraction the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges written in the state during the preceding calendar year.

2. If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" include reserves for incurred but not reported claims.

3. a. Each member's proportion of participation in the pool shall be determined annually by the board based on annual financial

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statements and other reports deemed necessary by the board and filed by the member with it.

b. Any deficit incurred by the pool shall be recouped by assessments apportioned under subsection (1) of this section by the board among members.

4. The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (1) of this section. The member receiving such abatement shall remain liable to the pool for the deficiency for 4 years.

Section 6. Minimum Benefits - Availability.

1. The pool shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered by the pool shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under paragraph (4)(d) of this section, up to a lifetime limit of $1,000,000 per covered individual. The maximum limit under this paragraph shall not be altered by the Board, and no actuarial equivalent benefit may be substituted by the Board.

2. Covered Expenses -- Covered expenses shall be the prevailing charge in the locality for the following services and articles when prescribed by a physician and determined by the pool to be medically necessary.

a. Hospital services.

b. Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, which are rendered by a physician, or by other licensed professionals at his direction.

c. Drugs requiring a physician's prescription.

d. Services of a licensed skilled nursing facility for not more than 120 days during a policy year.

e. Services of a home health agency up to a maximum of 270 visits per year.

f. Use of radium or other radioactive materials.

g. Oxygen.

h. Anesthetics.

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i. Prostheses other than dental.

j. Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the condition for which is prescribed.

k. Diagnostic X-rays and laboratory tests.

l. Oral surgery for excision of partially or completely unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

m. Services of a physical therapist.

n. Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition.

o. Services for diagnosis and treatment of alcoholism, drug abuse or nervous or mental conditions shall be covered in the manner prescribed in K.S.A. 40-2,105.

3. Exclusions -- Covered expenses shall not include the following:

a. Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions.

b. Care which is primarily for custodial or domiciliary purposes.

c. Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician.

d. That part of any charge for services rendered or articles prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality or for any charge not medically necessary.

e. Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles.

f. Any expense incurred prior to the effective date of coverage by the pool for the person on whose behalf the expense is incurred.

g. Dental care except as provided in subsection (3)(1) of this section.

h. Eyeglasses and hearing aids.

i. Illness or injury due to acts of war.

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j. Services of blood donors and any fee for failure to replace the first 3 pints of blood provided to an eligible person each policy year.

k. Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.

4. Premiums, Deductibles, and Coinsurance.

a. Premiums charged for coverages issued by the pool may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage.

b. Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks.

c. The pool shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be less than 150% of rates established as applicable for individual standard risks. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed 200% of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the Commissioner for approval.

d. The pool coverage defined in Section 6 shall provide optional deductibles of $1,500 or $3,500 per annum per individual, and coinsurance of 20%, such coinsurance and deductibles in the aggregate not to exceed $5,000 per individual nor $7,500 per family per annum. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.

5. Pre-Existing Conditions.

Pool coverage shall exclude charges or expenses incurred during the first twelve months following the effective date of coverage as to any condition, which during the six month period immediately preceding the effective date of coverage, (i) had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or (ii) for which medical advice, care or treatment was recommended or received. Such pre-existing condition exclusions shall be waived to the extent to which similar exclusions, if any, have been

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satisfied under any prior health insurance coverage which was involuntarily terminated; provided, that application for pool coverage is made not later than thirty-one (31) days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated.

6. Nonduplication of Benefits.

Benefits otherwise payable under pool coverage shall be reduced by amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any worker's compensation coverage, automobile medical payment and by any hospital or medical benefits paid or payable under or provided pursuant to any state or Federal law or program except Medicaid.

Section 7. Complaint and Grievance Procedure.

1. Purpose. The Pool recognizes that from time to time participants may encounter situations where the performance of the Pool does not meet their expectations. When this occurs, the participant may wish to call the matter to the attention of the Board of Directors of the Pool. It is the policy of the Pool to promptly and fairly consider all complaints and grievances of its participates. The procedure outlined in this Section is established to define and assure this policy.

2. Definitions. For the proposes of this Complaint and Grievance Section, the following terms and their definitions apply:

a. Complaint means a relatively minor verbal or written expression of concern about a condition in the Pool's operation which may be resolved on an informal basis.

b. Grievance means a more serious written expression of concern about the Pool's operation or a complaint which has not been resolved to the participant's satisfaction. Both situations require a formal response by the Pool, including a thorough investigation and appropriate answer to the participant.

c. Participant means applicants for insurance, insureds, agents and insurers.

3. Procedure for Filing a Complaint or Grievance.

a. A complaint may be directed to the Pool by the Participant by telephone, in person, or in writing expressing the details of the participant's concern. Complaints will be handled by the Pool complaint/grievance coordinator who may involve other staff members of the Pool or providers of care in making the determination. The objective is to handle the complaint as quickly and as courteously as possible. If the participant does not receive prompt resolution, or wishes to express his

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concern to a higher level of authority, he may file a written grievance with the Pool.

b. A grievance is to be submitted to the Pool by completing the Grievance Form available from the Pool's office. This form should be filed within 90 days after the incident occurred. The participant must sign the form acknowledging that all incidents are accurately described.

Upon receipt of the Grievance Form, the Pool will conduct a thorough review of the situation. A response to the participant's grievance will be prepared and the participate will be notified of the Pool's decision in writing. If the solution is satisfactory, the matter ends.

If the solution is not satisfactory to the participant, he may within 30 days submit a written request for review by the Grievance Committee of the Board of Directors of the Pool. The request for review must state the participant's reason for appeal, including his reason for dissatisfaction with the first grievance response. The Committee will be convened within 30 days after receipt of the appeal. The participant who submitted the appeal will be invited to appear before the Committee to explain his position. The Committee will review all previous findings of the Pool. The participant will be notified of the Committee's decision within 15 days after the date of the Committee review.

c. If any party involved is not satisfied with the decision of the Board of the Pool or its committee, he may pursue normal remedies of law including a right of appeal to the Commissioner of Insurance. Prior to the institution of any legal proceeding or suit against the Pool the foregoing "Complaint" and "Grievance" procedure shall be utilized by any party alleging a claim against the Pool. In all events, such suit or proceeding must be commenced not later than five (5) years after the date the notice of final determination under the grievance procedure is transmitted to such party.

