Approved 1/24/91
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

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

9 a.m./~~p.m.~~ on WEDNESDAY, JANUARY 23, 1991 in room 529-S of the Capitol.

All members ~~were~~ present except:

Senators Anderson, Francisco, D. Kerr, McClure, Moran, Parrish, Reilly, Strick and Yost.

Committee staff present:

Bill Wolff, Research Department
Fred Carman, Revisors Office
Louise Bobo, Secretary

Conferees appearing before the committee:

Ron Todd, Commissioner of Insurance, Kansas
Chip Wheelen, Kansas Medical Society
Richard Morrissey, Deputy Director, Division of Health, Kansas
Pam Byle, Kansas Nurses' Association and American Cancer Society

The meeting was called to order by Chairman Bond at 9:10 a.m.

Chairman Bond extended a warm welcome to Senator Ken Francisco who succeeded Senator Gerald Karr as a member of this committee. He also welcomed Fred Carman of the Revisor's office who is a new member of Staff.

Ron Todd, Commissioner of Insurance, appeared before the committee for the purpose of presenting the Insurance Department's legislative proposals to the committee. (Attachments 1-7) A brief discussion followed Mr. Todd's presentation. Senator Reilly made a motion to allow these proposals to be introduced. Senator Parrish seconded the motion and the motion carried.

SB 15 - Mammogram coverage in certain health and accident policies.

Chairman Bond informed the committee that the Interim Committee on Health Care Issues addressed the question of mandates on the health care industry as it relates to providers and to coverage and that SB 15 is one of two bills from the Interim Committee.

Chip Wheelen, Kansas Medical Society, appeared before the committee in opposition to SB 15. Mr. Wheelen stated that while his organization agreed that quality assurance standards should be applied to facilities which offer mammogram services, this bill might not be needed since the U.S. Congress had adopted provisions which require accreditation of facilities that are reimbursed for mammography services under the Medicare program. Adoption of the federal regulations will affect all mammography facilities and will be similar to the standards developed by the American College of Radiology. (Attachment 8)

Richard J. Morrissey, Deputy Director, Division of Health, appeared before the committee in support of SB 15. Mr. Morrissey advised that he did agree with Mr. Wheelen's interpretation of the federal law. He further explained that the new federal regulations governing mammograph screening facilities will require the addition of one full-time and one part-time position but that funding could be secured through Title XVIII funding. Mr. Morrisey stressed that these newly established federal standards will ensure quality mammography screening and that he hoped the legislative limit for new positions could be raised to include these positions. (Attachment 9)

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 SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE,

room 529S, Statehouse, at 9:00 a.m. on WEDNESDAY, JANUARY 23, 1991.

Pam Byle, Kansas Nurses' Association, told the committee that her organization supported the intent of SB 15. She informed the committee that the American College of Radiology has developed a program to insure high quality mammograms and that this program is supported by the American Cancer Society and the National Cancer Institute. Ms. Byle further stated that the Kansas Nurses' Association supports legislation linking third party reimbursement for screening mammography to Medicare certification. (Attachment 10)

Ms. Byle also appeared on behalf of the American Cancer Society in support of SB 15. (Attachment 11)

Discussion followed with committee members questioning the cost, the difficulty of rural facilities to comply with new regulations, and the date on which the bill should take effect. Following the discussion, Chairman Bond requested Staff, Mr. Wheelen and Mr. Morrissey, to come up with new language that would incorporate the Omnibus Budget Reconciliation Act language. He also requested information regarding the most effective date for enactment and advised that the committee will take up the bill for discussion at a later time.

The meeting adjourned at 10:04 a.m.

GUEST LIST

COMMITTEE: FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE DATE: Wed. Jan. 23, 1991

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Bill Sneed	Topeka	HIAA
Nancy Zogleman	Topeka	BC/BS of Ks
Jeri Rupoch	Topeka	American Cancer Society
Pamela Byl	Topeka	KSNA / ACS
Mary Kopp	Topeka	KSNA
Kesa Zagal	Topeka	Sen. Salisbury
Richard Morrissey	/	KDHE
Joseph Kroll	Topeka	KDHE
J. Greg Reser	Topeka	KDHE
Glenn Cogswell	Topeka	American Cancer Society Ks. Div.
Mary Neubauer	Topeka	Assoc. Press
Jim Oliver	Topeka	PIAK
Lee Wright	Overland Park	Farmers Ins Group
Chip Wheelen	Topeka	Ks Medical Soc.
Tom Bell	"	Ks. Hosp. Assn.

Explanatory Memorandum For

Legislative Proposal No. 1

This proposal is a modified version of the NAIC Model Insurers Rehabilitation and Liquidation Act. As its title implies, the purpose of this proposal is to establish a body of Kansas statutes containing the procedures to be followed in the event an insurer's financial condition deteriorates to the point that direct supervisory oversight is required or the company is insolvent and must be liquidated.

Enactment of this proposal will provide a consistent and comprehensive means of administering the insolvency of a domestic insurance company in the unlikely but possible event such situation would arise. More important, enactment of this proposal will lessen the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process.

FI & I
Jan. 23, 1991
Attachment 1

LEGISLATIVE PROPOSAL NO. 1

AN ACT relating to insurance; supervision, liquidation and rehabilitation; repealing K.S.A. 40-3601.

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

Section 1. This act shall be cited as the insurers supervision, rehabilitation and liquidation act.

Sec. 2. This act shall apply to all insurance companies, fraternal benefit societies, mutual nonprofit hospital and medical service corporations, health maintenance organizations, captive insurance companies, group funded workers compensation pools, municipal group funded pools, prepaid service plans operating under articles 19a, 19b or 19d of chapter 40 of the Kansas Statutes Annotated, regardless of whether such entities are authorized to do business in this state, and such entities which are in the process of organization.

Sec. 3. Definitions. For the purposes of this act:

(a) "Ancillary state" means any state other than a domiciliary state.

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

(c) "Creditor" is a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed or contingent.

(d) "Delinquency proceeding" means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer, and any summary proceeding under sections 9 or 10. "Formal delinquency proceeding" means any liquidation or rehabilitation proceeding.

(e) "Doing business" includes, but is not necessarily limited to, any of the following acts, whether effected by mail or otherwise:

(1) The issuance or delivery of contracts of insurance to persons resident in this state;

(2) the solicitation of applications for such contracts, or other negotiations preliminary to the execution of such contracts;

(3) the quoting of premiums, membership fees, assessments, or other consideration for such contracts;

(4) the transaction of matters subsequent to execution of such contracts and arising out of them; or

(5) operating under a license or certificate of authority, as an insurer, issued by the insurance department.

(f) "Domiciliary state" means the state in which an insurer is incorporated or organized; or, in the case of an alien insurer, its state of entry.

(g) "Fair consideration" is given for property or obligation:

(1) When in exchange for such property or obligation, as a fair equivalent therefore, and in good faith, property is conveyed or services are rendered or an obligation is incurred or an antecedent debt is satisfied; or

(2) when such property or obligation is received in good faith to secure a present advance or antecedent debt in amount not disproportionately small as compared to the value of the property or obligation obtained.

(h) "Foreign country" means any other jurisdiction not in any state.

(i) "General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, "general assets" includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and on deposit for the security or benefit of all policyholders or all policyholders and creditors, in more than a single state, shall be treated as general assets.

(j) "Guaranty association" means the Kansas insurance guaranty association created by K.S.A. 40-2901 as amended, the Kansas life and health insurance guaranty association created by K.S.A. 40-3001 as amended, and any other similar entity now or hereafter created by the legislature of this state for the payment of claims of insolvent insurers. "Foreign guaranty association" means any similar entities now in existence in or hereafter created by the legislature of any other state.

(k) "Insolvency" or "insolvent" means an insurer, that is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of:

(1) Any capital and surplus required by law for its organization; or

(2) the total par or stated value of its authorized and issued capital stock.

(l) "Insurer" means any person who has done, purports to do, is doing or is licensed to do an insurance business, and is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization, supervision, or conservation by, any insurance commissioner. For purposes of this act, any other persons included under section 2 shall be deemed to be insurers.

(m) "preferred claim" means any claim with respect to which the terms of this act accord priority of payment from the general assets of the insurer.

(n) "Receiver" means receiver, liquidator, rehabilitator or conservator as the context requires.

(o) "Reciprocal state" means any state other than this state in which in substance and effect sections 18a, 46, 47 and 49 through 51 are in force, and in which provisions are in force requiring that the commissioner or equivalent official be the receiver of a delinquent insurer, and in which some provision exists for the avoidance of fraudulent conveyances and preferential transfers.

(p) "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise; but not including special deposit claims or claims against general assets. The term also includes claims which have become liens upon specific assets by reason of judicial process.

(q) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

(r) "State" means any state, district, or territory of the United States and the Panama Canal Zone.

(s) "Transfer" shall include the sale and every other and different mode, direct or indirect, of disposing of or of parting with property or with an interest therein, or with the possession thereof or of fixing a lien upon property or upon an interest therein, absolutely or conditionally, voluntarily, by or without judicial proceedings. The retention of a

security title to property delivered to a debtor shall be deemed a transfer suffered by the debtor.

Sec. 4. (a) No delinquency proceeding shall be commenced under this chapter by anyone other than the commissioner of this state and no court shall have jurisdiction to entertain, hear or determine any proceeding commenced by any other person.

(b) No court of this state shall have jurisdiction to entertain, hear or determine any complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation or receivership of any insurer; or praying for an injunction or restraining order or other relief preliminary to, incidental to or relating to such proceedings other than in accordance with this chapter.

(c) In addition to other grounds for jurisdiction provided by the law of this state, a court of this state having jurisdiction of the subject matter has jurisdiction over a person served pursuant to K.S.A. 60-101, et seq., Kansas rules of civil procedure, or other applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in this state:

(1) If the person served is an agent, broker, or other person who has at any time written policies of insurance for or has acted in any manner whatsoever on behalf of an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer; or

(2) if the person served is a reinsurer who has at any time entered into a contract of reinsurance with an insurer against which a delinquency proceeding has been instituted, or is an agent or broker of or for the reinsurer, in any action on or incident to the reinsurance contract; or

(3) if the person served is or has been an officer, director, manager, trustee, organizer, promoter, or other person in a position of comparable authority or influence over an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer; or

(4) if the person served is or was at the time of the institution of the delinquency proceeding against the insurer holding assets in which the receiver claims an interest on behalf of the insurer, in any action concerning the assets; or

(5) if the person served is obligated to the insurer in any way whatsoever, in any action on or incident to the obligation.

(d) If the court on motion of any party finds that any action should as a matter of substantial justice be tried in a forum outside this state, the court may enter an appropriate order to stay further proceedings on the action in this state.

(e) All action herein authorized shall be brought in the district court of shawnee county Kansas.

Sec. 5. (a) Any receiver appointed in a proceeding under this act may at any time apply for, and any court of general jurisdiction may grant, such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to prevent:

(1) The transaction of further business;

(2) the transfer of property;

(3) interference with the receiver or with a proceeding under this act;

(4) waste of the insurer's assets;

(5) dissipation and transfer of bank accounts;

(6) the institution or further prosecution of any actions or proceedings;

(7) the obtaining of preferences, judgements, attachments, garnishments or liens against the insurer, its assets or its policyholders;

(8) the levying of execution against the insurer, its assets or its policyholders;

(9) the making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer;

(10) the withholding from the receiver of books, accounts, documents, or other records relating to the business of the insurer; or

(11) any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors or shareholders, or the administration of any proceeding under this act.

(b) The receiver may apply to any court outside of the state for the relief described in subsection (a).

Sec. 6. (a) Any officer, manager, director, trustee, owner, employee or agent of any insurer, or any other persons with authority over or in charge of any segment of the insurer's affairs, shall cooperate with the

commissioner in any proceeding under this act or any investigation preliminary to the proceeding. The term "person" as used in this section, shall include any person who exercises control directly or indirectly over activities of the insurer through any holding company or other affiliate of the insurer. "To cooperate" shall include, but shall not be limited to, the following:

(1) To reply promptly in writing to any inquiry from the commissioner requesting such a reply; and

(2) to make available to the commissioner any books, accounts, documents, or other records or information or property of or pertaining to the insurer and in his possession, custody or control.

(b) No person shall obstruct or interfere with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto.

(c) This section shall not be construed to abridge otherwise existing legal rights, including the right to resist a petition for liquidation or other delinquency proceedings, or other orders.

(d) Any person included within subsection (a) who fails to cooperate with the commissioner, or any person who obstructs or interferes with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto, or who violates any order the commissioner issued validly under this act may:

(1) Be sentenced to pay a fine not exceeding $10,000 or to undergo imprisonment for a term of not more than one year, or both; or

(2) after a hearing, be subject to the imposition by the commissioner of a civil penalty not to exceed $10,000 and shall be subject further to the revocation or suspension of any insurance licenses issued by the commissioner.

Sec. 7. Every proceeding heretofore commenced under the laws in effect before the enactment of this act shall be deemed to have commenced under this act for the purpose of conducting the proceeding henceforth, except that in the discretion of the commissioner the proceeding may be continued, in whole or in part, as it would have been continued had this act not been enacted.

Sec. 8. No insurer that is subject to any delinquency proceedings, whether formal or informal shall:

(a) Be released from such proceeding, unless such proceeding is converted into a judicial rehabilitation or liquidation proceeding;

(b) be permitted to solicit or accept new business or request or accept the restoration of any suspended or revoked license or certificate of authority;

(c) be returned to the control of its shareholders or private management; or

(d) have any of its assets returned to the control of its shareholders or private management;

until all payments of or on account of the insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the insurer shall have been approved by the guaranty association.

Sec. 9. (a) Whenever the commissioner has reasonable cause to believe, and determined after a hearing held under subsection (f), that any domestic insurer has committed or engaged in, or is about to commit or engage in, any act, practice, or transaction that would subject it to delinquency proceedings under this act, he may make and serve upon the insurer and any other persons involved, such orders as are reasonably necessary to correct, eliminate or remedy such conduct, condition or ground. Such orders may be made confidential by the commissioner and may not be subject to release under the Kansas open records act.

(b) If upon examination or at any other time the commissioner has reasonable cause to believe that any domestic insurer is in such condition as to render the continuance of its business hazardous to the public or to holders of its policies or certificates of insurance, or if such domestic insurer gives its consent, then the commissioner shall upon his determination:

(1) Notify the insurer of his determination; and

(2) furnish to the insurer a written list of the commissioner's requirements to abate his determination.

(c) If the commissioner makes a determination to supervise an insurer subject to an order under subsections (a) or (b), he shall notify the insurer that it is under the supervision of the commissioner. During the period of supervision, the commi·sioner may appoint a supervisor to

supervise such insurer. The order appointing a supervisor shall direct the supervisor to enforce orders issued under subsections (a) and (b) and may also require that the insurer may not do any of the following things during the period of supervision, without the prior approval of the commissioner or his supervisor:

(1) Dispose of, convey or encumber any of its assets or its business in force;

(2) withdraw from any of its bank accounts;

(3) lend any of its funds;

(4) invest any of its funds;

(5) transfer any of its property;

(6) incur any debt, obligation or liability;

(7) merge or consolidate with another company; or

(8) enter into any new reinsurance contract or treaty.

(d) No provision of subsection (c) of this section shall restrict the commissioner's authority to issue an order under K.S.A. 40-222 or K.S.A. 40-222b.

(e) Any insurer subject to an order under this section shall comply with the lawful requirements of the commissioner and, if placed under supervision, shall have 60 days from the date the supervision order is served within which to comply with the requirements of the commissioner. In the event of such insurer's failure to comply within such times, the commissioner may institute proceedings under sections 11 or 16 to have a rehabilitator or liquidator appointed, or extend the period of supervision.

(f) The notice of hearing under subsection (a) and any order issued pursuant to such subsection shall be served upon the insurer pursuant to the Kansas administrative procedures act.

(g) During the period of supervision the insurer may request the commissioner to review an action taken or proposed to be taken by the supervisor, specifying wherein the action complained of is believed not to be in the best interest of the insurer.

(h) If any person has violated any supervision order issued under this section which as to him was then still in effect, he shall be liable to pay a civil penalty imposed by the shawnee county district court not to exceed $10,000.

(i) The commissioner may apply for, and any court of general jurisdiction may grant, such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to enforce a supervision order.

(j) In the event that any person, subject to the provisions of this act, including those persons described in section 6(a), shall knowingly violate any valid order of the commissioner issued under the provisions of this section and, as a result of such violation, the net worth of the insurer shall be reduced or the insurer shall suffer loss it would not otherwise have suffered, said person shall become personally liable to the insurer for the amount of any such reduction or loss. The commissioner or supervisor is authorized to bring an action on behalf of the insurer in the shawnee county district court to recover the amount of the reduction or loss together with any costs.

