Approved February 21, 1991
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Representative Turnquist at
Chairperson

3:30 ~~a.m.~~/p.m. on Wednesday, February 20, 19~~9~~91 in room ~~531 N~~ of the Capitol.

All members were present except:

Committee staff present:

Bill Edds, Revisor
Chris Courtwright, Research
Bill Wolff, Research
Emalene Correll, Research
Nikki Feuerborn, Secretary
Gena Lott, Intern

Conferees appearing before the committee:

See Attached List

Representative Campbell moved for the approval of the minutes of February 19, 1991, with the correction of changing HB 2001 to HB 2002 on Page 2. Representative Welshimer seconded the motion. Motion carried.

Handouts of HB 2001 balloons and copies of a discussion outline were handed out to committee members. Chairman Turnquist announced the informality of the discussion and encouraged members and staff to participate fully. (See Attachment 1).

1. Prohibits exclusion of persons from eligibility or coverage under group health insurance.

Bill Edds, Revisor, said all companies, HMO's, PPO's, etc., would have to insure all members of the group. Not could be excluded for any reason.

NO OBJECTION

2. Disability coverage (loss of time) not included. Disability is also considered group sickness and accident insurance.

NO OBJECTION

3. Extraterritorial provision.

Any resident of the state may be part of a multijurisdictional group plan. They can be issued a certificate of participation. The plan must meet Kansas insurance standards.

NO OBJECTION

4. Prohibits individual underwriting.

Prohibits the ridering of specific conditions such as excluding heart conditions, etc. Must take the individuals as they come.

NO OBJECTION

5. Authorizes a waiting period for pre-existing conditions upon initial coverage.

The insuring group can establish a waiting period of six-twelve months depending on the condition. May be a 240 day wait if condition has appeared with 90 days prior to initial coverage.

NO OBJECTION

6. Portability provision - requires waiver of waiting period with no gap in coverage.

When an insured has been under a group policy and moves into another, the waiting period is not allowed.

NO OBJECTION

7. Applies to group policies issued directly to employers, associations, trusts, and other forms of group policies.

Municipal pools have little regulation, including MEWA's.

NO OBJECTION

8. Requires filing of group and blanket accident and sickness policies with Commissioner prior to use in state.

This is a new rating provision.

NO OBJECTION

9. Amended so disability insurance is not affected.

NO OBJECTION

10. Rating applicable to Kansas residents not to be unreasonable, excessive or unfairly discriminatory or discriminate against individuals eligible for participation in a group.

NO OBJECTION

11. Establishes a form of community rating for groups of 25 or fewer members. Authorizes variations in rate by no more than 50% above the community rate.

Divides the total cost of insurance by number of people enrolled. Variation no more than 50% of what rating should be. Would allow fluctuation or flexibility from group to group. Must build into the system an incentive program for individual action to keep healthy, therefore lowering the rates. Should be a variation from group to group. Market place will take care of issue if allowed to rate within community pool. Could have credits for wellness program.

If we get too specific it does not encourage other experimentation and does not have flexibility by allowing variations to take place. Does not prohibit classification of certain groups but there cannot be classification within a group, no tier rating within a group.

The option of giving a rebate for a wellness or stop smoking program was discussed. Perhaps encourage development of product which rewards good health and welfare in community rating.

Small groups have more problems with exclusion. They cannot tolerate a serious illness and the small group will suffer from aging factor. By moving the number from 25 to 50 some of this problem would be eliminated.

Group discussed possibility of 50% being too high. Perhaps there is a way to soften the impact of community rating: more restrictive, adverse selection.

NO OBJECTION

12. Has grandfather clause for existing policies and provide that no increase in rates may be made where the rate exceeds the community rate by more than 50% until the commencement of a rating period in which the rates would be lower than such 50% on Jan. 1, 1997.

NO OBJECTION

13. Makes foregoing applicable to BC/BS

NO OBJECTION

Mrs. Correll asked that Mr. Brock and Mr. Edds review HB 2610 and HB 2001 for possible correlation in restrictions on premiums.

The meeting was adjourned at 5:00 p.m.