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RE: PROPOSAL NO. 23 - CATASTROPHIC
HEALTH INSURANCE

Proposal No. 23 directed the Special Committee on Health Care Costs to determine whether the Legislature should enact a program of major medical insurance coverage for residents of Kansas.

Background

The 1979 Legislature was presented with at least three bills which concerned catastrophic health insurance, S.B. 277, H.B. 2529 and H.B. 2270. The latter measures are identical and would, if enacted, create a pooling mechanism or association comprised of all carriers and health maintenance organizations (HMOs) providing health insurance or health care services in Kansas. The association would make available to any person who could not obtain insurance in the private market and who could afford the premiums, catastrophic health insurance coverage for medical expenditures in excess of $5,000 per individual or $7,500 per family.

While it, too, related to catastrophic health insurance, S.B. 277 would apply to persons whose medical expenses were of such magnitude so as to constitute a financial catastrophe for themselves or for those responsible for their medical expenses. Generally, those eligible under S.B. 277 would be persons whose income was just above the eligibility level for state or federal assistance programs, but insufficient to afford the purchase of health insurance.

The issues presented in these bills are not new to the Kansas Legislature. For example, the provisions of H.B. 2270 are quite similar to those contained in catastrophic health insurance proposals presented by the Commissioner of Insurance since 1975. Nor are these issues unique to the Kansas situation. The National Association of Insurance Commissioners (NAIC), as early as June, 1976, adopted model comprehensive health insurance legislation, including health care cost containment provisions.

Because catastrophic illness and the financial impact of such illness are not solely Kansas phenomena, catastrophic coverage has been included in some national health insurance plans. Two national health insurance plans to include catastrophic coverage are the Carter Administration's proposal and the health insurance industry's plan. The catastrophic portion of the President's plan would, among other things, mandate that all employers provide full-time employees and their families both a standard benefits package and catastrophic protection. Employers would be required to pay at least 75 percent of the premiums and offer a benefits program available after $2,500 had been spent out-of-pocket. On the other hand, the health insurance industry plan proposes a partnership between the private health sector and the federal government -- private health insurers would administer and be financially responsible for providing catastrophic protection to cover all Americans who can afford to pay, while the government would continue to administer and be financially responsible for the Medicare and Medicaid programs.

Committee Activity

Prior to inviting conferees for a hearing on the Proposal, staff was informed that the Commissioner of Insurance intended to withdraw support for his bill on catastrophic insurance. Due to this withdrawal of support, only the Commissioner was invited to testify. Testimony was then received stating that this withdrawal of support is due to the continued apparent lack of support for the bill among legislators and representatives of the insurance industry. Nonetheless, the Commissioner believes that some program of catastrophic insurance may be needed.

Committee Recommendation

The Committee recommends that no bill on catastrophic insurance be passed at this time. This recommendation is based on several factors: state action in this area may be premature and unnecessary because

catastrophic coverage has been included in several national health insurance proposals; no reliable estimates as to the need for such a program in Kansas have been made; and proposals for catastrophic coverage could increase health care costs either by encouraging use of only the most expensive types of health care or by raising insurance premiums for all insureds if a pooling mechanism is mandated.

Respectfully submitted,

November 2, 1979

Rep. Rex Hoy,
Chairperson
Special Committee on Health Care Costs

Sen. Bill Morris,
Vice-Chairperson
Sen. Ron Hein
Sen. Mike Johnston
Sen. Frank Smith
Rep. Roy Ehrlich

Rep. Roy Garrett
Rep. Belva Ott
Rep. John Reimer
Rep. Kent Roth
Rep. Larry Turnquist

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RE: PROPOSAL NO. 11 -- FUNDING AN ACCIDENT AND HEALTH ASSIGNED RISK POOL

Proposal No. 11 directed the Special Committee on Commercial and Financial Institutions to study the implications of implementing the plan proposed by the Insurance Commissioner for the apportionment among accident and sickness insurers of applicants who are unable to procure insurance through ordinary methods and to review alternative funding mechanisms for such a plan.

Background

Consideration of issues relating to the creation of an accident and health insurance risk pool is not a new topic for the Kansas Legislature and its committees. In 1975 the Insurance Commissioner recommended a variety of health insurance proposals to the Legislature, including the creation of a joint underwriting mechanism to make health insurance available to persons unable to secure coverage by ordinary means. The 1975 proposals, which were considered by the Commissioner to be cost containment proposals, were neither drafted into bill form nor introduced. In 1979, the Commissioner proposed the creation of a catastrophic health insurance pooling mechanism or association composed of all carriers and health maintenance organizations providing health insurance or health care services in Kansas. The 1979 proposal was introduced as H.B. 2270 and was studied by the Special Committee on Health Care Costs as a part of 1979 Proposal No. 23 -- Catastrophic Health Insurance. The 1979 interim committee recommended that the 1979 bill not be enacted and noted in its report that the cost of required participation in such a pooling mechanism would be passed on to all insureds in the form of higher premiums.

In 1980, Governor Carlin proposed several bills based on model legislation prepared by the National Association of Insurance Commissioners, including a joint insurance underwriting mechanism that would have been implemented by 1980 S.B. 689. The bill died at the end of the 1980 Session. The issue of creating a pooled risk mechanism was again studied by the Special Committee on Commercial and Financial Institutions as a part of 1980 Proposal No. 3 -- Comprehensive Health Care Benefits. The 1980 study concluded that, although individual Kansans could not in some cases secure health insurance because of preexisting conditions or the cost, a pool would not ensure an improvement in the availability of insurance for these individuals since preexisting conditions would continue to be excluded for a period of time and the

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cost would be even higher than comparable insurance secured in the market. In 1985, the Commissioner of Insurance again recommended a bill that would have authorized the Commissioner to establish a health insurance pooling mechanism, H.B. 2167.