Sec. 10. (a) The commissioner may file in the shawnee county district court of this state a petition alleging, with respect to a domestic insurer:

(1) That there exists any grounds that would justify a court order for a formal delinquency proceeding against an insurer under this act;

(2) that the interests of policyholders, creditors or the public will be endangered by delay; and

(3) the contents of an order deemed necessary by the commissioner.

(b) Upon a filing under subsection (a), the court may issue forthwith, ex parte and without a hearing, the requested order which shall direct the commissioner to take possession and control of all or a part of the property, books, accounts, documents, and other records of an insurer, and of the premises occupied by it for transaction of its business; and until further order of the court enjoin the insurer and its officers, managers, agents, and employees from disposition of its property and from the transaction of its business except with the written consent of the commissioner.

(c) The court shall specify in the order what its duration shall be, which shall be such time as the court deems necessary for the commissioner to ascertain the condition of the insurer. On motion of either party or on its own motion, the court may from time to time hold such hearings as it deems desirable after such notice as it deems appropriate, and may extend, shorten, or modify the terms of the seizure order. The court shall vacate

the seizure order if the commissioner fails to commence a formal proceeding under this act after having had a reasonable opportunity to do so. An order of the court pursuant to a formal proceeding under this act shall ipso facto vacate the seizure order.

(d) Entry of a seizure order under this section shall not constitute an anticipatory breach of any contract of the insurer.

(e) An insurer subject to an ex parte order under this section may petition the court at any time after the issuance of such order for a hearing and review of the order. The court shall hold such a hearing and review not more than 15 days after the request. A hearing under this subsection may be held privately in chambers and it shall be so held if the insurer proceeded against so requests.

(f) If, at any time after the issuance of such an order, it appears to the court that any person whose interest is or will be substantially affected by the order did not appear at the hearing and has not been served, the court may order that notice be given. An order that notice be given shall not stay the effect of any order previously issued by the court.

Sec. 11. In all proceedings and judicial reviews thereof under sections 9 and 10, all records of the insurer, other documents, and all insurance department files and court records and papers, so far as they pertain to or are a part of the record of the proceedings, shall be and remain confidential except as is necessary to obtain compliance therewith, unless and until the shawnee county district court, after hearing arguments from the parties in chambers, shall order otherwise; or unless the insurer requests that the matter be made public. Until such court order, all papers filed with the clerk of the shawnee county district court shall be held by him in a confidential file.

Sec. 12. The commissioner may apply by petition to the shawnee county district court for an order authorizing him to rehabilitate a domestic insurer on any one or more of the following grounds:

(a) The insurer is in such condition that the further transaction of business would be hazardous financially to its policyholders, creditors or the public;

(b) there is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer, or other illegal

conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer.

(c) after demand by the commissioner under K.S.A. 40-222 or under this act, the insurer has failed to promptly make available for examination any of its own property, books, accounts, documents, or other records, or those of any subsidiary or related company within the control of the insurer, or those of any person having executive authority in the insurer so far as they pertain to the insurer;

(d) without first obtaining the written consent of the commissioner, the insurer has transferred or attempted to transfer, in a manner contrary to K.S.A. 40-3301, 40-221a or K.S.A. 40-309, substantially its entire property or business, or has entered into any transaction the effect of which is to merge, consolidate, or reinsurer substantially its entire property or business in or with the property or business of any other person;

(e) the insurer or its property has been or is the subject of an application for the appointment or a receiver, trustee, custodian, conservator or sequestrator or similar fiduciary of the insurer or its property otherwise than as authorized under the insurance laws of this state, and such appointment has been made or is imminent, and such appointment might oust the courts of this state of jurisdiction or might prejudice orderly delinquency proceedings under this act;

(f) the insurer has failed to pay within 60 days after due date any obligation to any state or any subdivision thereof or any judgement entered in any state, if the court in which such judgment was entered had jurisdiction over such subject matter except that such nonpayment shall not be a ground until 60 days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the commissioner or in the courts, or the insurer has systematically attempted to compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full; or

(g) the board of directors of the insurer request or consent to rehabilitation under this act.

Sec. 13. (a) An order to rehabilitate the business of a domestic insurer shall appoint the commissioner and his successors in office the rehabilitator, and shall direct the rehabilitator forthwith to take

possession of the assets of the insurer, and to administer them under the general supervision of the court. The filing or recording of the order with the clerk of the shawnee county district court or register of deeds of the county in which the principal business of the company is conducted, or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted. The order to rehabilitate the insurer shall by operation of law vest title to all assets of the insurer in the rehabilitator.

(b) Any order issued under this section shall require accounting to the court by the rehabilitator. Accountings shall be at such intervals as the court specifies in this order.

(c) Entry of an order of rehabilitation shall not constitute an anticipatory breach of any contracts of the insurer.

Sec. 14. (a) The commissioner as rehabilitator may appoint one or more special deputies, who shall have all the powers and responsibilities of the rehabilitator granted under this section, and the commissioner may employ such counsel, clerks and assistants as deemed necessary. The compensation of the special deputy, counsel, clerks and assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the commissioner, with the approval of the court and shall be paid out of the funds or assets of the insurer. The persons appointed under this section shall serve at the pleasure of the commissioner.

(b) The rehabilitator may take such action as he deems necessary or appropriate to reform and revitalize the insurer. He shall have all the powers of the directors, officers, and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. He shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

(c) If it appears to the rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employee or other person, he may pursue all appropriate legal remedies on behalf of the insurer.

(d) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer is appropriate, he shall prepare a plan to effect such changes. Upon application of the rehabilitator for approval of the plan, and after such notice and hearings as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section shall be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the policies of the company, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary.

(e) The rehabilitator shall have the power under sections 25 and 26 to avoid fraudulent transfers.

Sec. 15. (a) Any court in this state before which any action or proceeding in which the insurer is a party, or is obligated to defend a party, is pending when a rehabilitation order against the insurer is entered shall stay the action or proceeding for 90 days and such additional time as is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The rehabilitator shall take such action respecting the pending litigation as he deems necessary in the interests of justice and for the protection of creditors, policyholders, and the public. The rehabilitator shall immediately consider all litigation pending outside this state and shall petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer.

(b) No statute of limitations or defense of laches shall run with respect to any action by or against an insurer between the filing of a petition for appointment of a rehabilitator for that insurer and the order granting or denying that petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least 60 days after the order or rehabilitation is entered or the petition is denied. The rehabilitator may, upon an order for rehabilitation, within one year or such other longer time as applicable law may permit, institute an action or proceeding on behalf of the insurer upon

any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered.

(c) Any guaranty association or foreign guaranty association covering life or health insurance or annuities shall have standing to appear in any court proceeding concerning the rehabilitation of a life or health insurer if such association is or may become liable to act as a result of the rehabilitation.

Sec. 16. (a) Whenever the commissioner believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders or the public, or would be futile, the commissioner may petition the shawnee county district court of an order of liquidation. A petition under this subsection shall have the same effect as a petition under section 17. The court shall permit the directors of the insurer to take such actions as are reasonably necessary to defend against the petition and may order payment from the estate of the insurer of such costs and other expenses of defense as justice may require.

(b) The rehabilitator may at any time petition the court for an order terminating rehabilitation of an insurer. The court shall also permit the directors of the insurer to petition the court for an order terminating rehabilitation of the insurer and may order payment from the estate of the insurer of such costs and other expenses of such petition as justice may require. If the court finds that rehabilitation has been accomplished and that grounds for rehabilitation under section 12 no longer exist, it shall order that the insurer be restored to possession of its property and the control of the business. The court may also make that finding and issue that order at any time upon its own motion.

Sec. 17. The commissioner may petition the shawnee county district court for an order directing him to liquidate a domestic insurer on the basis:

(a) Of any ground for an order of rehabilitation as specified in section 12, whether or not there has been a prior order directing the rehabilitation of the insurer;

(b) that the insurer is insolvent; or

(c) that the insurer is in such condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors or the public.

Sec. 18. (a) An order to liquidate the business of a domestic insurer shall appoint the commissioner and his successors in office liquidator and shall direct the liquidator forthwith to take possession of the assets of the insurer and to administer them under the general supervision of the court. The liquidator shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books and records of the insurer ordered liquidated, wherever located, as of the entry of the final order of liquidation. The filing or recording of the order with the clerk of the shawnee county district court and the register of deeds of the county in which its principal office or place or business is located; or, in the case of real estate, with the register of deeds of the county where the property is located, shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that register of deeds would have imparted.

(b) Upon issuance of the order, the rights and liabilities of any such insurer and of its creditors, policyholders, shareholders, members and all other persons interested in its estate shall become fixed as of the date of entry of the order of liquidation, except as provided in sections 19 and 34.

(c) At the time of petitioning for an order of liquidation, or at any time thereafter; the commissioner, after making appropriate findings of an insurer's insolvency, may petition the court for a judicial declaration of such insolvency. After providing such notice and hearing as it deems proper, the court may make the declaration.

(d) Any order issued under this section shall require accounting to the court by the liquidator. Accounts shall be at such intervals as the court specifies in its order.

Sec. 19. (a) All policies, other than life or health insurance or annuities, in effect at the time of issuance of an order of liquidation shall continue in force only for the lesser of:

(1) A period of 30 days from the date of entry of the liquidation orders;

(2) the expiration of the policy coverage;

(3) the date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy; or

(4) the liquidator has effected a transfer of the policy obligation pursuant to section 21(a)(9).

(b) An order or liquidation under section 18 shall terminate coverages at the time specified in subsection (a) for purposes of any other statute.

(c) Policies of life or health insurance or annuities shall continue in force for such period and under such terms as is provided for by any applicable guaranty association or foreign guaranty association.

(d) Policies of life or health insurance or annuities or any period or coverage of such policies not covered by a guaranty association or foreign guaranty association shall terminate under subsections (a) and (b).

Sec. 20. The commissioner may petition for an order dissolving the corporate existence of a domestic insurer at the time he applies for a liquidation order. The court shall order dissolution of the corporation upon petition by the commissioner upon or after the granting of a liquidation order. If the dissolution has not previously been ordered, it shall be effected by operation of law upon the discharge of the liquidator if the insurer is insolvent but may be ordered by the court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason.

Sec. 21. (a) The liquidator shall have the power:

(1) To appoint a special deputy or deputies to act for him under this act, and to determine his reasonable compensation. The special deputy shall have all powers of the liquidator granted by this section. The special deputy shall serve at the pleasure of the liquidator;

(2) to employ employees and agents, legal counsel, actuaries, accountants, appraisers, consultants and such other personnel as he may deem necessary to assist in the liquidation;

(3) to fix the reasonable compensation of employees and agents, legal counsel, actuaries, accountants, appraisers and consultants with the approval of the court;

(4) to pay reasonable compensation to persons appointed and to defray from the funds or assets of the insurer all expenses of taking possession

of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of the insurer;

(5) to hold hearings, to subpoena witnesses to compel their attendance, to administer oaths, to examine any person under oath, and to compel any person to subscribe to his testimony after it has been correctly reduced to writing; and in connection therewith to require the production of any books, papers, records or other documents which he deems relevant to the inquiry. Such hearings shall be held in accordance with the Kansas administrative procedures act;

(6) to audit the books and records of all agents of the insurer insofar as those records relate to the business activities of the insurer;

(7) to collect all debts and moneys due and claims belonging to the insurer, wherever located, and for this purpose:

(A) to institute timely action in other jurisdictions, in order to forestall garnishment and attachment proceedings against such debts;

(B) to do such other acts as are necessary or expedient to collect, conserve or protect its assets or property, including the power to sell, compound, compromise or assign debts for purposes of collection upon such terms and conditions as he deems best; and

(C) to pursue any creditor's remedies available to enforce his claims.

(8) to conduct public and private sales of the property of the insurer;

(9) to use assets of the estate of an insurer under a liquidation order to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under section 37.

(10) to acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon or otherwise dispose of or deal with, any property of the insurer at its market value or upon such terms and conditions as are fair and reasonable. He shall also have power to execute, acknowledge and deliver any and all deeds, assignments, releases and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation.

(11) to borrow money on the security of the insurer's assets or without security and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation. Any such funds

borrowed may be repaid as an administrative expense and have priority over any other claims in class 1 under the priority of distribution;

(12) to enter into such contracts as are necessary to carry out the order to liquidate, and to affirm or disavow any contracts to which the insurer is a party;

(13) to continue to prosecute and to institute in the name of the insurer or in his own name any and all suits and other legal proceedings, in this state or elsewhere, and to abandon the prosecution of claims he deems unprofitable to pursue further. If the insurer is dissolved under section 20, he shall have the power to apply to any court in this state or elsewhere for leave to substitute himself for the insurer as plaintiff;

(14) to prosecute any action which may exist in behalf of the creditors, members, policyholders or shareholders of the insurer against any officer of the insurer, or any other person;

(15) to remove any or all records and property of the insurer to the offices of the commissioner or to such other place as may be convenient for the purposes of efficient and orderly execution of the liquidation. Guaranty associations and foreign guaranty associations shall have such reasonable access to the records of the insurer as is necessary for them to carry out their statutory obligations;

(16) to deposit in one or more banks in this state such sums as are required for meeting current administration expenses and dividend distributions;

(17) to invest all sums not currently needed, unless the court orders otherwise;

(18) to file any necessary documents for record in the office of any register of deeds or record office in this state or elsewhere where property of the insurer is located;

(19) to assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of frauds, and the defense of usury. A waiver of any defense by the insurer after a petition in liquidation has been filed shall not bind the liquidator. Whenever a guaranty association or foreign guaranty association has an obligation to defend any suit, the liquidator shall give precedence to such obligation and may defend only in the absence of a defense by such guaranty associations;

(20) to exercise and enforce all the rights, remedies, and powers of any creditor, shareholder, policyholder, or member; including any power to avoid any transfer or lien that may be given by the general law and that is not included with sections 25 through 27;

(21) to intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee, and to act as the receiver or trustee whenever the appointment is offered; and

(22) to enter into agreements with any receiver or commissioner of any other state relating to the rehabilitation, liquidation, conservation or dissolution of an insurer doing business in both states.

(b) The enumeration, in this section, of the powers and authority of the liquidator shall not be construed as limitation upon him, nor shall it exclude in any manner his right to do such other acts not herein specifically enumerated or otherwise provided for, as may be necessary or appropriate for the accomplishment of or in aid of the purpose of liquidation.

Sec. 22. (a) Unless the court otherwise directs, the liquidator shall give or cause to be given notice of the liquidation order as soon as possible:

(1) To the insurance commissioner of each jurisdiction in which the insurer is doing business;

(2) to any guaranty association or foreign guaranty association which is or may become obligated as a result of the liquidation;

(3) to all insurance agents of the insurer;

(4) to all persons known or reasonably expected to have claims against the insurer including all policyholders, at their last known address as indicated by the records of the insurer; and

(5) by publication in a newspaper of general circulation in the county in which the insurer has its principal place of business and in such other locations as the liquidator deems appropriate.

(b) Except as otherwise established by the liquidator with approval of the court, notice to potential claimants under subsection (a) shall require claimants to file with the liquidator their claims together with proper proofs thereof under section 33, on or before a date the liquidator shall specify in the notice. The liquidator need not require persons claiming cash surrender values or other investment values in life insurance and

annuities to file a claim. All claimants shall have a duty to keep the liquidator informed of any changes of address.

(c) If notice is given in accordance with this section, the distribution of assets of the insurer under this chapter shall be conclusive with respect to all claimants, whether or not they received notice.

Sec. 23. (a) Upon issuance of an order appointing a liquidator of a domestic insurer or of an alien insurer domiciled in this state, no action at law or equity or in arbitration shall be brought against the insurer or liquidator, whether in this state or elsewhere, nor shall any such existing actions be maintained or further presented after issuance of such order. The courts of this state shall give full faith and credit to injunctions against the liquidator or the company or the continuation of existing actions against the liquidator or the company, when such injunctions are included in an order to liquidate an insurer issued pursuant to corresponding provisions in other states. Whenever, in the liquidator's judgment, protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside this state, he may intervene in the action. The liquidator may defend any action in which he intervenes under this section at the expense of the estate of the insurer.