GUEST LIST

COMMITTEE: House Insurance DATE: 2/20/91

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Bill Sneed	Topeka	HIAA
Chuck Stones	"	KBA
Don Lynn	Topeka	BC/BS of Ks
John W Kwack	TOPEKA	BC/BS
William Pitsenberger	Topeka	BC/BS
LJ Schneider	"	State Farm
Nancy Zogleman	"	BC/BS of Ks
Cheryl Dillard	Kansas City	Kaiser Permanente
Tom Tunnell	Topeka	Kans Grain & Feed Assn
LISA Getz	WICHITA	WICHITA Hospitals
JOE FURJANIC	TOPEKA	KCA
Chip Wheelen	Topeka	KS Medical Soc.
Bill Curtis	Topeka	Ks Assoc. of School Bds
Jim Maag	"	KBA

House Insurance
Feb. 20, 1991
Attachment 1

Session of 1991

HOUSE BILL No. 2001

By Special Committee on Insurance

Re Proposal No. 11

12-28

AN ACT relating to insurance; concerning accident and sickness insurance and the regulation of the rates thereof by the commissioner of insurance; concerning eligibility for coverage under group policies; amending K.S.A. 1990 Supp. 40-19c09, 40-2209 and 40-2215 and repealing the existing sections; also repealing K.S.A. 1990 Supp. 40-19c07.

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

Section 1. K.S.A. 1990 Supp. 40-2209 is hereby amended to read as follows: 40-2209. (A) Group sickness and accident insurance is declared to be that form of sickness and accident insurance covering groups of persons, with or without one or more members of their families or one or more dependents; ~~or one or more members of their families or one or more dependents, and~~. *Except at the option of the employee or member and except employees or members enrolling in a group policy after the close of an open enrollment opportunity, no individual employee or member of an insured group and no individual dependent or family member may be excluded from eligibility or coverage under a policy providing hospital, medical or surgical expense benefits both with respect to policies issued or renewed within this state and with respect to policies issued or renewed outside this state covering persons residing in this state. No group policy providing hospital, medical or surgical expense benefits issued or renewed within this state or issued or renewed outside this state covering residents within this state shall limit or exclude benefits for specific conditions existing at or prior to the effective date of coverage thereunder. Such policy may impose a waiting period, not to exceed one year for benefits for conditions, including related conditions, for which diagnosis, treatment or advice was sought or received in the 90 days prior to the effective date of coverage. Such policy shall waive such a waiting period to the extent the employee or member or individual dependent or family member was covered by a group sickness and accident policy prior to the effective date of coverage with no gap in coverage. Such policy may*

Prohibits exclusion of persons from eligibility or coverage under group health insurance.

The term "hospital, medical or surgical expense" makes clear that disability coverage (loss of time) not included. Disability is also considered group sickness and accident insurance.

Extraterritorial provision - law applies to both contracts issued in Kansas and those issued outside of Kansas - prohibits individual underwriting (ridering of specific conditions)

Authorizes a waiting period for pre-existing conditions upon initial coverage.

Portability provision - requires waiver of waiting period to extent it served while covered under a prior group sickness and accident policy with no gap in coverage.

be issued *to such group* upon the following basis:

(1) Under a policy issued to an employer or trustees of a fund established by an employer, who is the policyholder, insuring at least five employees of such employer, for the benefit of persons other than the employer. The term "employees" shall include the officers, managers, employees and retired employees of the employer, the partners, if the employer is a partnership, the proprietor, if the employer is an individual proprietorship, the officers, managers and employees and retired employees of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, employees and retired employees of individuals and firms, the business of which and of the insured employer is under common control through stock ownership contract, or otherwise. The policy may provide that the term "employees" may include the trustees or their employees, or both, if their duties are principally connected with such trusteeship. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials. ~~No policy providing benefits for hospital, medical or surgical expense which replaces a policy issued under this section shall contain any provision which prevents any person insured under the replaced policy immediately prior to such replacement from being insured under the replacing policy. Except at the option of the employee, and except employees and individual dependent or family members enrolling in a group policy after the close of an open enrollment opportunity, no individual employee and no individual dependent or family member may be excluded from eligibility or coverage under a policy providing benefits for hospital, medical or surgical expense issued under this section. Notwithstanding the foregoing sentence, a waiting period, not to exceed one year, may be imposed upon coverage for conditions of health which existed prior to the date of enrollment of such employee, dependent or family member, hospitalization in progress on the date of enrollment need not be covered, and~~ The plan may impose participation requirements, define full-time employees and otherwise design the coverage for the group as a whole to be negotiated between the employer and insurer.