Another interim study conducted as 1985 Proposal No. 14 -- Health Insurance for Uninsurables -- originated out of interest generated by bills introduced in 1985. The 1985 study noted that an individual can be considered uninsurable by virtue of having inadequate resources available to pay for health insurance or by virtue of having a chronic illness or condition needing frequent medical care, which leads to difficulty in obtaining insurance or to the exclusion of a preexisting condition or the rating of the applicant for health insurance purposes. The former are often referred to as the medically indigent and a number of states have addressed this group in the context of indigent care programs. A subset of the latter have been addressed by some states through the creation of risk pools. The 1985 interim study recommended that a substitute for S.B. 121 and S.C.R. 1621 be enacted by the 1986 Legislature. 1986 Substitute for S.B. 121, which amended K.S.A. 40-2111, required the Commissioner of Insurance to accumulate data concerning declinations, terminations, and offers to provide accident and sickness insurance at higher than standard rates and to report such information to the Governor and the Legislature no later than commencement of the 1988 Legislature.

The Commissioner submitted a report entitled, Accident and Health Risk Pool Report, in January of 1988 as required by 1986 Substitute for S.B. 121. Data compiled in the report were collected from carriers authorized to transact accident and health insurance business in Kansas for the period July 1, 1986, to June 30, 1987, and from Blue Cross and Blue Shield of Kansas. Companies reported processing 79,230 applications for insurance, of which 5.14 percent were declined and 16.74 percent were issued with health restrictions, i.e., riders or higher rates after an underwriting review. The report noted that the data simply reported how many applications were denied during the time period of the study but did not report how many of the applicants denied by one company were accepted by another or later secured group coverage. Nor from the raw data submitted by carriers was it possible to determine how many of the applicants who were denied would have been able to afford to participate in a risk pool which, by definition, is more expensive than the same coverage secured in the market. Additionally, the data did not include persons who did not apply for insurance during the period because they knew they were not an insurable risk or that a preexisting condition would subject them to restrictions on any policy issued.

In the 1988 report, the Insurance Commissioner noted two options for providing coverage to those who are uninsured against catastrophic medical expense. One option is the creation of a pooled risk mechanism administered either through a risk assignment mechanism or through a single plan administered by a selected insurer or administrator to provide insurance coverage to those persons who can afford the cost of the insurance. The second option submitted involves the financing of catastrophic medical expenses directly by state appropriations administered by a state agency. Under the latter option, residents would become eligible for assistance if their medical bills exceed a specified portion of their income. Both options, according to the report, are designed to protect people who are in poor health and who need insurance protection. States have experimented with both options. The Insurance Department recommended the first option, noting that although a pooled risk program would provide the availability of coverage, it is important to recognize that affordability would not be assured, and that the uninsured in Kansas include the unemployed, self-employed, part-time and temporary workers, and those who cannot afford the employee health plans offered by their employers despite an employer contribution. Thus, the creation of a risk pooling mechanism would provide insurance to only a small subset of those without health insurance even if some subsidization by participating carriers or the state through a premium tax credit were included in the plan.

Two bills were introduced in 1988 -- S.B. 674, which was the plan proposed by the Insurance Department patterned on the model law prepared by the National Association of Insurance Commissioners, and S.B. 670, which would have amended K.S.A. 40-2111 to allow any insurer required to participate in an assigned risk plan to offset the amount assessed pursuant to such plan against its premium tax liability. Neither bill was enacted. Rather, a Senate Resolution requesting the Legislative Coordinating Council to assign an interim study was adopted.

The Special Committee on Commercial and Financial Institutions initiated study on Proposal No. 11 by reviewing the previous interim studies on the issue of creating an accident and health risk pool and the conclusions and recommendations reached by previous committees that had considered this subject. The Committee found that one additional avenue of study was available to the members in 1988, i.e., the experience of about half the 15 states that have enacted legislation authorizing the creation of a pooled risk mechanism. Additionally, a great deal of information is available about the uninsured and under-insured who are not covered by governmental or other third-party

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reimbursement and who may be at risk for access to basic health care, i.e., the population referred to as the medically indigent. The characteristics of the latter population give some guidance in determining the potential role of a pooled risk mechanism in serving the needs of those who have difficulty in accessing health care because of the cost of such care.

Experience in Other States

Comprehensive Health Care Associations. One of the strategies states have adopted to combat the problem of access to health care for those persons who are not covered by public or private third-party payors is the establishment of comprehensive health associations, usually referred to as risk pools. The first legislation enacted was that of Minnesota in 1975. Six legislatures had acted by 1984 to create accident and health pooling mechanisms, another two acted in 1985, two acted in 1986, and five acted in 1987. Even though many states without legislation requiring the creation of a risk pool considered legislation in 1988, none had enacted legislation by the time of the Committee study. Although the issue has been before the legislatures of the surrounding states frequently in recent years, only the neighboring state of Nebraska has acted affirmatively on such legislation.

The first legislation implemented was that of Connecticut and Minnesota, with both plans implemented in 1976. The next plan to be implemented was that of Wisconsin in 1981, and the Indiana and North Dakota plans were implemented the following year. In 1983, the Florida Comprehensive Health Association was implemented. Following a hiatus of several years, the Nebraska plan was implemented in 1986 and the Iowa, Montana, Tennessee, and Washington plans in 1987. The Illinois, Maine, New Mexico, and Oregon plans were all scheduled for implementation in 1988. For all practical purposes, only six of the 15 states that have created comprehensive health associations pursuant to legislative enactment have been in operation long enough to provide any data about cost and insureds and the extent to which the plans have accomplished the legislative intent in mandating their creation. All 15 states that have acted to create associations, unlike several of the Kansas proposals, have detailed the administration and the parameters governing the operation of the associations by statute rather than by authorizing a state official to create a plan and to implement it.