(b) The liquidator may, upon or after an order for liquidation, within two years or such other longer time as applicable law may permit, institute an action or proceeding on behalf of the estate of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered. Where, by any agreement, a period of limitation is fixed for instituting a suit or proceeding upon any claim, or for filing any claim, proof of claim, proof of loss, demand, notice, or the like, or where in any proceeding, judicial or otherwise, a period of limitation is fixed, either in the proceeding or by applicable law, for taking any action, filing any claim or pleading, or doing any act, and where in any such case the period had not expired at the date of the filing of the petition; the liquidator may, for the benefit of the estate, take any such action or do any such act, required of or permitted to the insurer, within a period of 180 days subsequent to the entry of an order for liquidation, or within such further period as is shown to the satisfaction of the court not to be unfairly prejudicial to the other party.

(c) No statute of limitation or defense of laches shall run with respect to any action against an insurer between the filing of a petition for liquidation against an insurer and the denial of the petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least 60 days after the petition is denied.

(d) Any guaranty association or foreign guaranty association shall have standing to appear in any court proceeding concerning the liquidation of an insurer if such association is or may become liable to act as a result of the liquidation.

Sec. 24. As soon as practicable after the liquidation order but not later than 120 days thereafter, the liquidator shall prepare in duplicate a list of the insurer's assets. The list shall be amended or supplemented from time to time as the liquidator may determine. One copy shall be filed in shawnee county district court and one copy shall be retained for the liquidator's files. All amendments and supplements shall be similarly filed.

Sec. 25. (a) Every transfer made or suffered and every obligation incurred by an insurer within one year prior to the filing of a successful petition for rehabilitation or liquidation under this act is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under this act, which is fraudulent under this section, may be avoided by the receiver, except as to a person who in good faith is a purchaser, lienor, or obligee for a present fair equivalent value, and except that any purchaser, lienor or obligee, who in good faith has given a consideration less than fair for such transfer, lien, or obligation, may retain the property, lien or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event, the receiver shall succeed to and may enforce the rights of the purchaser, leinor, or obligee.

(b)(1) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

(2) A transfer or real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(3) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(4) Any transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(5) The provisions of this subsection apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

(c) Any transaction of the insurer with a reinsurer shall be deemed fraudulent and may be avoided by the receiver under subsection (a) if:

(1) The transaction consists of the termination, adjustment or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transactions, unless the reinsurer gives a present fair equivalent value for the release; and

(2) Any part of the transaction took place within one year prior to the date of filing of the petition through which the receivership was commenced.

(d) Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under subsection (a) shall be personally liable therefore and shall be bound to account to the liquidator.

Sec. 26. (a) After a petition for rehabilitation or liquidation has been filed, a transfer of any of the real property of the insurer made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value; or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefore, for which amount the transferee shall have a lien on the property so transferred. The commencement of a proceeding in rehabilitation or liquidation shall be constructive notice upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the register of deeds in the county where any real property in question is located. The exercise by a court of the United States or any state or jurisdiction to authorize or effect a judicial sale of real property of the insurer within

any county in any state shall not be impaired by the pendency of such a proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale.

(b) After a petition for rehabilitation or liquidation has been filed and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted:

(1) A transfer of any of the property of the insurer, other than real property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value; or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefore, for which amount the transferee shall have a lien on the property so transferred.

(2) A person indebted to the insurer or holding property of the insurer may, if acting in good faith, pay the indebtedness or deliver the property, or any part thereof, to the insurer or upon his order, with the same effect as if the petition were not pending.

(3) A person having actual knowledge of the pending rehabilitation or liquidation shall be deemed not to act in good faith.

(4) A person asserting the validity of a transfer under this section shall have the burden of proof. Except as elsewhere provided in this section, no transfer by or on behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator shall be valid against the liquidator.

(c) Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under subsection (a) shall be personally liable therefore and shall be bound to account to the liquidator.

(d) Nothing in this act shall impair the negotiability of currency or negotiable instruments.

Sec. 27. (a)(1) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one year before the filing of a successful petition for liquidation under this act, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then such transfers shall be deemed

preferences if made or suffered within one year before the filing of the successful petition for rehabilitation, or within two years before the filing of the successful petition for liquidation, whichever time is shorter.

(2) Any preference may be avoided by the liquidator if:

(A) The insurer was insolvent at the time of the transfer; or

(B) the transfer was made within four months before the filing of the petition; or

(C) the creditor receiving it or to be benefited thereby or his agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or

(D) the creditor receiving it was an officer, or any employee or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer whether or not he held such position, or any shareholder holding directly or indirectly more than five per centum of any class of any equity security issued by the insurer, or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

(3) Where the preference is voidable, the liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property; except where a bona fide purchaser or lienor has given less than fair equivalent value, he shall have a lien upon the property to the extent of the consideration actually given by him. Where a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

Sec. 28. (a) No claims of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment or encumbrance voidable under this act; shall be allowed unless he surrenders the preference, lien conveyance, transfer, assignment or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the liquidator within 30 days from the date of the entering of the final judgment, except that the court having jurisdiction over the liquidation may allow further time if there is an appeal or other continuation of the proceeding.

(b) A claim allowable under subsection (a) by reason of the avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, transfer, assignment or encumbrance, may be filed as an excused last filing under section 36 if filed within 30 days from the date of the avoidance, or within the further time allowed by the court under subsection (a).

Sec. 29. (a) Mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this act shall be set off and the balance only shall be allowed or paid, except as provided in subsection (b).

(b) No setoff or counterclaim shall be allowed in favor of any person where:

(1) The obligation of the insurer to the person would not at the date of the filing of a petition for liquidation entitle the person to share as a claimant in the assets of the insurer;

(2) the obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff;

(3) the obligation of the person is to pay an assessment levied against the members or subscribers of the insurer, or is to pay a balance upon a subscription to the capital stock of the insurer, or is in any other way in the nature of a capital contribution; or

(4) the obligation of the person is to pay premiums, whether earned or unearned, to the insurer.

Sec. 30. The amount recoverable by the liquidator from reinsurers shall not be reduced as a result of the delinquency proceedings, regardless of any provision in the reinsurance contract or other agreement. Payment made directly to an insured or other creditor shall not diminish the reinsurer's obligation to the insurer's estate except when the reinsurance contract provided for direct coverage of a named insured and the payment was made in discharge of that obligation.

Sec. 31. (a) Within 120 days of a final determination of insolvency of an insurer by a court of competent jurisdiction of this state, the liquidator shall make application to the court for approval of a proposal to disburse assets out of marshalled assets, from time to time as such assets become available, to a guaranty association or foreign guaranty association having obligations because of such insolvency. If the liquidator determines that there are insufficient assets to disburse, the application required by

this section shall be considered satisfied by a filing by the liquidator stating the reasons for this determination.

(b) Such proposal shall at least include provisions for:

(1) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors, to the extent of the value of the security held, and claims falling within the priorities established in section 37, classes 1 and 2;

(2) disbursement of the assets marshalled to date and subsequent disbursement of assets as they become available;

(3) equitable allocation of disbursements to each of the guaranty associations and foreign guaranty associations entitled thereto;

(4) the securing by the liquidator from each of the associations entitled to disbursements pursuant to this section of an agreement to return to the liquidator such assets, together with income earned on assets previously disbursed, as may be required to pay claims of secured creditors and claims falling within the priorities established in section 36 in accordance with such priorities. No bond shall be required of any such association; and

(5) a full report to be made by each association to the liquidator accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on such assets and any other matter as the court may direct.

(c) The liquidator's proposal shall provide for disbursements to the associations in amounts estimated at least equal to the claim payments made or to be made thereby for which such associations could assert a claims against the liquidator, and shall further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of such claim payments made or to be made by the association then disbursements shall be in the amount of available assets.

(d) The liquidator's proposal shall, with respect to an insolvent insurer writing life or health insurance or annuities, provide for disbursements of assets to any guaranty association or any foreign guaranty association covering life or health insurance or annuities or to any other entity or organization reinsuring, assuming or guaranteeing policies or contracts of insurance under the acts creating such associations.

(e) Notice of such application shall be given to the association in and to the commissioners of insurance of each of the states. Any such notice shall be deemed to have been given when deposited in the United States certified mails, first class postage prepaid, at least 15 days prior to submission of such application to the court. Action on the application may be taken by the court provided the above required notice has been given and provided further that the liquidator's proposal complies with subsection (b)(1) and (b)(2).

Sec. 32. (a) Proof of all claims shall be filed with the liquidator in the form required by section 33 on or before the last day for filing specified by the court, except that proof of claims for cash surrender values or other investment values in life insurance and annuities need not be filed unless the liquidator expressly so requires.

(b) The liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if he were not late, to the extent that any such payment will not prejudice the orderly administration of the liquidation, under the following circumstances:

(1) The existence of the claim was not known to the claimant and that he filed his claim as promptly thereafter as reasonably possible after learning of it; or

(2) the valuation under section 36, of security held by a secured creditor shows a deficiency, which is filed, within 30 days after the valuation; and

(c) The liquidator shall permit late filing claims to share in distributions, whether past or future, as if they were not late, if such claims are claims of a guaranty association or foreign guaranty association for reimbursement of covered claims paid or expenses incurred, or both, subsequent to the last day for filing where such payments were made and expenses incurred as provided by law.

(d) The liquidator may consider any claim filed late which is not covered by subsection (b), and permit it to receive distributions which are subsequently declared on any claims of the same or lower priority if the payment does not prejudice the orderly administration of the liquidation. The late-filing claimant shall receive, at each distribution, the same percentage of the amount allowed on his claim as is then being paid to

claimants of any lower priority. This shall continue until his claim has been paid in full.

Sec. 33. (a) Proof of claim shall consist of a statement signed by the claimant that includes all of the following that are applicable:

(1) The particulars of the claim including the consideration given for it;

(2) the identity and amount of the security on the claim;

(3) the payments made on the debt, if any;

(4) that the sum claimed is justly owing and that there is no setoff, counterclaim or defense to the claim;

(5) any right of priority of payment or other specific right asserted by the claimants;

(6) a copy of the written instrument which is the foundation of the claim; and

(7) the name and address of the claimant and the attorney who represents him, if any.

(b) The liquidator may require that a prescribed form be used, and may require that other information and documents be included. The liquidator may request the claimant to present information or evidence supplementary to that required under subsection (a) and may take testimony under oath, require production of affidavits or depositions, or otherwise obtain additional information or evidence.

(c) All claims of a guaranty association or foreign guaranty association shall be in such form and contain such substantiation as may be agreed to by the association and the liquidator.

Sec. 34. (a) The claim of a third party which is contingent only on his first obtaining a judgment against the insured shall be considered and allowed as if there were no such contingency.

(b) A claim may be allowed even if contingent, if it is filed in accordance with section 32. It may be allowed and may participate in all distributions declared after it is filed to the extent that it does not prejudice the orderly administration of the liquidation.

(c) Claims that are due except for the passage of time shall be treated as absolute claims are treated, except that such claims may be discounted at the legal rate of interest.

(d) Claims made under employment contracts by directors, principal officers, or persons in fact performing similar functions or having similar powers are limited to payment for services rendered prior to the issuance of any order of rehabilitation or liquidation under section 13 or 18.

Sec. 35. (a) When a claim is denied in whole or in party by the liquidator, written notice of the determination shall be given to the claimant or his attorney by first class mail at the address shown in the proof of claim. Within 60 days from the mailing of the notice, the claimant may file his objections with the liquidator. If no such filing is made, the claimant may not further object to the determination.

(b) Whenever objections are filed with the liquidator and the liquidator does not alter his denial of the claim as a result of the objections, the claimant may ask the court for a hearing. The matter may be heard by the court or by a court-appointed referee who shall submit findings of fact along with his recommendation.

Sec. 36. (a) The value of any security held by a secured creditor shall be determined in one of the following ways, as the court may direct:

(1) By converting the same into money according to the terms of the agreement pursuant to which the security was delivered to such creditors; or

(2) by agreement, arbitration, compromise or litigation between the creditor and the liquidator.

(b) The determination shall be under the supervision and control of the court with due regard for the recommendation of the liquidator. The amount so determined shall be credited upon the secured claim, and any deficiency shall be treated as an unsecured claim. If the claimant shall surrender his security to the liquidator, the entire claim shall be allowed as if unsecured.

Sec. 37. The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is herein set forth. Every claim in each class shall be paid in full or adequate funds retained for such payment before the members of the next class receive any payment. No subclasses shall be established within any class. The order of distribution of claims shall be:

(a) Class 1. The costs and expenses of administration during rehabilitation and liquidation, including but not limited to the following:

(1) The actual and necessary costs of preserving or recovering the assets of the insurer;

(2) compensation for all authorized services rendered in the rehabilitation and liquidation;

(3) any necessary filing fees;

(4) the fees and mileage payable to witnesses;

(5) authorized reasonable attorney's fees and other professional services rendered in the rehabilitation and liquidation;

(6) the reasonable expenses of a guaranty association or foreign guaranty association in handling claims.

(b) Class 2. Reasonable compensation to employees for services performed to the extent that they do not exceed two months of monetary compensation and represent payment for services performed within one year before the filing of the petition for liquidation or, if rehabilitation preceded liquidation, within one year before the filing of the petition for rehabilitation.

(c) Class 3. All claims under policies including claims for unearned premium, such claims of the federal or any state or local government for losses incurred, third party claims and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to his employee shall be treated as a gratuity.

(d) Class 5. Claims of the federal or any state or local government except those under class 3 above. Claims, including those of any governmental body for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claim shall be postponed to the class of claims under subsection (f).

(e) Class 6. All other creditors.

(f) Class 7. The claims of shareholders or other owners in their capacity as shareholders.

Sec. 38. (a) The liquidator shall review all claims duly filed in the liquidation and shall make such further investigation as he shall deem necessary. He may compound, compromise or in any other manner negotiate the amount for which claims will be recommended to the court except where the liquidator is required by law to accept claims as settled by any person or organization, including any guaranty association or foreign guaranty association. Unresolved disputes shall be determined under section 37. As soon as practicable, he shall present to the court a report of the claims against the insurer with his recommendations. The report shall include the name and address of each claimant and the amount of the claim finally recommended, if any. If the insurer has issued annuities or life insurance policies, the liquidator shall report the persons to whom, according to the records of the insurer, amounts are owed as cash surrender values or other investment value and the amounts owed.

(b) The court may approve, disapprove or modify the report on claims by the liquidator. Such reports as are not modified by the court within a period of 60 days following submission by the liquidator shall be treated by the liquidator as allowed claims, subject thereafter to later modification or to rulings made by the court pursuant to section 35. No claim under a policy of insurance shall be allowed for an amount in excess of the applicable policy limits.

Sec. 39. All unclaimed funds subject to distribution remaining in the liquidator's hands when he is ready to apply to the court for discharge, including the amount distributable to any creditor, shareholder, member or other person who is unknown or cannot be found, shall be deposited with the state treasurer in accordance with the unclaimed property act.

Sec. 40. When all assets justifying the expense of collection and distribution have been collected and distributed under this act, the liquidator shall apply to the court for discharge. The court may grant the discharge and make any other orders, including an order to transfer any remaining funds that are uneconomic to distribute, as may be deemed appropriate.

Sec. 41. After the liquidation proceeding has been terminated and the liquidator discharged, the commissioner may at any time petition the shawnee

county district court to reopen the proceedings for good cause, including the discovery of additional assets. If the court is satisfied that there is justification for reopening, it shall so order.

Sec. 42. Whenever it shall appear to the commissioner that the records of any insurer in process of liquidation or completely liquidated are no longer useful, he may recommend to the court and the court shall direct what records should be retained for future reference and what should be destroyed.

Sec. 43. The court may, as it deems desirable, cause audits to be made of the books of the commissioner relating to any receivership established under this act, and a report of each audit shall be filed with the commissioner and with the court. The books, records and other documents of the receivership shall be made available to the auditor at any time without notice. The expense of each audit shall be considered a cost of administration of the receivership.

Sec. 44. (a) If a domiciliary liquidator has not been appointed, the commissioner may apply to the shawnee county district court by verified petition for an order directing him to act as conservator to conserve the property of a foreign insurer on any one or more of the following grounds:

(1) Any of the grounds in section 12;

(2) that any of its property has been sequestered by official action in its domiciliary state, or in any other state;

(3) that enough of its property has been sequestered in a foreign country to give reasonable cause to fear that the insurer is or may become insolvent;

(4) (A) That its certificate of authority to do business in this state has been revoked; and

(B) that there are residents of this state with outstanding claims or outstanding policies.