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

(3) Under a policy issued to the trustees of a fund established by two or more employers or business associations or by one or more labor unions or by one or more employers and one or more labor unions, which trustees shall be the policyholder, to insure

Applies to group policies issued directly to employers, associations and trusts and other forms of group policy issuance.

Deleted lines 18-34 eliminate provisions similar enacted in 1988 covering single employer groups

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employees of the employers or members of the union or members of the association for the benefit of persons other than the employers or the unions or the associations. The term "employees" shall include the officers, managers, employees and retired employees of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

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

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

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

(B) Each such policy shall contain in substance: (1) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or the insured's beneficiary.

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

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policy.

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

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

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

(D) A group policy of insurance delivered or issued for delivery or renewed which provides hospital, surgical or major medical expense insurance, or any combination of these coverages, on an expense incurred basis, shall provide that an employee or member or such employee's or member's covered dependents whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy or under any group policy providing similar benefits which it replaces for at least three months immediately prior to termination, shall be entitled to have such coverage nonetheless continued under the group policy for a period of six months and have issued to the employee or member or such employee's or member's covered dependents by the insurer, at the end of such six-month period of continuation, a policy of health insurance which conforms to the applicable requirements specified in this subsection. This requirement shall not apply to a group policy which provides

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benefits for specific diseases or for accidental injuries only or a group policy issued to an employer subject to the continuation and conversion obligations set forth at title I, subtitle B, part 6 of the employee retirement income security act of 1974 or at title XXII of the public health service act, as each act was in effect on January 1, 1987. An employee or member or such employee's or member's covered dependents shall not be entitled to have such coverage continued or a converted policy issued to the employee or member or such employee's or member's covered dependents if termination of the insurance under the group policy occurred because: (a) The employee or member or such employee's or member's covered dependents failed to pay any required contribution after receiving reasonable notice of such required contribution from the insurer in accordance with rules and regulations adopted by the commissioner of insurance; (b) any discontinued group coverage was replaced by similar group coverage within 31 days; (c) the employee or member is or could be covered by medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded); or (d) the employee or member is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. In the event the group policy is terminated and not replaced the employee or member, at the option of the employee or member or at the option of the insurer, may be issued a conversion policy or certificate which otherwise meets these provisions in lieu of the right to continue group coverage required herein. The continued coverage and the issuance of a converted policy shall be subject to the following conditions:

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

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

(3) The terminated employee or member shall pay to the insurer the premium for the six-month continuation of coverage and such premium shall be the same as that applicable to members or employees remaining in the group. Failure to pay such premium shall terminate coverage under the group policy at the end of the period for which the premium has been paid. The premium rate charged for converted policies issued subsequent to the period of continued coverage shall be such that can be expected to produce an anticipated

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loss ratio of not less than 80% based upon conversion, morbidity and reasonable assumptions for expected trends in medical care costs. In the event the group policy is terminated and is not replaced, converted policies may be issued at self-sustaining rates that are not unreasonable in relation to the coverage provided based on conversion, morbidity and reasonable assumptions for expected trends in medical care costs. The frequency of premium payment shall be the frequency customarily required by the insurer for the policy form and plan selected, provided that the insurer shall not require premium payments less frequently than quarterly.

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

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

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

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

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

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

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

(7) A converted policy may include a provision whereby the in-

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surer may request information in advance of any premium due date of such policy of any person covered as to whether:

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

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

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

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

(a) Either the benefits provided under the sources referred to in paragraphs (i) and (ii) above for such person or benefits provided or available under the sources referred to in paragraph (iii) above for such person, together with the benefits provided by the converted policy, would result in over-insurance according to the insurer's standards on file with the commissioner of insurance, or the converted policyholder fails to provide the requested information;

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

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

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

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

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

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

Plan A

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

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

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

Plan B

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

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

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

Plan C

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

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

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

The maximum dollar amounts of plan A shall be determined by the commissioner of insurance and may be redetermined by such official from time to time as to converted policies issued as new policies subsequent to such redetermination. At the request of the insured, such redetermined amounts shall, subject to the provisions

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of condition (17) and submission of reasonable evidence of insurability, be made available to the holders of converted policies which have been in effect at least three years on the date the redetermined amounts become effective. At the option of the insurer, any such requested increase or decrease in coverage on outstanding policies or any renewal thereof need not be made effective until the first policy anniversary date following the insured's request. Such redetermination shall not be made more often than once in three years. The maximum dollar amounts in plans A, B and C shall be rounded to the nearest multiple of $10.