Organization and Administration. While the operation of risk pools varies from state to state, there are some basic patterns that can be

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identified. The legislation requires the formation of an association of all health insurance carriers doing business in the state, and one organization is selected to administer the plan under the guidelines relating, among other things, to benefits, premiums, and deductibles set out in the state law. In all existing associations, Blue Cross and Blue Shield plans are also included in the association, and, in 12 of the 15 associations, health maintenance organizations are also required to be members. Although legislation mandating the creation of an association in six of the states includes self-insured organizations among those mandated to participate in the association, U.S. district courts have held that under the provisions of the Employee Retirement Income Security Act (ERISA), employers with self-insurance plans are exempt from state insurance regulation and cannot be required to participate in a plan. The association manages the pool program through its governing body which is constituted pursuant to state law. The association then contracts with an insurance company or another entity to carry out the day-to-day administration of the plan, i.e., issue policies, collect premiums, process claims, and maintain records.

Eligibility. All but two of the risk pools have general eligibility requirements for coverage in the risk pool. Three require the refusal of coverage by two insurers, and the other ten require refusal by one insurer. Some allow applications from persons who are offered only limited coverage by other insurers, and some allow applications from persons who have been offered coverage at high premiums by other insurers. Seven of the pools accept applications from individuals suffering from specified diseases. In some instances the eligibility provisions are set out in state law.

Coverage. Usually, the coverage provided through the association includes a fairly comprehensive package of benefits described as a minimum benefit package. Generally, a range of deductibles and coinsurance is offered by the plan, with resulting differences in premiums. The deductibles set by the pools are generally higher than deductibles under medium size and large group plans offered by employers. Deductibles ranged from a low of $150 to a high of $1,000 in Florida and Wisconsin under a low deductible plan and from a low of $1,000 in 11 plans to a high of $2,000 in two plans under the high deductible plans offered at the time of the Committee study by 14 of the associations. Risk pool coinsurance requirements were more comparable with the group plans offered by large and medium sized employer-sponsored plans, i.e., 13 of the pools required an insured to pay 20 percent of covered medical expenses after meeting the deductible requirements, and Nebraska required a 10 percent coinsurance payment.

State laws may set a maximum out-of-pocket loss which may be experienced by an insured. In 1987 the limits on cost sharing ranged from a low of $1,000 for an individual in one plan to a high of $5,000 for an individual insured in another. Cost sharing was also limited for a covered family. All but two of the 15 risk pools also had a maximum lifetime benefit ranging from a low of $250,000 for four of the pools to a high of $1,000,000 for two of the pools.

All the risk pools in operation or about to become operational in 1988 issue policies that exclude preexisting medical conditions from coverage for a period of time. Preexisting conditions are those that were diagnosed or treated during a specified period of time before the effective date of the policy. Costs of treating preexisting conditions are not covered for a specified period after the effective date of the policy. Traditionally, insurers use waiting periods for preexisting conditions to prevent persons in poor health from purchasing insurance only when they plan to seek treatment. The risk pools that were in operation set the period for determining a preexisting condition from a low of 60 days to a high of six months. The lowest exclusion of a preexisting condition and the most common was six months. The highest was 12 months. Several of the pools allowed a waiver of the preexisting condition exclusion if insurance had been in force prior to enrollment in the risk pool, and several allowed a waiver if the applicant paid a premium surcharge. In one instance a waiver could be granted if insurance had been in force and if a premium surcharge were paid. Most of the plans excluded applicants who were eligible for Medicaid from coverage and some excluded applicants who were eligible for Medicare.

Premiums. The legislation mandating the creation of a risk pool usually sets out the basis for setting the insurance premiums that may be charged by the comprehensive insurance association. Premiums are usually established on the basis of rates charged for private health insurance in the state and vary by age and, in some cases by sex and geographic area. Although the rates are generally set by the legislation on the basis of premiums that are believed to be adequate to cover anticipated claims, experience has shown that the legislatively set "caps" are inadequate to cover the losses experienced by the comprehensive associations. State laws usually limit premium rates to a multiple of the rates charged by private insurers. Legislation in 12 of the 15 states provides for premiums based on multiples that range between 125 and 150 percent. Three states provide for higher multiples, including the Montana legislation which provides for a 400 percent limit. Of the six states surveyed by the General Accounting Office, the annual premium rates for a 55-year old female with a $1,000 deductible policy with 20

percent coinsurance provisions ranged from a low of $999 to a high of $3,153 in 1987. The state pool having the low premium was in Minnesota where the legislation limits premiums to 125 percent of the rates charged for private health insurance in the state, and the high --emium was in Florida where premiums are limited to 200 percent of the ,tes charged for private health insurance.

Funding. Authorizing legislation usually prescribes how program operating deficits are to be financed. In 12 of the 15 states, deficits are shared by association members through assessments on the members. It is usual to distribute assessments in proportion to each member's share of total premium income in the state, i.e., the revenue an insurer earns from the sale of insurance. Under the Connecticut law, assessments are apportioned according to the share of total claims paid by individual members of the association, and in Washington assessments are based on the total share of health insurance subscribers of each member of the association. Maine plans to finance deficits through a tax on hospital revenues, and Illinois will subsidize its risk pool through state general revenues. The Tennessee law provides for up to $2 million a year from general revenues to cover deficits with any remaining deficits to be made up from assessments against association members. Oregon assessed association members for start-up costs, but the legislation does not address how operating deficits are to be financed. In all but three of the states that allow an assessment against participants in the pool, the members are allowed to offset any deficits assessed as a credit against premiums tax or other taxes. In eight of the states the tax credit equals 100 percent of the assessment. The New Mexico law will allow a partial offset against taxes after a specified loss through assessment has been met, and beginning January 1, 1988, Wisconsin will allow tax relief in a specified amount from general revenues for pool members. Only Connecticut and Minnesota do not provide for some form of subsidy for the losses experienced by the pool members, although Minnesota law provided for a tax credit until it was repealed in 1987. In the latter two states, losses may be taken into account when carriers apply for rate increases allowing losses to be passed on to other persons in the state who purchase health insurance.