(b) When an order is sought under subsection (a), the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

(c) The court may issue the order in whatever terms it shall deem appropriate. The filing or recording of the order with the clerk of the court or the register of deeds of the county in which the principal business of the company is located, shall impart the same notice as a deed, bill of

sale or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(d) The conservator may at any time petition the court for an order terminating conservation of an insurer. If the court finds that the conservation is no longer necessary, it shall order that the insurer be restored to possession of its property and the control of its business. The court may also make such finding and issue such order at any time upon motion of any interested party, but if such motion is denied all costs shall be assessed against such party.

Sec. 45. (a) If no domiciliary receiver has been appointed, the commissioner may apply to the shawnee county district court by verified petition for an order directing him to liquidate the assets found in this state of a foreign insurer or an alien insurer not domiciled in this state, on any of the following grounds:

(1) Any of the grounds in section 12 or 17; or

(2) any of the grounds specified in section 44(a)(2) through (4).

(b) When an order is sought under subsection (a), the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

(c) If it shall appear to the court that the best interests of creditors, policyholders and the public require, the court may issue an order to liquidate in whatever terms it shall deem appropriate. The filing or recording of the order with the clerk of the court or the register of deeds of the county in which the principal business of the company is located or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(d) If a domiciliary liquidator is appointed in a reciprocal state while a liquidation is proceeding under this section, the liquidator under this section shall thereafter act as ancillary receiver under section 48. If a domiciliary liquidator is appointed in a nonreciprocal state while a liquidation is proceeding under this section, the liquidator under this section may petition the court for permission to act as ancillary receiver under section 47.

(e) On the same grounds as are specified in subsection (a), the commissioner may petition any appropriate federal district court to be appointed receiver to liquidate that portion of the insurer's assets and business over which the court will exercise jurisdiction, or any lesser part thereof that the commissioner deems desirable for the protection of the policyholders and creditors in this state.

(f) The court may order the commissioner, when he has liquidated the assets of a foreign or alien insurer under this section, to pay claims of residents of this state against the insurer under such rules as to the liquidation of insurers under this act as are otherwise compatible with the provisions of this section.

Sec. 46. (a) The domiciliary liquidator of an insurer domiciled in a reciprocal state shall, except as to special deposits and security on secured claims under section 47(c), be vested by operation of law with the title to all of the assets, property, contracts and rights of action, agents' balances, and all of the books, accounts and the other records of the insurer located in this state. The date of vesting shall be the date of the filing of the petition, if that date is specified by the domiciliary law for the vesting of property in the domiciliary state. Otherwise, the date of vesting shall be the date of entry of the order directing possession to be taken. The domiciliary liquidator shall have the immediate right to recover balances due from agents and to obtain possession of the books, accounts and other records of the insurer located in this state. He also shall have the right to recover all other assets of the insurer located in this state, subject to section 39.

(b) If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the commissioner of this state shall be vested by operation of law with the title to all of the property, contracts and right of action, and all of the books, accounts and other records of the insurer located in this state, at the same time that the domiciliary liquidator is vested with title in the domicile. The commissioner of this state may petition for a conservation or liquidation order under section 44 or 45, for an ancillary receivership under section 47, or after approval by the court may transfer title to the domiciliary liquidator, as the interests of justice and the equitable distribution of the assets require.

(c) Claimants residing in this state may file claims with the liquidator or ancillary receiver, if any, in this state or with the domiciliary liquidator, if the domiciliary law permits. The claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings.

Sec. 47. (a) If a domiciliary liquidator has been appointed for an insurer not domiciled in this state, the commissioner may file a petition with the shawnee county district court requesting appointment as ancillary receiver in this state:

(1) If he finds that there are sufficient assets of the insurer located in this state to justify the appointment of an ancillary receiver;

(2) if the protection of creditors or policyholders in this state so requires.

(b) The court may issue an order appointing an ancillary receiver in whatever terms it shall deem appropriate. The filing or recording of the order with the register of deeds in this state imparts the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that register of deeds.

(c) When a domiciliary liquidator has been appointed in a reciprocal state, then the ancillary receiver appointed in this state may, whenever necessary, aid and assist the domiciliary liquidator in recovering assets of the insurer located in this state. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this state, and shall pay the necessary expenses of the proceedings. He shall promptly transfer all remaining assets, books, accounts and records to the domiciliary liquidator. Subject to this section, the ancillary receiver and his deputies shall have the same powers and be subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in this state.

(d) When a domiciliary liquidator has been appointed in this state, ancillary receivers appointed in reciprocal states shall have, as to assets and books, accounts, and other records in their respective states, corresponding rights, duties and powers to those provided in subsection (c) for ancillary receivers appointed in this state.

Sec. 48. The commissioner in his sole discretion may institute proceedings under section 9 through 11 at the request of the commissioner or other appropriate insurance official of the domiciliary state of any foreign or alien insurer having property located in this state.

Sec. 49. (a) In a liquidation proceeding begun in this state against an insurer domiciled in this state, claimants residing in foreign countries or in states not reciprocal states must file claims in this state, and claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary liquidator, Claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceeding.

(b) Claims belonging to claimants residing in reciprocal states may be proved either in the liquidation proceeding in this state as provided in this act, or in ancillary proceedings, if any, in the reciprocal states. If notice of the claims and opportunity to appear and be heard is afforded the domiciliary liquidator of this state as provided in section 50(b) with respect to ancillary proceedings, the final allowance of claims by the courts in ancillary proceedings in reciprocal states shall be conclusive as to amount and as to priority against special deposits or other security located in such ancillary states, but shall not be conclusive with respect to priorities against general assets under section 37.

Sec. 50. (a) In a liquidation proceeding in a reciprocal state against an insurer domiciled in that state, claimants against the insurer who reside within this state may file claims either with the ancillary receiver, if any, in this state, or with the domiciliary liquidator. Claims must be filed on or before the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

(b) Claims belonging to claimants residing in this state may be proved either in the domiciliary state under the law of that state, or in ancillary proceedings, if any, in this state. If a claimant elects to prove his claim in this state, he shall file his claim with the liquidator in the manner provided in sections 32 and 33. The ancillary receiver shall make his recommendation to the court as under section 38. He shall also arrange a date for hearing if necessary under section 35 and shall give notice to the liquidator in the domiciliary state, either by certified mail or by personal service at leas[t] 40 days prior to the date set for hearing. If the

domiciliary liquidator, within 30 days after the giving of such notice, gives notice in writing to the ancillary receive and to the claimant, either by certified mail or by personal service, of his intention to contest the claim, he shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim.

(c) The final allowance of the claim by the courts of this state shall be accepted as conclusive as to amount and as to priority against special deposits or other security located in this state.

Sec. 51. During the pendency in this or any other state of a liquidation proceeding, whether called by that name or not, no action or proceeding in the nature of an attachment, garnishment or levy of execution shall be commenced or maintained in this state against the delinquent insurer or its assets.

Sec. 52. (a) In a liquidation proceeding in this state involving one or more reciprocal states, the order of distribution of the domiciliary state shall control as to all claims of residents of this and reciprocal states. All claims of residents of reciprocal states shall be given equal priority of payment from general assets regardless of where such assets are located.

(b) The owners of special deposit claims against an insurer for which a liquidator is appointed in this or any other state shall be given priority against the special deposits in accordance with K.S.A. 40-222b. If there is a deficiency in any deposit, so that the claims secured by it are not fully discharged from it, the claimants may share in the general assets, but the sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(c) The owner of a secure claim against an insurer for which a liquidator has been appointed in this or any other state may surrender his security and file his claim as a general creditor, or the claim may be discharged by resort to the security in accordance with section 36, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors.

Sec. 53. If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to transfer to the domiciliary

liquidator in this state any assets within his control other than special deposits, diminished only by the expenses of the ancillary receivership, if any, the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class of claims under section 37(e).

Sec. 54. If any provision of this act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the act and the application of such provision to other persons or circumstances shall not be affected thereby.

Sec. 55. K.S.A. 40-3601 is hereby repealed.

Sec. 56. This act shall take effect and be in force from and after its publication in the statute book.

Explanatory Memorandum For

Legislative Proposal No. 2

This proposal reflects a conceptual change with respect to the frequency and scope of on-site financial examinations of insurers. The proposal continues to authorize the Commissioner to conduct examinations whenever it is deemed necessary but reintroduces the concept of a periodic examination and, more important, the Commissioner is given greater flexibility deciding the scope of the examination. The criteria for determining when a company should be examined and the scope of that examination and the procedures to be employed is a complex matter. Therefore, the proposal requires the Commissioner to observe the directions set forth in the NAIC Examiner's Handbook with respect to the scheduling, scope and conduct of examinations. In addition, the proposal adds new provisions relating to the timely preparation and review of examination reports as well as facilitating the release of examination findings to other regulatory officials.

The conceptual change reflected by this proposal can be accomplished because over the last several years a variety of additional financial regulatory tools have been developed and implemented including annual independent CPA audits, opinions on insurance reserves by qualified actuaries, annual financial statement analyses and other analytical tools which alleviate the universal necessity for comprehensive periodic examinations.

Enactment of this proposal will not diminish the Commissioner's authority to conduct examinations but rather will see that examinations are a more effective part of the Department's financial regulation and surveillance program. Moreover, the amendments suggested by this proposal are drawn from a new model examinations law adopted by the National Association of Insurance Commissioners at its December 1990 meeting. Therefore, because it is one of the financial regulation standards needed for accreditation, interstate examination efficiency will ultimately be enhanced because it will be enacted by most states and will therefore produce a greater consistency in examination scheduling and conduct among the several states.

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Attachment 2

LEGISLATIVE PROPOSAL NO. 2

AN ACT relating to insurance; examination of insurance companies; scheduling; conduct reports; suspension or revocation of certificate of authority; amending K.S.A. 40-222 and repealing the existing section.

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

New Section 1. Definitions. The following terms as used in this act shall have the respective meanings hereinafter set forth:

(a) "Commissioner" means the commissioner of insurance of this state;

(b) "company" means any person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to the administrative, regulatory or taxing authority of the commissioner;

(c) "department" means the department of insurance of this state;

(d) "examiner" means any individual or firm having been authorized by the commissioner to conduct an examination under this act;

(e) "insurer" shall have the meaning ascribed to the term "insurance company" by K.S.A. 40-222(c); and

(f) "person" means any individual, aggregation of individuals, trust, association, partnership or corporation, or any affiliate thereof.

Sec. 2. K.S.A. 40-222 is hereby amended to read as follows: 40-222. (a) Whenever the commissioner of insurance deems it necessary but at least once every 5 years, the commissioner may make, or direct to be made, an examination of the affairs and financial condition of any insurance company in the process of organization, or applying for admission or doing business in this state.

(b) In scheduling and determining the nature, scope and frequency of examinations of financial condition, the commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants and other criteria as set forth in the examiners' handbook adopted by the national association of insurance

commissioners and in effect when the commissioner exercises discretion under this paragraph.

(c) For the purpose of such examination, the commissioner of insurance or the persons appointed by the commissioner, for the purpose of making such examination shall have free access to the books and papers of any such company that relate to its business and to the books and papers kept by any of its agents and may examine under oath, which the commissioner or the persons appointed by the commissioner are empowered to administer, the directors, officers, agents or employees of any such company in relation to its affairs, transactions and condition.

(d) The commissioner may also examine or investigate any person, or the business of any person, in so far as such examination or investigation is, in the sole discretion of the commissioner, necessary or material to the examination of the company.

(e) In lieu of examining a foreign or alien insurance company, the commissioner of insurance may accept the report of the examination made by or upon the authority of ~~the supervising insurance official of any other state~~ the company's state of domicile or port-of-entry state until January 1, 1994. Thereafter, such reports as they relate to financial condition may only be accepted if:

(1) The insurance department conducting the examination was at the time of the examination accredited under the national association of insurance commissioners' financial regulation standards and accreditation program; or

(2) the examination is performed under the supervision of an accredited insurance department, or with the participation of one or more examiners who are employed by such an accredited insurance department and who after a review of the examination work papers and report state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(f) Upon determining that an examination should be conducted, the commissioner or his designee shall appoint one or more examiners to perform the examination and instruct them as to the scope of the examination. In conducting an examination of financial condition, the examiner shall observe those guidelines and procedures set forth in the examiners' handbook adopted by the national association of insurance commissioners. The commissioner

may also employ such other guidelines or procedures as the commissioner may deem appropriate.

(g) The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted in accordance with the provisions of the Kansas administrative procedures act.

(h) When making an examination under this act, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners, the cost of which shall be borne by the company which is the subject of the examination.

(i) Nothing contained in this act shall be construed to limit the commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

(j) Nothing contained in this act shall be construed to limit the commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report in the furtherance of any legal or regulatory action which the commissioner may, in his sole discretion, deem appropriate.

(k)(1) No later than 30 days following completion of the examination or at such earlier time as the commissioner shall prescribe, the examiner in charge shall file with the department a verified written report of examination under oath. No later than 30 days following receipt of the verified report, the department shall transmit the report to the company examined, together with a notice which shall afford such company examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(2) Within 30 days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and

review the report, together with any written submissions or rebuttals and any relevant portions of the examiners workpapers and enter an order:

(A) Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation or prior order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure such violation; or

(B) rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and refiling pursuant to this subsection; or

(C) call and conduct a fact-finding hearing in accordance with K.S.A. 40-281 for purposes of obtaining additional documentation, data, information and testimony.

(3) All orders entered as a result of revelations contained in the examination report shall be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner workpapers and any written submissions or rebuttals. Within 30 days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

(4) Upon the adoption of the examination report, the commissioner shall hold the content of the examination report as private and confidential information for a period of 30 days except to the extent provided in subparagraph 5. Thereafter, the commissioner may open the report for public inspection so long as no court of competent jurisdiction has stayed its publication.

(5) Nothing contained in this act shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of this or any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this act.

(6) In the event the commissioner determines that regulatory action is appropriate as a result of any examination, he or she may initiate any proceedings or actions as provided by law.

(7) All working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the commissioner or any other person in the course of an examination made under this act must be given confidential treatment and are not subject to subpoena and may not be made public by the commissioner or any other person, except to the extent otherwise specifically provided in K.S.A. 45-215 et seq. Access may also be granted to the national association of insurance commissioners. Such parties must agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained.

Whenever it appears to the commissioner of insurance from such examination or other satisfactory evidence that the solvency of any such insurance company is impaired, or that it is doing business in violation of any of the laws of this state, or that its affairs are in an unsound condition so as to endanger its policyholders, the commissioner of insurance~~,--before--filing--such--report--or--making--it--public,~~ shall give the company a notice and an opportunity for a hearing in accordance with the provisions of the Kansas administrative procedure act. If the hearing confirms the report of the examination, the commissioner shall suspend the certificate of authority of such company until its solvency shall have been fully restored and the laws of the state fully complied with. The commissioner may, if there is an unreasonable delay in restoring the solvency of such company and in complying with the law, revoke the certificate of authority of such company to do business in this state. Upon revoking any such certificate the commissioner ~~may--communicate--the--fact--to the--attorney--general,--whose--duty--it~~ shall ~~be--to~~ commence ~~and--prosecute~~ an action ~~in--the--proper--court~~ to dissolve such company or to enjoin the same from doing or transacting business in this state.

Sec. 3. K.S.A. 40-222 is hereby repealed.

Sec. 4. This act shall take effect and be in force from and after January 1, 1992 and its publication in the statute book.

Explanatory Memorandum For

Legislative Proposal No. 3

With the exception of a section relating to permissible investments, Kansas substantively enacted the NAIC Insurance Holding Company System Regulatory Act in 1974. Aside from some fairly technical amendments such as removing the act's application to securityholders, removal of some notification requirements and assigning responsibility for the payment of some of the costs incurred when formal hearings are conducted, the Kansas law relating to holding company systems has not been materially changed since its inception.

On the other hand, the NAIC has adopted significant amendments since 1974. Therefore, this proposal is intended to update Kansas law in order that we will be able to exercise some regulatory control over acquisitions, mergers and other holding company transactions not addressed in current statutes. In addition, the proposal and the present NAIC model include penalties and sanctions that are more compatible with regulatory needs.

A section by section summary of the proposed changes follows:

Section 1 - The amendments to K.S.A. 40-3303 are editorial in nature to remove the proviso and add clarity to the statute.

New Section 2 - These provisions are those contained in a National Association of Insurance Commissioners (NAIC) Model Acquisition and Merger Law which was originally drafted as a separate model. In 1980, the NAIC incorporated this law into its Model Holding Company Act and Legislative Proposal No. 3 now suggests its addition to the Kansas statutes governing holding company transactions.

These additional provisions apply to acquisitions involving non-domiciliary companies doing business in Kansas and gives Kansas the authority to take corrective action when an acquisition or merger adversely impacts competition in Kansas.