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

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

(i) The smaller of the following amounts:

1. The maximum benefit provided under the group policy.

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

(ii) The smaller of the following amounts:

1. The maximum benefit provided under the group policy.

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

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

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

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accordance with the requirements of any state or federal law and, if pursuant to condition (12), the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits.

If the maximum benefit is determined by paragraph (a)(ii) above, the insurer may require that the deductible be satisfied during a period of not less than three months if the deductible is $100 or less, and not less than six months if the deductible exceeds $100.

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

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

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

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

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

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

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ployment or membership.

(15) The converted policy may provide for reduction of coverage on any person upon such person's eligibility for coverage under medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded) or under any other state or federal law providing for benefits similar to those provided by the converted policy.

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

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

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

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

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

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

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

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

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

Sec. 2. K.S.A. 1990 Supp. 40-2215 is hereby amended to read as follows: 40-2215. (a) No individual policy of accident and sickness insurance as defined in K.S.A. 40-2201 and amendments thereto shall be issued or delivered to any person 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 group or blanket policy of accident and sickness insurance shall be issued or delivered to any person in this state, nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof has been filed with the commissioner of insurance.

~~(b)~~ *(c)* No such policy shall be issued, nor shall any application, rider or endorsement be used in connection therewith, until the expiration of 30 days after it has been filed unless the commissioner gives written approval thereof.

~~(c)~~ *(d)* The commissioner may, within 30 days after the filing of any ~~such~~ form *required to be filed pursuant to subsection (a)*, disapprove such form: (1) If the benefits provided therein are unreasonable in relation to the premium charged; or (2) if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of such policy. If the commissioner notifies the insurer which has filed any such form that it does not comply with the provisions of this section or K.S.A. 40-2202 and 40-2203, and amendments thereto, it shall be unlawful thereafter for such insurer to issue such form or use it in connection with any policy. In such notice the commissioner shall specify the reasons for disapproval and state that a hearing will be granted within 20 days after request in writing by the insurer.

(e) (1) Any risk classifications, premium rates, rating formulae, and all modifications of either applicable to Kansas residents shall not establish an unreasonable, excessive or unfairly discriminatory rate or, with respect to group or blanket policies issued pursuant to K.S.A. 40-2209 or 40-2210, and amendments thereto, discriminate against any individuals eligible for participation in a group, or establish rating classifications within a group except those based on criteria solely and directly relevant to recognition of rating differ-

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Requires filing of copies of group and blanket accident and sickness policies with commissioner prior to use in state.

Should be amended to add "providing hospital, medical and surgical expense benefits" so that disability insurance is not affected.

Rating applicable to Kansas residents not to be unreasonable, excessive or unfairly discriminatory or discriminate against individuals eligible for participation in a group.

ences attributable to the marital status of a group's members and persons eligible for dependents' benefits.

(2) All rates for accident and sickness insurance covering Kansas residents shall be made in accordance with the following provisions: (A) Due consideration shall be given to: (i) Past and prospective loss experience; (ii) past and prospective expenses; (iii) adequate contingency reserves; and (iv) all other relevant factors within and without the state;

(B) risks may be grouped by classifications for the establishment of rates for individual, group or blanket policies;

(C) rates shall be reasonable, not excessive and not unfairly discriminatory; and