Experience. According to a General Accounting Office study of the six plans that had been in operation long enough to have an experience history, all have consistently operated at a loss. According to estimates prepared by the Health Care Financing Administration, private insurers paid about $.87 in claims for each dollar of premium income collected in 1986. During the same period, the six pools paid an average of $1.60 on claims for each dollar of premium income collected. The six pools

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had an aggregate net operating loss of about $18.1 million in 1986, with Minnesota experiencing the largest loss at $9,024,288.

Enrollment in risk pools has increased since 1983, the first year the six pools with experience were offering policies, from 13,842 to 20,545 at the end of 1986. However, about half the insured at the end of 1986 were in Minnesota. The number of insured over the period would be greater than the 1986 total because of turnover in enrollees. Wisconsin, the only state with data on why former enrollees had cancelled their policies, found that about one-fourth of those who responded to a survey indicated they had cancelled because they could not afford the premiums. Other cancellations were due to enrollees becoming eligible for group coverage, moving, or becoming eligible for Medicare. A large majority of the policies issued by the pools represented individual rather than family coverage.

Conferees

Conferees who met with the Special Committee included representatives of the Kansas Division of the American Cancer Association; the American Diabetes Association-Kansas Affiliate,Inc.; Kaiser Permanente, Blue Cross-Blue Shield; the Health Insurance Association of America; a Kansas commercial carrier who also represented the Kansas Life Association and the National Life and Health Insurance Association; and an insurance salesman and two registered nurses. Additionally, the Committee received written testimony from the Topeka Cystic Fibrosis Action/Support Group, the Sunflower Branch of the Cystic Fibrosis Foundation, United Cerebral Palsy of Kansas, and the Sedgwick County Medical Society. Testimony centered on (1) the difficulty of survivors of childhood cancer in securing life and health insurance as opposed to a control group of siblings, i.e., 24 of 100 patients reported difficulty in obtaining health insurance while none of the control group experienced difficulty, and 15 patients did not have health insurance as opposed to seven persons in the control group; (2) the difficulty persons with diabetes mellitus experience in securing health insurance without exclusion of the preexisting condition and the lack of coverage for diabetic supplies, equipment, and education in standard health insurance coverage even though a publication presented to the Committee by a conferee indicates that an estimated 92 percent of all persons with diabetes have at least some health insurance; (3) the difficulty persons with cystic fibrosis have in securing insurance; (4) the difficulty persons with cerebral palsy have in obtaining insurance without a preexisting condition clause that will be in effect for a period of time and the fact

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that insurance frequently does not cover certain therapies; (5) proposals to decrease the "cap" on premiums and the copayments and deductibles as well as the period of time that preexisting conditions could be excluded from a risk pool as set out in the legislation proposed in 1988; (6) the need to expand the funding base for any risk pool to include employers who do not offer group health insurance coverage to employees as well as to those who self-insure; and (7) questions about the extent to which a risk pool would, in fact, increase access to health care for Kansans who are a part of the estimated 37,000,000 persons in the United States who do not have health insurance or other third-party coverage. While no conferee expressed complete opposition to the creation of an accident and health insurance pooling mechanism, questions were raised about the purpose of such a mechanism, the funding, and the need for a pool in Kansas.

Actuarial Study

The Kansas Insurance Department retained Tillinghast, Nelson and Warren to perform an actuarial review to determine the fiscal impact of a proposed accident and health risk pool in Kansas. The report entitled "Report on Accident and Health Risk Pool Study - State of Kansas" was made available to the Special Committee in August. The study contains two major actuarial items -- a determination of premium rates and financial projections -- based on data provided by the Insurance Department and various insurance carriers. The study was constructed on the basis of the Insurance Commissioner's proposed legislation, i.e., initial rates of not less than 150 percent of the five largest carriers offering comparable coverage in Kansas and benefits as set out in the proposed legislation. The report presents five different financial projections, with one identified as the baseline or best estimate projection, and all using the assumption that rates would begin at 150 percent of the projected industry rates initially and rise to 200 percent over the life of the projection. The baseline projections of Tillinghast indicate a first-year enrollment of 582 and a tenth-year enrollment of 2,950 individuals. The projected accrued loss in the first year is $325,000 or $558 per enrollee and $.13 per Kansas resident. In the tenth year, the accrued loss is projected at $4,865,000 or $1,649 per enrollee and $1.69 per Kansas resident. None of the projections make any explicit provision for increased adverse claims experienced due to AIDS. The projected initial premium rates, which vary by attained age, sex, and geographical location of the applicant as well as by the amount of the deductible at $1,500 or $3,500, would range from a high of $3,552 for a male at an attained age of 60-64 with a $1,500 deductible to a low

of $446 for a child under family coverage. Rates assume a "cap" of 150 percent of the standard rate for the first two years, an increase to 175 percent in years three through five, and 200 percent after the fifth year. The actuarial study also included the following suggestions: consideration of setting the initial premiums higher than 150 percent of standard; adding eligibility requirements such as having been declined at least once for health insurance; adding authority for an initial assessment to provide for working capital; consideration of the inclusion of routine maternity benefits as appropriate for coverage under a risk plan; and whether Medicare eligible persons should be included.

The actuarial study did not include consideration of the expansions in coverage and the reductions in out-of-pocket costs to insureds covered by policies issued by a risk pool that were recommended to the Special Committee by conferees. It would appear that any such expansions would result in increased premiums and increased revenue losses through state subsidy of the pool.