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Attachment 3

New Section 3 - This section adds provisions which will provide a receiver administering a liquidation or rehabilitation, authority to recover distributions of dividends, bonuses, and other specified payments from a parent, holding company or other controlling affiliate under certain conditions.

Section 4 - These amendments pertain to the information required to be provided on registration statements required to be filed with the Commissioner. Requirements for more information including a summary of the registration statement, dividends to shareholders and tax allocation agreements.

Section 5 - The additions to subsection (a) of this section are designed to elicit information or assure the availability of information to more clearly determine what was an "extraordinary" dividend and its reasonableness in relation to the insurer's financial condition.

New subsection (c) provides for pre-notification and disapproval authority regarding various specific transactions involving a domestic company and any person in its holding company system.

Section 6 - Replaces the current penalty provisions for violations of the holding company act with the more specific penalties contained in the NAIC model.

LEGISLATIVE PROPOSAL NO. 3

AN ACT relating to insurance; insurance holding company systems; acquisition; liquidation or rehabilitation; recoveries; requirements; amending K.S.A. 40-3303, K.S.A. 1989 Supp. 40-3305, 40-3306 and K.S.A. 40-3311 and repealing the existing sections.

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

Section 1. K.S.A. 40-3303 is hereby amended to read as follows: 40-3303. Any domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries~~: Provided, Such organization or acquisition is~~ otherwise permitted under ~~all other sections of this chapter~~ Kansas law.

New Section 2. (a) Definitions. The following definitions shall apply for the purposes of this section only:

(1) "Acquisition" means any agreement, arrangement or activity the consummation of which results in a person acquiring directly or indirectly the control of another person, and includes but is not limited to the acquisition of voting securities, the acquisition of assets, bulk reinsurance and mergers.

(2) An "involved insurer" includes an insurer which either acquires or is acquired, is affiliated with an acquirer or acquired or is the result of a merger.

(b) Scope.

(1) Except as exempted in paragraph (2) of this subsection, this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this state.

(2) This section shall not apply to the following:

(A) An acquisition subject to approval or disapproval by the commissioner pursuant to K.S.A. 1989 Supp. 40-3304;

(B) a purchase of securities solely for investment purposes so long as such securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this state. If a purchase of securities results in a presumption of control

under K.S.A. 1989 Supp. 40-3302(c); it is not solely for investment purposes unless the commissioner of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and such disclaimer action or affirmative finding is communicated by the domiciliary commissioner to the commissioner of this state;

(C) the acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if pre-acquisition notification is filed with the commissioner in accordance with subsection (c)(1) of this section thirty days prior to the proposed effective date of the acquisition. However, such pre-acquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from this section by any other subparagraph of subsection (b)(2) of this section;

(D) the acquisition of already affiliated persons;

(E) an acquisition if, as an immediate result of the acquisition,

(i) in no market would the combined market share of the involved insurers exceed five percent of the total market;

(ii) there would be no increase in any market share; or

(iii) in no market would

(aa) the combined market share of the involved insurers exceeds twelve percent of the total market, and

(bb) the market share increases by more than two percent of the total market.

For the purpose of this subparagraph (2)(E), a market means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state;

(F) an acquisition for which a pre-acquisition notification would be required pursuant to this section due solely to the resulting effect on the ocean marine insurance line of business;

(G) an acquisition of an insurer whose domiciliary commissioner affirmatively finds that such insurer is in failing condition; there is a lack of feasible alternative to improving such condition; the public benefits of improving such insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition;

and such findings are communicated by the domiciliary commissioner to the commissioner of this state.

(c) Pre-acquisition notification, waiting period. An acquisition covered by subsection (b) may be subject to an order pursuant to subsection (e) unless the acquiring person files a pre-acquisition notification and the waiting period has expired. The acquired person may file a pre-acquisition notification. The commissioner shall give confidential treatment to information submitted under this subsection in the same manner as provided in K.S.A. 40-3308.

(1) The pre-acquisition notification shall be in such form and contain such information as prescribed by the national association of insurance commissioners relating to those markets which, under subsection (b)(2)(E), cause the acquisition not to be exempted from the provisions of this section. The commissioner may require such additional material and information as he or she deems necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard of subsection (d). The required information may include an opinion of an economist as to the competitive impact of the acquisition in this state accompanied by a summary of the education and experience of such person indicating his or her ability to render an informed opinion.

(2) The waiting period required shall begin on the date of receipt of the commissioner of a pre-acquisition notification and shall end on the earlier of the thirtieth day after the date of such receipt, or termination of the waiting period by the commissioner. Prior to the end of the waiting period, the commissioner on a one-time basis may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period shall end on the earlier of the thirtieth day after receipt of such additional information by the commissioner or termination of the waiting period by the commissioner.

(d) Competitive standard.

(1) The commissioner may enter an order under subsection (e)(1) with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly therein or if the insurer fails to file adequate information in compliance with subsection (c).

(2) In determining whether a proposed acquisition would violate the competitive standard of paragraph (1) of this subsection, the commissioner shall consider the following:

(A) Any acquisition covered under subsection (b) involving two or more insurer competing in the same market is prima facie evidence of violation of the competitive standards

(i) If the market is highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
4%	4% or more
10%	2% or more
15%	1% or more

(ii) or, if the market is not highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
5%	5% or more
10%	4% or more
15%	3% or more
19%	1% or more

A highly concentrated market is one in which the share of the four largest insurers is seventy-five percent or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two insurers are involved, exceeding the total of the two columns in the table is prima facie evidence of violation of the competitive standard in paragraph (1) of this subsection. For the purpose of this subparagraph, the insurer with the largest share of the market shall be deemed to be Insurer A.

(B) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two largest to the eight largest, has increased by seven percent or more of the market over a period of time extending from any base year five to ten years prior to the acquisition up to the time of the acquisition. Any acquisition or merger covered under subsection (b) involving two or more insurers competing in the same market is prima facie evidence of violation of the competitive standard in paragraph (1) of this subsection if:

(i) There is a significant trend toward increased concentration in the market;

(ii) one of the insurers involved is one of the insurers in a grouping of such large insurers showing the requisite increase in the market share; and

(iii) another involved insurer's market is two percent or more.

(C) For the purposes of subsection (d)(2):

(i) The term "insurer" includes any company or group of companies under common management, ownership or control;

(ii) The term "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the commissioner shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the national association of insurance commissioners and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in this state, and the relevant geographical market is assumed to be this state.

(iii) The burden of showing prima facie evidence of violation of the competitive standard rests upon the commissioner.

(D) Even though an acquisition is not prima facie violative of the competitive standard under subparagraphs (2)(A) and (2)(B) of this subsection, the Commissioner may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is prima facie violative of the competitive standard under subparagraphs (2)(A) and (2)(B) of this subsection, a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this paragraph include, but are not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry and exit into the market.

(3) An order may not be entered under subsection (e)(1) if:

(A) The acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies

exceed the public benefits which would arise from not lessening competition; or

(B) the acquisition will substantially increase the availability of insurance, and the public benefits of such increase exceed the public benefits which would arise from not lessening competition.

(e) Orders and penalties.

(1)(A) If an acquisition violates the standards of this section, the commissioner may enter an order

(i) Requiring an involved insurer to cease and desist from doing business in this state with respect to the line or lines of insurance involved in the violation, or

(ii) denying the application of an acquired or acquiring insurer for a license to do business in this state.

(B) Such an order shall not be entered unless (i) there is a hearing, (ii) notice of such hearing is issued prior to the end of the waiting period and not less than fifteen days prior to the hearing, and (iii) the hearing is concluded and the order is issued no later than 60 days after the end of the waiting period. Every order shall be accompanied by a written decision of the commissioner setting forth his findings of fact and conclusions of law.

(C) An order entered under this paragraph shall not become final earlier than 30 days after it is issued, during which time the involved insurer may submit a plan to remedy the anticompetitive impact of the acquisition within a reasonable time. Based upon such plan or other information, the commissioner shall specify the conditions, if any, under the time period during which the aspects of the acquisition causing a violation of the standards of this section would be remedied and the order vacated or modified.

(D) An order pursuant to this paragraph shall not apply if the acquisition is not consummated.

(2) Any person who violates a cease and desist order of the commissioner under paragraph (1) and while such order is in effect, may after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to any one or more of the following:

(A) a monetary penalty of not more than $10,000 for every day of violation and/or

(B) suspension or revocation of such person's license.

(3) Any insurer or other person who fails to make any filing required by this section and who also fails to demonstrate a good faith effort to comply with any such filing requirement, shall be subject to a fine of not more than $50,000.

(f) Inapplicable provisions. K.S.A. 40-3310(b) and (c) do not apply to acquisitions covered under subsection (b) of this section.

New Sec. 3. (a) If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer, (1) from any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions (other than distributions of shares of the same class of stock) paid by the insurer on its capital stock, or (2) any payment in the form of a bonus, termination settlement or extraordinary lump sum salary adjustment made by the insurer or its subsidiary(s) to a director, officer or employee, where the distribution or payment pursuant to (1) or (2) is made at any time during the one year preceding the petition for liquidation, conservation or rehabilitation, as the case may be, subject to the limitations of subsections (b), (c), and (d) of this section.

(b) No such distribution shall be recoverable if the parent or affiliate shows that when paid such distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that such distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(c) Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time such distributions were paid shall be liable up to the amount of distributions or payments under (a) such person received. Any person who otherwise controlled the insurer at the time such distributions were declared shall be liable up to the amount of distributions he would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(d) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the impaired or

insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

(e) To the extent that any person liable under subsection (c) of this section is insolvent or otherwise fails to pay claims due from it pursuant to such paragraph, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid, shall be jointly and severely liable for any resulting deficiency in the amount recovered from such parent corporation or holding company or person who otherwise controlled it.

Sec. 4. K.S.A. 1989 Supp. 40-3305 is hereby amended to read as follows: 40-3305. (a) Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the commissioner of insurance, except a foreign insurer subject to disclosures requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in this section. Any insurer which is subject to registration under this section shall register within 60 days after the effective date of this act or 15 days after it becomes subject to registration, whichever is later, unless the commissioner of insurance for good cause shown extends the time for registration, and then within such extended time. The commissioner of insurance may require any authorized insurer which is a member of a holding company system which is not subject to registration under this section to furnish a copy of the registration statement or other information filed by such insurance company with the insurance regulatory authority of domiciliary jurisdiction.

(b) Every insurer subject to registration shall file a registration statement on a form provided by the commissioner of insurance, which shall contain current information about:

(1) the capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer;

(2) the identity of every member of the insurance holding company system;

(3) the following agreements in force, relationships subsisting, and transactions currently outstanding between such insurer and its affiliates;

(A) loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(B) purchases, sales, or exchanges of assets;

(C) transactions not in the ordinary course of business;

(D) guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(E) all management and service contracts and all cost sharing arrangements, other than cost allocation arrangements based upon generally accepted accounting principles; ~~and~~

(F) reinsurance agreements covering all or substantially all of one or more lines of insurance of the ceding company~~.~~;

(G) dividends and other distributions to shareholders; and

(H) consolidated tax allocation agreements.

(4) other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the commissioner of insurance~~.~~;

(5) any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

(c) No information need be disclosed on the registration statement filed pursuant to subsection (b) of this section if such information is not material for the purpose of this section. Unless the commissioner of insurance by rule, regulation or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, or investments, involving .5% or less of an insurer's admitted assets as of the December 31 next preceding shall not be deemed material for purposes of this section.

(d) Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on amendment forms provided by the commissioner of insurance within 15 days after the end of the month in which it learns of each such change or addition, except that subject to subsection (c) of K.S.A. 40-3306 and amendments thereto, each registered insurer shall report

all dividends and other distributions to shareholders within two business days following the declaration thereof.

(e) The commissioner of insurance shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

(f) The commissioner of insurance may require or allow two or more affiliated insurers subject to registration hereunder to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

(g) The commissioner of insurance may allow an insurer which is authorized to do business in this state and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection (a) of this section and to file all information and material required to be filed under this section.

(h) The provisions of this section shall not apply to any insurer, information or transaction if and to the extent that the commissioner of insurance by rule, regulation or order shall exempt the same from the provisions of this section.

(i) Any person may file with the commissioner of insurance a disclaimer of affiliation with any authorized insurer or such a disclaimer may be filed by such insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between such person and such insurer as well as the basis for disclaiming such affiliation. After a disclaimer has been filed, the insurer shall be relieved of any duty to register or report under this section which may arise out of the insurer's relationship with such person unless and until the commissioner of insurance disallows such a disclaimer. The commissioner of insurance shall disallow such a disclaimer only after furnishing all parties in interest with notice and opportunity to be heard in accordance with the provisions of the Kansas administrative procedure act.

~~(j) The--failure--to--file--a--registration--statement--or--any--amendment thereto-required-by-this-section-within-the-time-specified-for-such-filing shall-be-a-violation-of-this-section.~~

Sec. 5. K.S.A. 1989 Supp. 40-3306 is hereby amended to read as follows: 40-3306. (a) Material transactions by registered insurers with their affiliates shall be subject to the f llowing standards:

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(1) The terms shall be fair and reasonable;

(2) the books, accounts and records of each party shall be so maintained as to clearly and accurately disclose the precise nature and details of the transactions; ~~and~~

(3) the insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliate shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs~~.~~ ;

(4) the books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; and

(5) the insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(b) For purposes of this act, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;

(2) the extent to which the insurer's business is diversified among the several lines of insurance;

(3) the number and size of risks insured in each line of business;

(4) the extent of the geographical dispersion of the insurer's insured risks;

(5) the nature and extent of the insurer's reinsurance program;

(6) the quality, diversification, and liquidity of the insurer's investment portfolio;

(7) the recent past and projected future trend in the size of the insurer's surplus as regards policyholders;

(8) the surplus as regards policyholders maintained by other comparable insurers;

(9) the adequacy of the insurer's reserves; and

(10) the quality and liquidity of investments in subsidiaries made pursuant to K.S.A. 40-3303, and amendments thereto. The commissioner of insurance may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the commissioner's judgment such investment so warrants.

(c) The following transactions involving a domestic insurer and any person in its holding company system may not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into such transaction at least 30 days prior thereto, or such shorter period as the commissioner may permit, and the commissioner has not disapproved it within such period.

(1) Sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments provided such transactions are equal to or exceed:

(A) With respect to nonlife insurers, the lesser of three percent of the insurer's admitted assets or 25% of surplus as regards policyholders;

(B) with respect to life insurers, three percent of the insurer's admitted assets; each as of the 31st day of December next preceding;

(2) loans or extensions of credit to any person who is not an affiliate, where the insurer makes such loans or extensions of credit with the agreement or understanding that the proceeds of such transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit provided such transactions are equal to or exceed:

(A) With respect to nonlife insurers, the lesser of three percent of the insurer's admitted assets or 25% of surplus as regards policyholders;

(B) with respect to life insurers, three percent of the insurer's admitted assets; each as of the 31st day of December next preceding;

(3) reinsurance agreements or modifications thereto in which the reinsurance premium or a change in the insurer's liabilities equals or exceeds five percent of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a non-affiliate, if an agreement or understanding exists between the insurer

and non-affiliate that any portion of such assets will be transferred to one or more affiliates of the insurer

(4) all management agreements, service contracts and all cost-sharing arrangements; and

(5) any material transactions, specified by regulation, which the commissioner determines may adversely affect the interests of the insurer's policyholders;

Nothing herein contained shall be deemed to authorize or permit any transactions which, in the case of an insurer not a member of the same holding company system, would be otherwise contrary to law.

(d) No insurer subject to registration under K.S.A. 40-3305, and amendments thereto, shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until:

(1) Thirty days after the commissioner of insurance has received notice of the declaration thereof and has not within such period disapproved such payment, or

(2) the commissioner of insurance shall have approved such payment within such 30-day period.

For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding 12 months exceeds the greater of:

(1) Ten percent of such insurer's surplus as regards policyholders as of December 31 next preceding, or

(2) the net gain from operations of such insurer, if such insurer is a life insurer, or the net investment income, if such insurer is not a life insurer, for the 12-month period ending December 31 next preceding, but shall not include pro rata distributions of any class of the insurer's own securities. An extraordinary dividend or distribution shall also include any dividend or distribution made or paid out of any funds other than surplus profits arising from the insurer's business, as defined in K.S.A. 40-233, and amendments thereto. The provisions of K.S.A. 40-233, and amendments thereto, shall not be construed so as to prohibit an insurer, subject to registration under K.S.A. 40-3305, and amendments thereto, from making or paying an extraordinary dividend or distribution in accordance with this section.