(D) rates charged to an employer of 25 or fewer employees under group and blanket policies, including such employers covered under a policy issued to an association or trust located within or outside this state covering an employer which is a resident of this state, shall be based on the aggregate loss and expense experience of all such employers insured by the insurer, contingency reserves and other factors required to be considered in making rates to which this act applies. Such rates shall apply to all such employers insured in this state by the insurance company using the rates on a per person basis but may vary with the number of persons in a family, and may vary from employer to employer from a community rate by no more than 50% above the community rate. As used herein, "community rate" means the rate which would be derived by dividing all of the claims expense or anticipated claims expense for the rating period for which such rates will be in effect and all of the administrative expense and other retentions for all such employers covered by the same or similar coverage which is equivalent in value by all of the persons covered by such coverage. For the purposes of this definition, employee, family, spouse and dependent expense and numbers of such persons covered may be separately aggregated and divided. With respect to policies issued prior to the effective date of this act, in any case where the premium rate exceeds the community rate by more than 50%, no increase in such rates may be made until the later of the beginning of a rating period in which such premium rates would be lower than 50% more than the community rate or five years following the effective date of this act. Thereafter, the rates for such policies shall comply with the requirements of this subsection.

(3) Nothing in this act is intended to prohibit or discourage reasonable competition or discourage or prohibit uniformity of rates except to the extent necessary to accomplish the aforementioned pur-

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Rates to take into consideration items enumerated on lines 5-8.

Establishes a form of community rating for groups of 25 or fewer members. Authorizes variations in rate by no more than 50% above the community rate. Defines community rate.

Lines 33-40 have a grandfather clause for existing policies and provide that no increase in rates may be made where the rate exceeds the community rate by more than 50% until the commencement of a rating period in which the rates would be lower than such 50% on January 1, 1997.

pose. The commissioner is hereby authorized to issue such rules and regulations as are necessary and not inconsistent with this act.

~~(d)~~ *(f)* The commissioner may at any time, after a hearing of which not less than 20 days' written notice shall be given to the insurer, withdraw approval of any such form ~~on any of the grounds stated in this section~~ *or rate in the event the commissioner finds such filing no longer meets the requirements of this section or of article 22 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto.* It shall be unlawful for the insurer to issue such form or use it in connection with any policy after the effective date of such withdrawal of approval.

(g) Violations of subsection (e) shall be treated as violations of the unfair trade practices act and subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411 and amendments thereto.

~~(e)~~ *(h)* Hearings under this section shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

Sec. 3. K.S.A. 1990 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of K.S.A. 1990 Supp. 40-2250 and 40-2251 and to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, 40-2a01 *et seq.*, 40-2111 to 40-2116, inclusive, ~~40-2216~~ *40-2215* to 40-2220, inclusive, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, and amendments thereto, and to the provisions of K.S.A. 1989 Supp. 40-2221a, 40-2221b, 40-2229 and 40-2230, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

Sec. 4. K.S.A. 1990 Supp. 40-19c07, 40-19c09, 40-2209 and 40-2215 are hereby repealed.

Sec. 5. This act shall take effect and be in force from and after January 1, 1992, and its publication in the statute book.

Rule and regulation authority of commissioner

Clerical error - line 6

Rate violations subject to penalties under unfair trade practices act.

40-19c09 is amended to make the foregoing applicable to Blue Cross/Blue Shield rather than doing so in a separate statute.

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I. Discussion of HB 2001

Suggested balloons by Bill Edds.

_____ 1. Prohibits exclusion of persons from eligibility or coverage under group health insurance.

_____ 2. Disability coverage (loss of time) not included. Disability is also considered group sickness and accident insurance.

_____ 3. Extraterritorial provision.

_____ 4. Prohibits individual underwriting.

_____ 5. Authorizes a waiting period for pre-existing conditions upon initial coverage

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_____ 6. Portability provision - requires waiver of waiting period with no gap in coverage

_____ 7. Applies to group policies issued directly to employers, associations, trusts, and other forms of group policies. (Page 12)

_____ 8. Requires filing of group and blanket accident and sickness policies with Commissioner prior to use in state.

_____ 9. Amended so disability insurance is not affected.

_____ 10. Rating applicable to Kansas residents not to be unreasonable, excessive or unfairly discrimionatory or discriminate against individuals eligible for participation in a group.

_____ 11. Establishes a form of community rating for groups of 25 or fewer members. Authorizes variations in rate by no more than 50% above the community rate.

_____ 12. Has grandfather clause for existing policies and provide that no increase in rates may be made where the rate exceeds the community rate by more than 50% until the commencement of a rating period in which the rates would be lower than such 50% on Jan. 1, 1997.

_____ 13. Makes foregoing applicable to BC/BS