Conclusions

During the Committee study, the members were reminded by conferees of the creation of the Commission on Access to Services for the Medically Indigent and Homeless pursuant to legislation enacted in 1987. It was noted that the Commission is charged with making recommendations to the Governor and the Legislature on ways to provide access to health care for those Kansans who are uninsured, under-insured, not eligible for governmental programs, and not able to pay all or part of the costs of necessary health care. A subset of the group that is the subject of Commission study is comprised of those persons who find it difficult to secure insurance at a price they can afford or who face high out-of-pocket costs because of incomplete coverage or the exclusion of preexisting conditions. In light of the potential cost to the state of a health and accident risk pooling mechanism as proposed by the Insurance Commissioner (over $4 million in the tenth year of a plan) and the relatively small number of persons projected to be assisted (about 3,000 individuals), the Special Committee concluded that a potential drain on state revenues of this magnitude should not be recommended at this time. In reaching this conclusion, the members were mindful of two things -- the demonstrated difficulty faced by persons suffering from certain conditions and diseases in securing adequate health insurance coverage in the market and the probability that consideration will be given to recommendations that would improve the access of a greater number of persons to basic health care at a yet

unknown cost to the state in the near future. While the members are sympathetic with the problems faced by conferees, they are also mindful that a health and accident risk pool would assist only a small number of Kansans in improving their access to health care and that conferees indicated that changes in the proposal presented by the Insurance Commissioner are desirable that would undoubtedly increase state revenue losses if a risk pool is to meet their needs. Thus, the members believe that a pool should be considered only in conjunction with other proposals to meet the needs of Kansans whose access to health care is restricted. The preface to the Model Health Insurance Pooling Mechanism Act developed by the National Association of Insurance Commissioners contains the following statement, "Each state is urged to determine, through independent study, whether a pooling mechanism is needed and whether enactment of the model would be cost effective." Some members of the Committee concluded the criteria of cost effectiveness may not be met by proposals that have been studied by the Legislature.

Recommendations

The Special Committee on Commercial and Financial Institutions recommends that no legislation be enacted that would direct or authorize the creation of a health and accident insurance pooling mechanism in Kansas at this time. If legislation of this type is to be considered in the future, it should be considered only within the context of the broader goal of improving the access to health care for persons who would not benefit from a risk pooling mechanism.

Respectfully submitted,

November 11, 1988

Rep. Dale Sprague, Chairman
Special Committee on Commercial and Financial Institutions

Sen. Neil Arasmith, Vice-Chairman
Sen. Eugene Anderson
Sen. Roy Ehrlich
Sen. Phil Martin
Sen. John Strick*
Sen. Merrill Werts

Rep. Kenneth Francisco
Rep. Clyde Graeber
Rep. Richard Harper
Rep. J. C. Long
Rep. Kerry Patrick
Rep. L. V. Roper
Rep. Don Sallee
Rep. Tim Shallenburger
Rep. Larry Turnquist
Rep. Bill Wisdom

* Ranking Minority Member

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Explanatory Memorandum For

Legislative Proposal No. 6

The laws relating to the agents qualifying examination describe several situations where the commissioner is required to waive the examination when such situations exist. One of the described situations relates to licensed agents who have been previously licensed and certified but whose "... license and certification have been permitted to lapse for not more than two years ...".

We have encountered situations where applicants for an agents license have qualified and successfully completed the examination either for their initial license or for an additional class of insurance but have not been certified because of a clerical error on the part of the insurance company they represent. If the lack of certification exists for less than a 2 year period, the Department has applied the above waiver provision. However, in instances where the error is not discovered for more than 2 years, there is no existing remedy. These situations have not been frequent but when they occur, the agent is placed in an untenable situation even though they have done everything required and expected of them.

This proposal would address these rare but, to the agent involved, quite significant situations by requiring the commissioner to waive the examination when they occur.

LEGISLATIVE PROPOSAL NO. 6

AN ACT relating to insurance; insurance agents; license; waiver of examination; amending K.S.A. 40-241c and repealing the existing section.

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

Section 1. K.S.A. 40-241c is hereby amended to read as follows: 40-241c. The commissioner of insurance, under appropriate rules and regulations, shall waive examinations when the applicant establishes that:

(a) The applicant has been engaged in active career as an insurance agent in a specified class or classes of insurance in some other state, territory or the District of Columbia and that the license held in such other state, territory or the District of Columbia: (1) Was based upon a written examination; (2) that the state, territory or District of Columbia from which the applicant comes has standards equal to those maintained in Kansas; (3) that the applicant's license has never been suspended or revoked; and (4) the applicant shall file a certificate from such licensing authority which shall provide the class or classes of insurance which the agent was authorized to write and such further information as the commissioner may require; or

(b) the applicant seeks a license as travel insurance agent to persons selling transportation tickets of common carriers, who shall act as such agent only as to transportation ticket policies, or health or accident insurance, or baggage insurance on personal effects in connection with such transportation tickets of common carriers; or

(c) the applicant has been licensed and certified in Kansas for the class of insurance the applicant is applying for and where the license and certifications have been permitted to lapse for not more than two years prior to the date of the application and where the commissioner of insurance is satisfied that the applicant is trustworthy and competent; ~~or~~

(d) the applicant is an applicant for a license to write insurance on growing crops in this state and has been continuously certified to write such coverage in this state on and after April 30, 1986~~.~~ ; or

(e) the applicant has qualified by examination but due to clerical error by an insurance company the applicant was not certified pursuant to K.S.A. 40-241i. Such insurance company shall pay all certification fees that would have been paid had the applicant been properly certified plus the penalty prescribed by K.S.A. 1989 Supp. 40-241i for each violation.

Sec. 2. K.S.A. 40-241c is hereby repealed.

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. 7

Legislative Proposal No. 7 would require the commissioner of insurance to establish a billing system for the collection of required certification fees when an insurer authorizes or continues an authorization of an agent to represent them.

The current statute requires the fee to accompany the request for certification. This often entails the repeated processing of a series of relatively small payments by both the state and insurers. However, even more troublesome is the fact that, particularly when multiple agents are involved, it is not unusual for the amount accompanying the request for certification to be in error. When this occurs, the certifications are not only delayed but the processing time and resources are multiplied. Legislative Proposal No. 7 provides a means of addressing these inefficiencies while at the same time assuring the prompt collection of the correct fees.