Notwithstanding any other provisions of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval thereof, and such a declaration shall confer no rights upon shareholders until:

(1) The commissioner of insurance has approved the payment of such dividend or distribution or

(2) the commissioner of insurance has not disapproved such payment within the 30-day period referred to above.

Sec. 6. K.S.A. 40-3311 is hereby amended to read as follows: 40-3311. ~~If the commissioner of insurance finds any insurer or any person has committed a violation of this act and knew or reasonably should have known they were in violation of any provisions of this act which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the commissioner may, after a hearing held upon not less than twenty (20) days notice to interested parties, determine to suspend, revoke or refuse to renew such insurer's certificate of authority to do business in this state and/or order the payment of a monetary fine in an amount of not more than twenty thousand dollars ($20,000.00)~~

(a) Any insurer failing, without just cause, to file any registration statement within the time prescribed in subsections (a) and (d) of K.S.A. 1989 Supp. 40-3305 shall be subject to a penalty of $100 for each day's delay. The maximum penalty under this section is $10,000. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

(b) Every director or officer of an insurance holding company system who knowingly violates, participates in, or assents to, or who knowingly shall permit any of the officers or agents of the insurer to engage in transactions which have not been properly reported or submitted pursuant to K.S.A. 1989 Supp. 40-3305(a), 40-3306(c) or 40-3306(d), or which otherwise violate this article, shall pay, in their individual capacity, a civil forfeiture of not more than $5,000 per violation, after notice and hearing before the commissioner. In determining the amount of the civil forfeiture, the commissioner shall take into account the appropriateness of the forfeiture with respect to the gravity of the violation, the history of previous violations, and such other matters as justice may require.

(c) Whenever it appears to the commissioner that any insurer subject to this act or any director, officer, employee or agent thereof has engaged in any transaction or entered into a contract which is subject to K.S.A. 1989 Supp. 40-3306 and which would not have been approved had such approval been requested, the commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing the commissioner may also order the insurer to void any such contracts and restore the status quo if such action is in the best interest of the policyholders, creditors or the public.

(d) Whenever it appears to the commissioner that any insurer or any director, officer, employee or agent thereof has committed a willful violation of this article, the commissioner may cause criminal proceedings to be instituted by the district court for the county in which the principal office of the insurer is located or if such insurer has no such office in this state, then by the district court for shawnee county against such insurer or the responsible director, officer, employee or agent thereof. Any insurer which willfully violates this article may be fined not more than $50,000. Any individual who willfully violates this article may be fined in his/her individual capacity not more than $10,000 or, be imprisoned for not more than one to three years or both.

(e) Any officer, director, or employee of an insurance holding company system who knew or reasonably should have known they were subscribing to or making or causing to be made any false statements or false reports or false filings with the intent to deceive the commissioner in the performance of his or her duties under this article, upon conviction thereof, shall be imprisoned for not more than 5 to 10 years or fined $100,000 or both. Any fines imposed shall be paid by the officer, director, or employee in his/her individual capacity.

Sec. 7. K.S.A. 40-3303, K.S.A. 1989 Supp. 40-3305, 40-3306 and K.S.A. 40-3311 are hereby repealed.

Sec. 8. This act shall take effect and be in force from and after its publication in the statute book.

Explanatory Memorandum For

Legislative Proposal No. 5

This proposal consists of an editorial amendment to the statutes governing investments of domestic insurance companies. The designation used by the National Association of Insurance Commissioners to identify investment grade bonds has been changed from a "yes"/"no" designation to a "1" through "6" designation as part of a revised procedure adopted by the NAIC to establish a more refined system for valuing the quality of bonds. Kansas investment statutes incorporate the NAIC designations by reference. Therefore, this proposal is necessary to reflect the change.

FI & I
1/23/91
Attachment 4

LEGISLATIVE PROPOSAL NO. 5

AN ACT relating to insurance; investments by insurance companies; corporate obligations; limitations; amending K.S.A. 1989 Supp. 40-2a05 and 40-2b05 repealing the existing sections.

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

Section 1. K.S.A. 1989 Supp. 40-2a05 is hereby amended to read as follows: 40-2a05. Any insurance company other than life heretofore or hereafter organized under any law of this state may invest by loans or otherwise, with the direction or approval of a majority of its board of directors or authorized committee thereof, any of its funds, or any part thereof in bonds or other evidences of indebtedness issued, assumed or guaranteed by a corporation or trust organized under the laws of the United States of America, or of any state, district, insular or territorial possession thereof, or of the Dominion of Canada or any province thereof which are designated ~~"yes"~~ "1" or "2" by the national association of insurance commissioners in their most recently published Valuations of Securities Manual or are rated investment grade in Standard & Poor's (at least BBB-) or Moody's (at least Baa3) corporate bond guides at the time of acquisition; or which meet the following qualifications:

(a) If fixed-interest bearing obligations, the average fixed charges shall have been covered at least 1 1/2 times by the average net earnings available for fixed charges of the last five years, and the company shall have earnings in two of the last three fiscal years immediately preceding the date of acquisition. In the case of obligations of finance companies, the coverage shall be at least 1 1/4 times;

(b) if income, or other contingent interest obligations, the net earnings available for fixed charges of the corporation for the five fiscal years next preceding the date of acquisition of the obligations shall have averaged per year not less than 1 1/2 times the sum of the fixed charges and the maximum contingent interest to which the corporation is subject as of the date of acquisition, and the company shall have earnings in two of the last three fiscal years immediately preceding the date of acquisition. In

the case of obligations of finance companies, the coverage shall be at least 1 1/4 times;

(c) the corporation or a predecessor thereof must have been in existence for a period of not less than five years;

(d) investments in any corporate obligations under this act shall not be eligible if the corporation is in default on any fixed obligations as of the date of acquisition. Statements adjusted to show the actual condition at the time of acquisition or at effect of new financing (known commercially as pro forma statements) may be used when determining investments in this act or in compliance with requirements.

(e) As used in this section:

(1) The term "fixed charges" shall include actual interest incurred in each year on funded and unfunded debt. In the testing of obligations where interest is partially or entirely contingent upon earnings, fixed charges shall include contingent interest payments; and

(2) the term "net earnings available for fixed charges" shall mean income, before deducting interest on funded and unfunded debt and after deducting operating and maintenance expenses, taxes other than income taxes, depreciation and depletion. Extraordinary, nonrecurring items of income or expense shall be excluded.

Sec. 2. K.S.A. 1989 Supp. 40-2b05 is hereby amended to read as follows: 40-2b05. Any life insurance company heretofore or hereafter organized under any law of this state may invest by loans or otherwise, with the direction or approval of a majority of its board of directors or authorized committee thereof, any of its funds, or any part thereof in bonds or other evidences of indebtedness issued, assumed, or guaranteed by a corporation incorporated under the laws of the United States of America, or of any state, district, insular or territorial possession thereof; or of the Dominion of Canada or any province thereof which are designated ~~"yes"~~ <u>"1" or "2"</u> by the national association of insurance commissioners in their most recently published Valuations of Securities Manual or are rated investment grade in Standard & Poor's (at least BBB-) or Moody's (at least Baa3) corporate bond guides at the time of acquisition; or which meet the following qualifications:

(a) If fixed-interest bearing obligations, the average fixed charges shall have been covered at least 1 1/2 times by the average net earnings

available for fixed charges of the last five years, and the company shall have earnings in two of the last three fiscal years immediately preceding the date of acquisition. In the case of obligations of finance companies, the coverage shall be at least 1 1/4 times;

(b) if income, or other contingent interest obligations, the net earnings available for fixed charges of the corporation for the five fiscal years next preceding the date of acquisition of the obligations shall have averaged per year not less than 1 1/2 times the sum of the fixed charges and the maximum contingent interest to which the corporation is subject as of the date of acquisition, and the company shall have earnings in two of the last three fiscal years immediately preceding the date of acquisition. In the case of obligations of finance companies, the coverage shall be at least 1 1/4 times;

(c) the corporation or a predecessor thereof must have been in existence for a period of not less than five years;

(d) investments in any corporate obligations under this act shall not be eligible if the corporation is in default on any fixed obligations as of the date of acquisition. Statements adjusted to show the actual condition at the time of acquisition or at effect of new financing (known commercially as pro forma statements) may be used when determining investments in this act or in compliance with requirements.

(e)(1) The term "fixed charges" shall include actual interest incurred in each year on funded and unfunded debt. In the testing of obligations where interest is partially or entirely contingent upon earnings fixed charges shall include contingent interest payments; and

(2) the term "net earnings available for fixed charges" shall mean income, before deducting interest on funded and unfunded debt and after deducting operating and maintenance expenses, taxes other than income taxes, depreciation and depletion. Extraordinary, nonrecurring items of income or expense shall be excluded.

Sec. 3. K.S.A. 1989 Supp. 40-2a05 and 40-2b05 are hereby repealed.

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

Explanatory Memorandum For

Legislative Proposal No. 9

At the Insurance Department's request, the 1988 legislature amended the statutes governing health maintenance organizations (HMOs) to include a limited conversion right for persons terminated from HMO coverage. The legislation enacted at that time attempted to provide for an appropriate notice of conversion by referring to the notice requirement contained in K.S.A. 40-2209(D)(21). However, this provision relates the notice requirement to the continuation period other insurers are required to provide. HMOs are not required to provide a continuation period and because of this ambiguity and despite the clear intent of the statute, at least one HMO has disputed the need to provide notice of conversion rights.

As a result of this controversy Legislative Proposal No. 9 consists of a proposed amendment to K.S.A. 1990 Supp. 40-3209 which would add a specific notice requirement to the HMO conversion provisions.

FI & I
1/23/91
Attachment 5

LEGISLATIVE PROPOSAL NO. 9

AN ACT relating to health maintenance organizations; conversion coverage; notice; amending K.S.A. 1989 Supp. 40-3209 and repealing the existing section.

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

Section 1. K.S.A. 1989 Supp. 40-3209 is hereby amended to read as follows: 40-3209. (a) All forms of contracts issued by the organization to enrollees or other marketing documents purporting to describe the organization's health care services shall contain as a minimum:

(1) A complete description of the health care services and other benefits to which the enrollee is entitled;

(2) the locations of all facilities, the hours of operation and the services which are provided in each facility;

(3) the predetermined periodic rate of payment which the enrollee is obliged to pay;

(4) all exclusions and limitations on services or any other benefits to be provided including any deductible or copayment feature and all restrictions relating to pre-existing conditions;

(5) all criteria by which an enrollee may be disenrolled or denied re-enrollment;

(6) service priorities in case of epidemic, or other emergency conditions affecting demand for medical services; and

(7) a provision that an enrollee or a covered dependent of an enrollee whose coverage under a health maintenance organization group contract has been terminated for any reason but who remains in the service area and who has been continuously covered by the health maintenance organization for at least three months shall be entitled to obtain a converted contract. The converted contract shall provide coverage at least equal to the conversion coverage options generally available from insurers or mutual nonprofit hospital and medical service corporations in the service area at the applicable premium cost. The group enrollee or enrollees shall be solely responsible for paying the premiums for the alternative coverage. The

frequency of premium payment shall be the frequency customarily required by the health maintenance organization, mutual nonprofit hospital and medical service corporation or insurer for the policy form and plan selected, except that the insurer, mutual nonprofit hospital and medical service corporation or health maintenance organization shall require premium payments at least quarterly. The coverage shall be available to all enrollees of any group without medical underwriting. The requirement imposed by this subsection shall not apply to a contract which provides benefits for specific diseases or for accidental injuries only, nor shall it apply to any employee or member or such employee's or member's covered dependents when:

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

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

(C) the employee or member is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. Written application for the converted contract shall be made and the first premium paid not later than 31 days after termination of the group coverage or receipt of notice of conversion rights from the health maintenance organization, whichever is later, and shall become effective the day following the termination of coverage under the group contract. The health maintenance organization 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 within 15 days of termination of coverage under the group contract. In addition, the converted contract shall be subject to the provisions contained in paragraphs (2), (4), (5), (6), (7), (8), (9), (13), (14), (15), (16), (18), (19), and (20) ~~and (21)~~ of subsection (D) of K.S.A. 40-2209, and amendments thereto.

(b) No health maintenance organization authorized under this act shall contract with any provider under provisions which require enrollees to guarantee payment, other than copayments and deductibles, to such provider in the event of nonpayment by the health maintenance organization for any services which have been performed under contracts between such enrollees and the health maintenance organization.

(c) No contract form or amendment to an approved contract form shall be issued unless it is filed with the commissioner. Such contract form or amendment shall become effective within 30 days of such filing unless the commissioner finds that such contract form or amendment does not comply with the requirements of this section.

(d) Every contract shall include a clear and understandable description of the health maintenance organization's method for resolving enrollee grievances.

(e) The rate of payment for a health maintenance contract shall be a part of the contract and shall be stated in individual contracts by endorsement or certificate of coverage issued to enrollees.

Sec. 2. K.S.A. 1989 Supp. 40-3209 is hereby repealed.

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

SB 66

Explanatory Memorandum For

Legislative Proposal No. 10

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Legislative Proposal No. 10 suggests several amendments to the statutes governing the continuation and conversion of group accident and health insurance policies issued by Blue Cross and Blue Shield organizations and insurance companies.

It will be obvious that some of the suggested changes are of an editorial nature but most of the proposed amendments involve provisions that have been difficult to administer or are not producing the results originally intended.

A more specific explanation of the substantive changes and the reasons therefor follows:

Section 1(e)(2)- In 1987 an exception to continuation and conversion rights under state law was created for policies or subscription agreements issued to employers subject to continuation requirements imposed by the federal law known as COBRA. The exception was intended to eliminate confusion over complying with two sets of mandates. Since the federal requirements provided a longer continuation period, it was believed there would be no adverse impact to consumers.

However, in applying the law after enactment of the exception for COBRA groups, it became apparent there were "gaps" which left certain persons without or with less continuation or conversion rights than they had prior to the 1987 legislation. The most common examples include:

(1) COBRA group ceases to provide any coverage which would not be a "qualifying event" needed to trigger COBRA, and

(2) COBRA provides no conversion rights.

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1/23/91
Attachment 6

This amendment would restore rights under state law to persons covered through groups subject to COBRA to the extent COBRA does not provide equal or greater rights.

Section 1(e)(2)(B) - Amendment provides an exception to Blue Cross and Blue Shield organizations' obligations to provide continuation and conversion rights for persons eligible for Medicare. A similar provision currently exists in the statutes governing continuation and conversion for other insurers (K.S.A. 1989 Supp. 40-2209(D)(c).

Section 1(e)(2)(C) - The first amendment to this paragraph clarifies the covered person must be covered to the same extent by the replacement coverage in order to relieve the replaced insurer from its obligation to provide continuation and conversion rights to that covered person. This should close the gap which exists for a person who had been receiving benefits under a replaced plan, but is not eligible for such benefits under the new plan (even though it may be identical) because of pre-existing condition limitations, waiting periods, etc.

The second amendment to this paragraph merely clarifies replacement coverage which is not insured must be a lawful self-insured arrangement in order to terminate the replaced insurer's continuation and conversion obligations.

The third amendment to this paragraph clarifies an ambiguity relative to issuing a conversion in lieu of continuation and allows the insurer to issue an individual policy if the coverage is substantially similar and at the same or a lesser premium. This should provide consumers with equal or greater substantive coverage rights while allowing insurers the option to provide such coverage in a manner more administratively feasible. The employee or member retains the right to be issued a conversion policy (which generally has lesser benefits) in lieu of continuation, in case the conversion policy would be more affordable than continuing the group policy.

Section 2(D) - (See discussion of Section 1(e)(2) above.)

Section 2(D)(d) - (See discussion of Section 1(e)(2)(C) above.)

Section 2(D)(9) - Amendment requires converted policy to provide credit for deductibles, copayments and other conditions satisfied under the group policy if benefits under the converted policy are reduced by payments and benefits payable under the group policy.

LEGISLATIVE PROPOSAL NO. 10

AN ACT relating to insurance; accident and sickness insurance; continuation and conversion rights; amending K.S.A. 1989 Supp. 40-19c06 and 40-2209 and repealing the existing sections.

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

Section 1. K.S.A. 1989 Supp. 40-19c06 is hereby amended to read as follows: 40-19c06. (a) No subscription agreement, except as provided in subsection (d), between a corporation organized under the nonprofit medical and hospital service corporation act and a subscriber, shall entitle more than one person to benefits, except that a "family subscription agreement" may be issued, at an established subscription charge, to a husband and wife, or husband, wife, and their dependent child or children and any other person dependent upon the subscriber. Only the subscriber must be named in the subscription agreement.

(b) Every subscription agreement entered into by any such corporation with any subscriber shall be in writing and a certificate stating the terms and conditions shall be furnished to the subscriber to be kept by the subscriber. No such certificate form shall be made, issued or delivered in this state unless it contains the following provisions: (1) A statement of the nature of the benefits to be furnished and the period during which they will be furnished, and if there are any benefits to be excepted, a detailed statement of such exceptions printed as hereinafter specified; (2) a statement of the terms and conditions, if any, upon which the subscription agreement may be canceled or otherwise terminated at the option of either party; (3) a statement that the subscription agreement includes the endorsements and attached papers, if any, and contains the entire contract; (4) a statement that no statement by the subscriber in the application for a subscription agreement shall avoid the subscription agreement or be used in any legal proceeding, unless such application or an exact copy is included in or attached to such subscription agreement, and that no agent or representative of such corporation, other than an officer of officers

designated therein, is authorized to change the subscription agreement or waive any of its provisions; (5) a statement that if the subscriber defaults in making any payments under the subscription agreement, the subsequent acceptance of a payment by the corporation or by one of its duly authorized agents shall reinstate the subscription agreement but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of such acceptance; (6) a statement of the period of grace which will be allowed the subscriber for making any payment due under the subscription agreement. Such period shall not be less than 10 days; and (7) if applicable, a statement of the kind of hospital in which the subscriber may receive benefits and the types of benefits to which the subscriber may be entitled to in such kinds of hospitals. The subscriber shall be entitled to benefits in any nonparticipating hospital in Kansas which is licensed by the secretary of health and environment and in which the average length of stay of patient is similar to the average length of stay in participating hospitals.

(c) In every such subscription agreement made, issued or delivered in this state: (1) All printed portions shall be plainly printed; (2) the exceptions of the subscription agreement shall appear with the same prominence as the benefits to which they apply; (3) if the subscription agreement contains any provisions purporting to make any portion of the articles of incorporation or bylaws of the corporation a part of the subscription agreement, such portion shall be set forth in full; and (4) there shall be a brief description of the subscription agreement on the first page and on its filing back.

(d) Any such corporations may issue a group or blanket subscription agreement, provided the group of persons insured conforms to the requirements of law applicable to other companies writing group or blanket sickness and accident insurance policies and provided such subscription agreement and the individual certificates issued to members of the group shall comply in substance with this section. Any such subscription agreement may provide for the adjustment of the premiums based upon the experience at the end of the first year or of any subsequent year of insurance, and such readjustment may be made retroactive in the form of a rate credit or a cash refund.

(e)(1) Any group subscription agreement issued pursuant to subsection (d) shall provide that an employee or member or such employee's or member's covered dependents whose insurance under the group subscription agreement has been terminated for any reason, including discontinuance of the group in its entirety or with respect to an insured class, and who has been continuously insured under the group subscription agreement or under any group policy or subscription agreement providing similar benefits which it replaces for at least three months immediately prior to termination, shall be entitled to have such coverage nonetheless continued under the group policy for a period of six months and at the end of such six-month period of continuation, such employee or member or such employee's or member's covered dependents shall be entitled to obtain, at the employee's, member's or dependent's option either:

(A) A converted subscription agreement providing coverage equal to 80% of that afforded under the group subscription agreement for basic hospital, surgical and medical benefits. Persons selecting this option shall also be entitled to obtain major medical expense coverage which will provide hospital, medical and surgical expense benefits to an aggregate maximum of not less than $50,000. The major medical expense coverage may be subject to a copayment by the covered person of not more than 20% of covered charges and a deductible stated on a per person, per family, per illness, per benefit period, or per year basis or a combination of such bases of not more than $500 per person subject to a maximum annual deductible of $750 per family; or

(B) a subscription agreement which imposes a deductible of not less than $1,000 per subscriber and not less than $2,000 per family and subjects the covered person to a copayment of not more than 20% of covered charges with a $1,000 maximum copayment per subscriber and $2,000 maximum copayment per family per contract year and providing a lifetime maximum benefit of not less than $1,000,000.

(2) The ~~requirement~~ requirements imposed by this subsection (d) (e) shall not apply to:

A group subscription agreement which provides benefits for specific diseases or for accidental injuries only or any group subscription agreement 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, ~~nor--shall--it--apply--to~~ to the extent federal law provides the employee or member or such employee's or member's covered dependents with equal or greater continuation or conversion rights, or any employee or member or such employee's or member's covered dependents whose termination of insurance under the group subscription agreement occurred because:

(A) Such person failed to pay any required contribution after receiving reasonable notice of such required contribution from the insurer in accordance with rules and regulations adopted by the commissioner of insurance;

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

(C) the employee or member is or could be covered to the same extent by any other insured or ~~noninsured~~ lawful self-insured 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~~ an individual policy or certificate ~~which-otherwise-meets-these-provisions~~ in lieu of a conversion policy or the ~~right-to-continue~~ continuation of group coverage required herein if the individual policy or certificate provides substantially similar coverage for the same or less premium as the group subscription agreement. In any event, the employee or member shall have the option to be issued a conversion policy which meets the requirements set forth in this subsection (e) in lieu of the right to continue group coverage.

(3) Written application for the converted subscription agreement shall be made and the first premium paid to the insurer not later than 31 days after termination of the group coverage and shall become effective the day following the termination of insurance under the group subscription agreement. In addition, the converted subscription agreement shall be subject to the provisions contained in paragraphs (2), (3), (4), (5), (6),

(7), (8), (9), (13), (14), (15), (16), (18), (19), (20) and (21) of subsection (D) of K.S.A. 40-2209 and amendments thereto.

Sec. 2. K.S.A. 1989 Supp. 40-2209 is hereby amended to read as follows: 40-2209. (A) Group sickness and accident insurance is declared to be that form of sickness and accident insurance covering groups of persons, with or without one or more members of their families or one or more dependents, or one or more members of their families or one or more dependents, and issued 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

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

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

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

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

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

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

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

(4) A provision that the 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 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 to the extent federal law provides the employee or member or such employee's or member's covered dependents with equal or greater continuation or conversion rights; or 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 to the same extent by any other insured or ~~noninsured~~ lawful self-insured 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~~ issue an individual policy or certificate ~~which otherwise meets these provisions~~ in lieu of a conversion policy or the ~~right to continue~~ continuation of group coverage required herein if the individual policy or certificate provides substantially similar coverage for the same or less premium as the group policy. In any event, the employee or member shall have the option to be issued a conversion policy which meets the requirements set forth in this subsection (D) in lieu of the right to continue group coverage.

The continued coverage and the issuance of a converted policy shall be subject to the following conditions:

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

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

(3) The terminated employee or member shall pay to the insurer the premium for the six-month continuation of coverage and such premium shall be the same as that applicable to members or employees remaining in the group. Failure to pay such premium shall terminate coverage under the group policy at the end of the period for which the premium has been paid. The premium rate charged for converted policies issued subsequent to the period of continued coverage shall be such that can be expected to produce an anticipated loss ratio of not less than 80% based upon conversion, morbidity and reasonable assumptions for expected trends in medical care costs. In the event the group policy is terminated and is not replaced, converted policies may be issued at self-sustaining rates that are not unreasonable in relation to the coverage provided based on conversion, morbidity and

reasonable assumptions for expected trends in medical care costs. The frequency of premium payment shall be the frequency customarily required by the insurer for the policy form and plan selected, provided that the insurer shall not require premium payments less frequently than quarterly.

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

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

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

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

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

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

(b) the benefits provided under the sources referred to in 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 insurer may request information in advance of any premium due date of such policy of any person covered as to whether:

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

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

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

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

(a) Either the benefits provided under the sources referred to in 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. If the converted policy ~~may-provide~~ provides

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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~~.~~ or the converted policy ~~may also include~~ includes 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~~.~~ , the converted policy shall provide credit for deductibles, copayments and other conditions satisfied under the group policy.

(10) Subject to the provisions and conditions of this act, if the group insurance policy from which conversion is made insurers 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 boar daily expense benefits in a maximum dollar amount equal to 50% of the maximum dollar amount determined for plan A, for a maximum duration of 70 days,

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

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

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

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

(a) A maximum benefit at least equal to either, at the option of the insurer, 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:

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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 o medical service subscriber contract or medical practice or other prepayment plan, or any other plan or program whether on an insured or uninsured basis, or in accordance with the requirements of any state or federal law and, if pursuant to condition (12), the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits.

If the maximum benefit is determined by 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

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surgical expense insurance as well as major medical expense insurance, make available the plans of benefits set forth in conditions (10) and (11). At the option of the insurer, such plans of benefits may be provided under one policy.

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

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

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

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

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

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

(b) to the spouse of the employee or member upon termination of coverage of the spouse, while the employee or member remains insured under the group

policy, by reason of ceasing to be a qualified family member under the group policy, with respect to the spouse and such children whose coverage under the group policy terminates at the same time; or

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

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

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

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

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

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

Sec. 3. K.S.A. 1989 Supp. 40-19c06 and 40-2209 are hereby repealed.

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

Explanatory Memorandum For

Legislative Proposal No. 12

The persons employed by the Department to conduct on-site examinations of insurance companies are paid only for the time actually spent in conducting the examination and for the travel time occupied in going to and returning from the examination. Therefore, unless special provisions are included in the law, examiners receive no paid vacation or sick leave.

Several years ago the law was amended to establish a means of accumulating funds to provide vacation leave for examiners on the same basis as state employees in the classified service. Legislative Proposal No. 12 suggests that an allowance for sick leave now be accommodated in the same way. As more and more states add sick leave to the benefits available to examiners, the competition for this type of expertise is becoming more intense. This compounds an already difficult problem because the number of persons with the necessary accounting expertise and willingness to constantly travel is in short supply. As a result, it is necessary that Kansas' examiner compensation and benefits at least remain reasonably equivalent to those available elsewhere.

It is important to note that the state is reimbursed for the examiners compensation, expenses, benefits and other costs associated with the examination by the entity being examined. Therefore, providing sick leave for examiners as suggested by this proposal will not require a general fund expenditure.

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LEGISLATIVE PROPOSAL NO. 12

AN ACT relating to insurance; fees for examinations; examiners; sick leave; amending K.S.A. 1989 Supp. 40-223 and repealing the existing section.

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

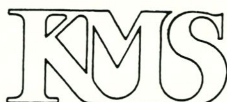
Section 1. K.S.A. 1989 Supp. 40-223 is hereby amended to read as follows: 40-223. Any person who makes any examination under the provisions of this act, except as provided in K.S.A. 40-110 and 40-253 and amendments thereto, may receive as full compensation for such person's services, on a per diem basis an amount fixed by the commissioner, which shall not exceed the amount recommended by the national association of insurance commissioners, for such time necessarily and actually occupied in going to and returning from the place of such examination and for such time the examiner is necessarily and actually engaged in making such examination including any day within the regular workweek when the examiner would have been so engaged had the company or society been open for business, together with such necessary and actual expenses for traveling and subsistence as the examiner shall incur because of the performance of such services. For the purposes of this act, "necessary and actual expenses" shall be limited, whether for travel within the state or travel outside the state, to those limitations expressed in K.S.A. 75-3207 and amendments thereto which pertain to official travel outside the state. The daily charge shall be calculated by dividing the amount the examiner is authorized by the commissioner of insurance to charge per week by the number of days in the regular workweek of the company or society being examined.

All of such compensation, expenses, the employer's share of the federal insurance contributions act taxes, the employer's contribution to the Kansas public employees retirement system as provided in K.S.A. 74-4920 and amendments thereto, the self-insurance assessment for the workmen's compensation act as provided in K.S.A. 44-576 and amendments thereto, the employer's cost of the state health care benefits program under K.S.A. 75-6507, a pro rata amount determined by the commissioner to provide ~~annual~~

vacation and sick leave for the examiner not to exceed the number of days allowed state officers and employees in the classified service pursuant to regulations promulgated in accordance with the Kansas civil service act, all outside consulting and data processing fees necessary to perform any examination, and a pro rata amount determined by the commissioner not to exceed an annual aggregate of $18,000 to fund the purchase, maintenance and enhancement of examination equipment and computer software shall be paid to the commissioner of insurance by the insurance company or society so examined, on demand of the commissioner. The amount paid for all outside consulting and data processing fees necessary to perform any examination, and the pro rata amount to fund the purchase of examination equipment and computer software shall not collectively total more than $25,000 at any one company examination including examination of its subsidiaries or combination thereof. Such demand shall be accompanied by the sworn statement of the person making such examination, setting forth in separate items the number of days necessarily and actually occupied in going to and returning from the place of such examination, the number of days the examiners were necessarily and actually engaged in making such examination including those days within the regular workweek while the examination was in progress and the company or society had closed for business, and the necessary and actual expenses for traveling and subsistence, incurred in and on account of such services. A duplicate of every such sworn statement shall be kept on file in the office of the commissioner of insurance. All moneys so paid to the commissioner of insurance shall be remitted to the state treasurer and the state treasurer shall issue duplicate receipts therefor, one to be delivered to the commissioner of insurance and the other to be filed with the director of accounts and reports.

Sec. 2. K.S.A. 1989 Supp. 40-223 is hereby repealed.

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



KANSAS MEDICAL SOCIETY

1300 Topeka Avenue • Topeka, Kansas 66612 • (913) 235-2383
Kansas WATS 800-332-0156 FAX 913-235-5114

January 23, 1991

TO: Senate Financial Institutions and Insurance Committee

FROM: Kansas Medical Society Chip Wheelen

SUBJECT: Senate Bill 15; Mammogram Coverage Under Health and Accident Insurance

Thank you for this opportunity to comment on the provisions of SB 15. The Kansas Medical Society agrees that quality assurance standards should be applied to facilities which offer mammogram services. We do, however, need to point out a potential flaw in the construction of the bill, as well as the possibility that federal law might preclude the necessity for legislation at the state level.

If SB 15 were to become law on July 1, 1991, there would then be a perhaps lengthy period of time during which the Department of Health and Environment would propose and eventually adopt regulations governing mammography facilities, and also a period of time during which mammography facilities would apply for, be examined, and eventually receive accreditation. This would mean hypothetically that insurers could suspend reimbursement for mammography services throughout that period of time, however long it may be. This problem could be corrected by inserting a date after which reimbursement would be tied to the accreditation requirement.

On the other hand, passage of SB 15 may not be needed at all. During the period of time that the 1990 Special Committee on Insurance was studying health insurance issues, the U.S. Congress was also focusing some concern on quality assurance standards in mammography facilities. As a result, the Congress adopted provisions in the budget reconciliation package which require accreditation of facilities that are reimbursed for mammography services under the federal Medicare program. This means that adoption of the federal regulations will affect virtually all mammography facilities. It is very likely that all Medicare facilities would apply for accreditation. It is also likely that the standards employed for accreditation will be similar or identical to the standards developed by the American College of Radiology. We are advised by specialists in diagnostic radiology that the ACR standards are reasonable and appropriate.

It is for these reasons that we respectfully suggest that your committee not take action on SB 15. Thank you for your consideration.

/cb

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State of Kansas
Joan Finney, Governor
Department of Health and Environment
Division of Health
Acting
Stanley C. Grant, Ph.D., Secretary
Landon State Office Bldg., Topeka, KS 66612-1290
Reply to: ____________
FAX (913) 296-6231

Testimony presented to
Senate Committee on Financial Institutions and Insurance

by

The Kansas Department of Health and Environment

Senate Bill 15

Background

I am pleased to provide testimony today related to Senate Bill 15. The early detection and prevention of breast cancer has been a recognized public health issue both on the national and state level for the past several years. In fact, Medicare coverage of screening mammography services was part of the Medicare Catastrophic Coverage Act of 1988 (known as the Pepper bill), which was enacted on July 1, 1988. Section 204 of that law would have provided coverage for screening mammography, effective January 1, 1990. However, this benefit was repealed on December 13, 1989, with the enactment of the Medicare Catastrophic Coverage Repeal Act of 1990.

Throughout the debate in Congress related to these pieces of legislation, strong concerns were expressed about the quality of screening mammography services. In May, 1989, a report by the U.S. Preventive Services Task Force to the Secretary of Health and Human Services entitled," Guide to Clinical Preventive Services," found that "wide variation is found in the quality and consistency of mammography, as well as in the accuracy of interpretation, radiation exposure and cost."

More recently, Section 4163 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) again authorizes the coverage of mammography services under the Medicare program, effective January 1, 1991. The quality standards for such facilities were published in the Federal Register on December 31, 1990. KDHE's Bureau of Adult and Child Care has received information from the Health Care Financing Administration (HCFA) related to the certification of mammography screening suppliers.