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LEGISLATIVE PROPOSAL NO. 7

AN ACT relating to insurance; agents; certification fee; billing procedures; amending K.S.A. 1989 Supp. 40-241i and repealing the existing section.

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

Section 1. K.S.A. 1989 Supp. 40-241i is hereby amended to read as follows: 40-241i. (a) Any company authorized to transact business in this state may, upon determining that the agent is of good business reputation and, if an individual, has had experience in insurance or will immediately receive a course of instruction in insurance and on the policies and policy forms of such company, certify such agent as the agent of the company under the license in effect for the agent. The certification shall be made to the commissioner on a form prescribed by the commissioner within 15 days of appointment of the agent by the company ~~and-shall-be-accompanied-by-the certification-fees-set-forth-in-K.S.A.-40-252,-and-amendments-thereto~~. Such appointment shall be effective immediately and shall remain in effect until May 1, unless the commissioner is notified to the contrary or the license of the certified agent is terminated. The certification fee set forth in K.S.A. 1989 Supp. 40-252 and amendments thereto shall be paid in accordance with the billing procedures established by the commissioner. The certification fee shall not be returned for any reason, and failure of the company to certify an agent within 15 working days of such agent's appointment shall subject the company to a penalty of not less than $25 per calendar day from the date of appointment to the date proper certification is recorded by the insurance department.

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

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

(d) Duly licensed insurance agents transacting business in accordance with the provisions of article 41 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto, shall be deemed to be certified by a company for the kinds of insurance permitted under the license in effect for the agent.

Sec. 2. K.S.A. 1989 Supp. 40-241i is hereby repealed.

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. 8

In 1968 separate and specific statutory provisions were enacted to identify, authorize and regulate entities engaged solely in the business of financing insurance premiums. Since inception, there has been no general review or revision of these statutory provisions. Therefore, in 1989 former Commissioner of Insurance Fletcher Bell created a study group consisting of representatives of premium finance companies doing business in this state and members of the Insurance Department staff to review the relevant statutes and recommend any appropriate changes.

Legislative Proposal No. 8 consists of the recommended amendments resulting from that effort. Several editorial changes are included such as incorporating reference to the consumer credit code instead of its predecessors; and referring to the current statutory provision relating to the legal interest rate as opposed to a statute that was repealed some time ago.

The more substantive amendments include changes necessary to issue premium finance companies a continuous license to parallel the process used for insurance entities and agents; provide for a pro rata calculation of unearned service charges in all instances; remove the $5 limit on delinquency charges in order that the charge will vary with the magnitude of the delinquency; and establish a specific time limit for the return of unearned premiums to the premium finance company by insurers in the event a financed policy is cancelled.

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LEGISLATIVE PROPOSAL NO. 8

AN ACT relating to premium finance companies; continuous license; pro rata return of finance charges; allowance for no fund or insufficient fund checks; return of unearned premium; amending K.S.A. 40-2603, 40-2604, 40-2610, 40-2611, 40-2612 and repealing the existing sections.

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

Section 1. K.S.A. 40-2603 is hereby amended to read as follows: 40-2603. The provisions of this act shall not apply with respect to: (a) Any insurance company authorized to do business in the state of Kansas, or any agent or agency of an insurance company financing premiums on policies written by such agent or agency,

(b) any bank, trust company, savings and loan association, consumer loan licensee or sales finance company authorized to do business in this state,

(c) the enrollment of individuals under a group policy or the inclusion of insurance in a credit transaction under an arrangement for its purchase by the creditor in compliance with the applicable provisions of the Kansas consumer ~~loss-act-or-the-Kansas-sales-finance-act~~ credit code, and

(d) the financing of insurance premiums in Kansas in accordance with the provisions of K.S.A. ~~16-202~~ 16-207 relating to legal interest rate.

Section 2. K.S.A. 40-2604 is hereby amended to read as follows: 40-2604. No person shall engage in the business of financing insurance premiums under this act in this state without first having obtained a license as a premium finance company from the commissioner of insurance. Every violation of any of the provisions of this act shall subject the person violating the same to a penalty not to exceed five hundred dollars ($500) for each violation or by imprisonment not to exceed six (6) months in jail or both.

The ~~annual~~ license continuation fee shall be one hundred dollars ($100). The fee for said ~~license~~ continuation shall be paid to the commissioner to be deposited in the state general revenue fund.

Licenses may be ~~renewed~~ continued from year to year as of May 1 of each year upon payment of the ~~renewal~~ continuation fee. Every licensee shall, on or before the first day of April, pay to the commissioner the sum of one hundred dollars ($100) as a ~~license~~ continuation fee for the succeeding year. Failure to pay ~~such license~~ the continuation fee within the time prescribed shall automatically revoke ~~such~~ the license.

The applicant for such license shall file with the commissioner his or her written application and shall make sworn answers to such interrogatories as the commissioner may require on forms prepared by him. The commissioner shall have authority, at any time, to require the applicant fully to disclose the identity of all stockholders, partners, officers and employees, and he may, in his discretion, refuse to issue or renew a license in the name of any firm, partnership, or corporation if he is not satisfied that any officer, employee, stockholder, or partner thereof who may materially influence the applicant's conduct meets the standards of this act.

Sec. 3. K.S.A. 40-2610 is hereby amended to read as follows: 40-2610. A premium finance company shall not charge, contract for, receive, or collect a service charge other than as permitted by this act.

The service charge shall be computed on the balance of the premiums due (after subtracting the down payment made by the insured in accordance with the premium finance agreement) from the effective date of the insurance coverage, for which the premiums are being advanced, to and including the date when the final installment of the premium finance agreement is payable.