Impact on KDHE

It is expected that approximately 7,000 suppliers of mammography screening services will apply for certification nationally. Staff of the Bureau of Environmental Health Services estimates that approximately 135 suppliers are eligible in Kansas.

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Director of Health
(913) 296-1343

James Power, P.E.
Director of Environment
(913) 296-1535

Lorne Phillips, Ph.D.
Director of Information Systems
(913) 296-1415

Roger Carlson, Ph.D.
Director of the Kansas Health and Environment Laboratory
(913) 296-1619

Senate Bill 15 as written, would require the development of standards or regulations by which the Secretary could accredit mammography screening facilities; standards that may not be necessary given the Medicare certification now available. For Medicare certification purposes, potential suppliers will be allowed to attest in writing that screening mammography requirements and quality standards are being met. If this self attestation is received before June 30, 1991, an effective date of January 1, 1991 will be given to the service suppliers. If an attestation is received after July 1, 1991, the date the attestation is received by the Bureau of Adult and Child Care will be the effective date. Once the Health Care Financing Administration develops survey instruments, onsite inspections will be conducted at the facilities.

The Department, through the Bureau of Environmental Health Services, currently registers and inspects radiation equipment under the authority of KSA 48-1601 and KAR 28-35-135 et. seq. However, federal regulations developed in response to Public Law 101-508 are more specific to mammography screening services. Standards will require the use of equipment specifically designed for mammography which meets Food and Drug Administration (FDA) specifications, compliance with safety standards and personnel requirements, and the maintenance of a quality assurance program. Conditions for Coverage appear in the Federal Register, Volume 55, No. 251, Part 494.50 through 494.64.

The new federal legislation will provide a breast scan every other year for about 18 million women over the age of 65. Approximately 1.5 million disabled women under the age of 65 will also be covered. It is anticipated that this new benefit will lead suppliers to seek Medicare certification while providing specific standards for use by other party payers.

Conclusion

Through its role as the state public health agency, KDHE supports the inclusion of mammogram coverage in health and accident policies and contracts.

In its regulatory role we believe that the adoption, by the health insurance industry, of these newly established federal standards will further ensure quality mammography screening as sought by Senate Bill 15. It is, therefore, recommended that Section 1 (a) (2) of Senate Bill 15 be amended to read: "mammograms performed at a Medicare certified facility and at the direction of a person licensed to practice medicine and surgery by the board of healing arts within the lawful scope of such person's license."

We have included a fiscal note with the bill brief for Senate Bill 15. However, we anticipate that funding for the one full-time and one part-time positions can be secured through Title XVIII funding. It is hoped that the legislative limit for new positions could be raised to include these positions.

Testimony presented by: Richard J. Morrissey
Deputy Director
Division of Health
January 23, 1991

KSNA

the voice of Nursing in Kansas

For More Information Contact:
Terri Roberts J.D., R.N.
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Topeka, Kansas 66603-3731
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SENATE BILL 15

Senator Bond, Senate Financial Institutions and Insurance Committee, my name is Pamela Byl. I'm a registered nurse at a local women's health center. I represent the Kansas State Nurses' Association and speak in support of the intent of S.B. 15.

The overall mortality rate from breast cancer in women in the United States has not changed in more than 60 years. Approximately 44,000 women in the U.S. and 475 women in Kansas were projected to die of breast cancer in 1990 and projections currently are for about 1% increase in deaths each year.

A multitude of factors account for our failure to decrease mortality from this dreaded disease even though it has been proven that breast cancer can be beaten if it is caught early enough: 1) Approximately 59% of women have never had a mammogram; 2) Delayed diagnosis of breat cancers in young women; 3) Variability in the effectiveness of diagnostic and treatment modalities.

The American College of Radiology (ACR) has developed a comprehensive mammography accreditation program that allows mammography centers to demonstrate the quality of their services. This program is a method to insure the provision of high quality mammograms at a low patient dose of radiation. In addition, the program has provided a basis for quality standards in mammography.

The American Cancer Society (ACS), the National Cancer Institute, and other organizations are providing women with referrals for screening mammograms based on ACR accreditation. Furthermore, several states including Michigan and New Mexico have passed legislation which mandates quality assurance requirements for

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those facilities providing screening mammography. Additionally, many third party payers are also linking reimbursement to accreditation, including Blue Cross Blue Shield of Maryland, the District of Columbia, Kentucky, and Michigan.

For those states who choose to require ACR accreditation, we understand that there may be anti-trust issues, and for those states who decide to get into the accrediting business we can imagine huge fiscal notes.

The Federal Health Care Financing Administration (HCFA) has developed screening mammography accreditation criteria for Medicare reimbursement. It is our understanding that these criteria are consistent in intent with those of ACR. Apparently screening mammography providers will be required to submit an "atestation form" testifying to their compliance with criteria in order to obtain Medicare reimbursement.

Kansas State Nurses' Association supports legislation that would link third party reimbursement for screening mammography to Medicare certification. We would recommend that the legislation take effect at a date that would allow facilities who do not currently meet accreditation criteria a reasonable length of time with which to meet the criteria. We believe such legislation could contribute to reducing breast cancer mortality rates.

Thank you very much.

Pam Byfe, R.N.

KANSAS DIVISION, INC.

January 23, 1991

Senate Committee on Financial Institutions and Insurance

The American Cancer Society's 1990 Cancer Facts and Figures predicted that approximately 150,900 new cases of breast cancer would be diagnosed and 44,000 women would die of the disease in the United States last year. In Kansas, approximately 1600 new cases of breast cancer would be diagnosed and 475 Kansas women would die of the disease.

Overall, one of every ten women will develop breast cancer at some time in their lives. Breast cancer incidence rates have increased about 1% a year since the early 1970s and some of this is attributed to earlier detection of tumors through screening programs before they become clinically apparent -- some tumors can be found by mammography 2-4 years earlier than physical examination. It is important to note that while incidence rates are increasing, early detection of the disease and improved treatment have kept mortality rates fairly stable over the past 50 years.

We do not yet know what causes breast cancer, nor do we know how to prevent it. But appropriate use of screening mammography, in conjunction with clinical examination and breast self-examination (BSE), as recommended by the American Cancer Society, can enable us to detect many breast cancers early in their development. Such cancers require less arduous treatment, and increase the chances for long-term survival by as much as 40 percent. Indeed, survival rates in excess of 90% can be achieved when the disease is detected early.

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(913) 273-4114 • FAX (913) 273-1503

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As more women become aware of the steps they can take to increase their chances of surviving breast cancer, it is imperative that we ensure the efficacy of procedures designed to detect the disease.

Senator Brock Adams of Washington reports that, "less than one-third of the mammography units in the United States have applied for professional accreditation available since 1987, and about one-third of those who applied failed on their first attempt. Overall, it is estimated that less than 20 percent of providers nationally meet voluntary professional quality assurance standards that were established by the American College of Radiology in 1987.

The Office of Technology Assessment also raised concern over the quality of the mammography services in light of "the rapid expansion of new free-standing breast screening services." The proliferation of radiological equipment and the increasing number of mammography facilities over the last 5 years has gone virtually unchecked. Today there are estimated to be more than 10,000 machines in use for mammography."

For these reasons, the Kansas Division of the American Cancer Society supports the concept of certifying mammography facilities. For the past three years we have worked in conjunction with the American College of Radiologists and fully support their Mammography Accreditation Program. Attached you will find a list of the 28 Kansas institutions which have received their accreditation. You will also find a description of the requirements for the American College of Radiologists Accreditation Program. The Kansas Division of the American Cancer Society supports adoption of these standards and the accreditation program.

If the state adopts a certification program, it is our recommendation that the effective date be set at July 1, 1993 or later to allow sufficient time for mammography facilities to apply for and receive accreditation. Until

that time current requirements would remain in effect.

The primary goal of this legislation when it was first introduced in 1988 was to improve access to mammography and pap smears. We need to carefully scrutinize any amendments which might inadvertently restrict that access.

(The National American Cancer Society is currently reviewing the HICVA regulations relating to medicare coverage of mammography and will make recommendations to the appropriate federal agencies prior to March 1.)

Thank you for the opportunity to appear before you today on this important topic.

American College of Radiology
Accredited Mammography Facilities

Fort Scott

Mercy Hospital
821 Burke Street
Fort Scott, KS 66701
316 223-2200
Approved: 6-12-90

Kansas City

Bethany Medical Center
51 North 12th Street
Kansas City, KS 66102
913 281-8931
Approved: 6-8-88

Providence-St. Margaret Health Center
8929 Parallel Parkway
Kansas City, KS 66112
913 596-4000
Approved: 6-8-88

Radiology Chartered
155 South 18th Street
Kansas City, KS 66102
913 371-4343
Approved: 10-4-88

University of Kansas Medical Center
Department of Diagnostic Radiology
39th & Rainbow Blvd.
Kansas City, KS 66103
913 588-6800
Approved: 7-17-89

Lawrence

Lawrence Imaging Assoc.
500 Rockledge Road
Lawrence, KS 66049
913 841-2000
Approved: 4-25-90

Lawrence Memorial Hospital
325 Maine St.
Lawrence, KS 66044
913 749-6195
Approved: 10-7-88

Manhattan

Memorial Hospital
1205 Sunset
Post Office Box 1208
Manhattan, KS 66502
913 776-3300
Approved: 6-19-90

November 1990

The Saint Mary Hospital
P.O. Box 1047
1823 College Avenue
Manhattan, KS 66502
913 776-3322
Approved: 6-2-89

Merriam

Womens Imaging Center
8901 West 74th, Suite 2
Merriam, KS 66204
913 676-7766
Approved: 3-16-89

Newton

Axtell Clinic, P.A.
203 E. Broadway
Newton, KS 67114
316 283-2800
Approved: 8-31-89

Medical Services, Ltd.
215 South Pine
Suite 202
Newton, KS 67114
316 283-4400
Approved: 8-10-90

Overland Park

Humana Hospital - Overland Park
10500 Quivira Road
Overland Park, KS 66215
913 541-5385
Approved: 11-30-88

Diagnostic Imaging Ctr/Women's Diagnostic Imaging
5520 College Boulevard
Overland Park, KS 64131
913 491-9299
Approved: 1-5-90

Johnson County Imaging Center
P.O. Box 10919
12000 W. 110th St., Suite 500
Overland Park, KS 66210
913 469-8998
Approved: 2-15-88

Parsons

Labette County Medical Center
Post Office Box 956
Parsons, KS 67357
316 421-4880
Approved: 3-15-90

Pittsburg	Mount Carmel Medical Center Centennial & Rouse Pittsburg, KS 66762 316 231-6100 Approved: 12-1-87
Topeka	Stormont-Vail Reg. Medical Ctr-Breast Clinic 1500 W. 10th St. Topeka, KS 66604-1353 913 354-6180 Approved: 11-15-87
	Jane C. Stormont Women's Health Center 823 Mulvane, Suite 102 Topeka, KS 66606 913 354-5960 Approved: 5-22-89
	St. Francis Hospital & Medical Center 1700 W. 7th St. Topeka, KS 66606 913 295-8011 Approved: 1-15-88
Wichita	Breast Clinic Wichita Kansas 8100 E. 22 Bldg. 1600 Wichita, KS 67226 316 681-1827 Approved: 11-1-87
	HCA Wesley Medical Center 550 N. Hillside Avenue Wichita, KS 67214 316 688-2015 Approved: 3-14-88
	Medical Imaging Office 144 S. Hillside Wichita, KS 67211 316 685-9289 Approved: 12-23-88
	St. Francis Regional Medical Center 929 N. St. Francis Wichita, KS 67214 316 268-5967 Approved: 4-15-88
	St. Joseph Medical Center 3600 E. Harry Wichita, KS 67218 (316) 689-5050 Approved: 11-6-90

Wichita

Wichita Clinic, PA
3311 E. Murdock
Wichita, KS 67208
(316) 689-9532
Approved: 11-6-90

Wichita Clinic, PA - Maple Ridge
222 S. Ridge Road
Wichita, KS 67209
(316) 689-9532
Approved: 11-6-90

Wichita Radiological Group
Suite 214, 3333 E. Central
Wichita, KS 67208
316 685-1292
Approved: 11-1-87

ACR MAMMOGRAPHY ACCREDITATION PROGRAM

The ACR Mammography Accreditation Program offers radiologists the opportunity for peer review and evaluation of their facility's staff qualifications, equipment, quality control and quality assurance programs, image quality, and breast dose.

This voluntary program is directed by the ACR Committee on Practice Accreditation of the Commission of Radiologic Practice. The ACR Task Force on Breast Cancer and a Physics Subcommittee assisted in developing this program.

The impetus for the program came as a result of the concerns of radiologists, other national medical organizations, the government, and the public that qualified personnel perform and interpret mammograms and that dedicated mammographic equipment be used to ensure that women receive optimum mammographic examinations with the lowest possible risk.

Each facility must complete an application questionnaire concerning the qualifications of personnel including radiologists, radiologic physicists, and radiologic technologists. To more specifically address the need for high quality mammography, the physician supervising and/or interpreting mammography will be required to meet the following minimum criteria:

> Have had two months of documented, formal training in reading mammograms with instruction in medical radiation physics, radiation effects, and radiation protection with evidence of a formal examination in these subjects.
>
> OR
>
> Certified by the American Board of Radiology or the American Osteopathic Board of Radiology.

11-8

AMERICAN COLLEGE OF RADIOLOGY
1891 Preston White Drive, Reston, Virginia 22091 (703) 648-8900

In addition, the physician must also:

Read a minimum of 480 mammograms per year.

AND

Maintain record concerning outcome data for correlation of positive mammograms to biopsies done and the number of cancers detected.

AND

Initially, must have documented 40 hours of Category 1 Credits in mammography and, following the initial accreditation, must have documented 15 hours of Category 1 Credits in mammography in the past three years.

The radiologic technologists must have American Registry of Radiologic Technology certification or the equivalent state license. The technologist should also have had special training in mammography, either in their training curriculum or through special courses. The mammogram must be performed only on dedicated mammographic equipment, or equipment adequately modified in the case of xerography, and have adequate device for compression. Information will also be collected on the quality control and quality assurance program which is in place. The radiologic physicist should calibrate the unit at installation and then at least annually. Additionally, information is collected on follow-up procedures, data collection, and record and film retention.

If the facility fulfills the criteria related to the application form, then image quality and breast dose data is obtained. Image quality, dose, and half value-layer evaluation will be obtained using a specially designed breast phantom and thermoluminescent dosimeter which will be exposed in the same exposure. The image of the phantom as well as two sets of clinical films, one of a fatty and one of a dense breast, will be submitted for scoring to a review panel of radiologists and radiologic physicists. Each set will consist of two views of each breast totaling four films for each type of breast. The committee set standards for the number or sizes of fibrils, specks, and masses which must be visualized on the phantom image

as well as determined the parameters which will be scored on the clinical images. These include:

- Positioning
- Compression
- Exposure level
- Resolution
- Contrast
- Noise
- Exam Identification
- Artifacts

The average glandular dose as determined by the dosimeter may not exceed 0.4 rads per view.

The phantom must be purchased for use in the accreditation program and for use in the institution's ongoing quality control program.

Those institutions meeting the criteria will be awarded a three-year accreditation, a certificate for each approved mammography unit, and listing on the American Cancer Society's referral list of approved mammographic centers. Recommendations for improvement will be made for those not meeting the criteria.

The fee for accreditation is $550 for the first unit and $450 for each additional unit regardless of the location. The discounted charge for the phantom is $325 plus applicable taxes and handling charges and is paid directly to the manufacturer.

The ACR office in Reston, Virginia should be contacted for further information (703) 648-8900, extension 4997.

acr

TECHNICAL SPECIFICATIONS FOR MAMMOGRAPHY ACCREDITATION

1. BREAST PHANTOM:

   The lucite breast phantom with a wax insert containing fibrils, specks, and masses is of a thickness to simulate a 4.5 cm compressed breast.

   The test objects are:

Fibrils	1.56 mm in diameter
	1.12 mm
	0.89 mm
	0.75 mm
	0.54 mm
	0.40 mm
Specks	0.74 mm in diameter
	0.54 mm
	0.32 mm
	0.24 mm
	0.20 mm
Masses	2.00 mm thick
	1.00 mm
	0.75 mm
	0.50 mm
	0.25 mm

2. Dosimeter

   Information obtained from the dosimeter will include filter thickness, exposure (mR), average exposure, and a calculated half-value layer value.

   A computer program will use this information to calculate an average glanduar dose for each mammographic unit.

acr

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