The total service charges shall be a maximum of twelve dollars ($12) per one hundred dollars ($100) per year, plus an additional charge of ten dollars ($10) per premium finance agreement, which need not be refunded on prepayment. No insurance premium finance company shall induce an insured to become obligated under more than one premium finance agreement for the purpose of obtaining more than one additional charge of ten dollars ($10). The insured may prepay the premium finance agreement at any time and if the premium finance agreement is prepaid in full (by cash, renewal or refinancing) one month or more before the final payment is due, any unearned service charge shall be refunded on ~~the~~ a pro rata basis ~~of the rule commonly known as the rule of seventy-eighths (78ths), which is computed as follows:~~ .

The amount refunded shall be the proportion of the service charge which the sum of the monthly balances scheduled to follow the date of prepayment in full bears to the sum of the scheduled monthly balances of the premium finance agreement.

Sec. 4. K.S.A. 40-2611 is hereby amended to read as follows: 40-2611. A premium finance agreement may provide for the payment by the insured of a delinquency charge of one dollar ($1) to a maximum of five percent (5%) of the delinquent installment ~~but--not--to--exceed--five--dollars--($5)~~ on any installment which is in default for a period of five (5) days or more. If the default results in the cancellation of any insurance contract listed in the agreement, the agreement may provide for the payment by the insured of a cancellation charge. The charge shall be five dollars ($5), less any delinquency charge on the installment in default.

New Sec. 5. A premium finance agreement may provide that, in lieu of the civil remedies prescribed by K.S.A. 60-2610, a penalty equal to 10% of the amount of the check may be charged for any worthless check as defined by K.S.A. 21-3707 used to remit payment for any installment due.

Sec. 6. K.S.A. 40-2612 is hereby amended to read as follows: 40-2612. (a) When a premium finance agreement contains a power of attorney enabling the premium finance company to cancel any insurance contract or contracts listed in the agreement, the insurance contract or contracts shall not be canceled by the premium finance company unless such cancellation is effectuated in accordance with this section.

(b) In the event the insured fails to make the payments at the time and in the amount provided in the premium finance agreement, the premium finance company shall mail to the insured a written notice of the intent of the premium finance company to cancel the insurance contract because of the default in payments by the insured unless the default in payments is cured within a time certain stated in said notice, which time shall not be less than ten (10) days. A copy of said notice shall also be sent to the insurance agent or insurance broker indicated on the premium finance agreements.

(c) After expiration of such ten (10) day period, the premium finance company may thereafter request in the name of the insured, cancellation of such insurance contract or contracts by mailing to the insurer a notice of cancellation, and the insurance contract shall be canceled as if such notice

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of cancellation had been submitted by the insured himself, but without requiring the return of the insurance contract or contracts. The premium finance company shall also mail a notice of cancellation to the insured at his last known address and to the insurance agent or insurance broker indicated on the premium finance agreement.

(d) All statutory, regulatory, and contractual restrictions providing that the insurance contract may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party shall apply where cancellation is effected under the provisions of this section. The insurer shall give the prescribed notice in behalf of itself or the insured to any governmental agency, mortgagee, or other third party on or before the second business day after the day it receives the notice of cancellation from the premium finance company and shall determine the effective date of cancellation taking into consideration the number of days notice required to complete the cancellation.

(e) Whenever a financed insurance contract is canceled, the insurer shall, within 20 days of the effective date of cancellation, return whatever gross unearned premiums are due under the insurance contract to the premium finance company, either directly or via the agent or agency writing the insurance, where an assignment of such funds is included in the premium finance agreement for the account of the insured or insureds.

(f) In the event that the crediting of return premiums to the account of the insured results in a surplus over the amount due from the insured, the premium finance company shall refund such excess to the insured via his insurance agent or agency provided that no such refund shall be required if it amounts to less than one dollar ($1).

Sec. 7. K.S.A. 40-2603, 40-2604, 40-2610, 40-2611 and 40-2612 are hereby repealed.

Sec. 8. 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. 11

This proposal relates to the minimum education requirements applicable to insurance brokers. Specifically, it adds provisions which would permit life and health courses and professional designation courses equivalent to 15 hours of college credit to qualify.

The other amendments are editorial in nature to recognize that colleges and universities do not in and of themselves teach and to eliminate the now obsolete "grandfather" provisions.

LEGISLATIVE PROPOSAL NO. 11

AN ACT relating to insurance; insurance brokers; education requirements; amending K.S.A. 40-3707 and repealing the existing section.

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

Section 1. K.S.A. 40-3707 is hereby amended to read as follows: 40-3707. (a) ~~Except-as-provided--in-subsection--(b)--of-this-section,~~ Each life insurance broker, within five (5) years from the date of original licensure hereunder, shall submit evidence of completion of fifteen (15) credit hours, or the equivalent thereof, of business or ~~accounting~~ life/health insurance courses ~~taught--by~~ provided through an accredited college, university or community college; or, an equivalent professional designation.

~~(b) The-requirements-of-subsection-(a)-of-this-section-shall-not-apply to--any--person--who--holds--a--Kansas--life--and--accident--and--health--insurance agent's-license-on-July--1,--1978,-provided-such-person-applies-for-licensure as-a-life-insurance-broker-under-this-act-on-or-before-July-1,-1983.~~

~~(c)~~ (b) ~~Except--as--provided--in--subsection--(d)--of--this--section,~~ Each casualty insurance broker, within five (5) years from the date of original licensure hereunder, shall submit evidence of completion of fifteen (15) credit hours, or the equivalent thereof of business or ~~accounting~~ property/casualty insurance courses ~~taught-by~~ provided through an accredited college, university or community college; or, an equivalent professional designation.

~~(d) The-requirements-of-subsection-(c)-of-this-section-shall-not-apply to-any-person-who-holds-a-Kansas-fire-and-casualty-insurance-agent's-license on--July--1,--1978,--provided-such-person--applies--for-licensure--as--a-casualty insurance-broker-under-this-act-on-or-before-July-1,-1983.~~

Sec. 2. K.S.A. 40-3707 is hereby repealed.

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