Approved 3/18/91
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

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

9:00 a.m./~~p.m.~~ on WEDNESDAY, MARCH 6, , 1991 in room 529-S of the Capitol.

All members were present ~~except~~:

Committee staff present:
Bill Wolff, Research Department
Fred Carman, Revisors Office
Louise Bobo, Secretary

Conferees appearing before the committee:
Senator Douglas Walker

Chairman Bond called the meeting to order at 9:09 a.m.

SB 205 - Health care for Kansans.

Senator Douglas Walker was requested by the Chairman to explain this bill in detail to the committee. Senator Walker stated that this plan was based on a Canadian system and provides for access to basic, primary health care services for every Kansan. The bill would authorize appointment of a 21 member Health Care Commission to manage health care in Kansas. The Plan has two parts: Part I coverage would include basic health care services and Part II coverage would be optional and cover procedures and treatments not covered in Part I. Senator Walker advised that this bill was important because it would alert providers that we think the health system needs and overhaul and also would alert the federal government that something needs to be done. (Attachment 1)

During the discussion which followed, Chairman Bond advised that the Oregon Plan was very troubled at the beginning because they attempted to pass legislation and set up a state wide plan without the full backing of the public. Senator Walker agreed that this could happen in Kansas but said there are several plans in the works to outline and address the problems to the public. He said that there was a great deal of interest in health care reform and that the public seemed more willing to try something new than the Legislature. Senator Walker concluded by stating that SB 205 could be used as a starting point to have the public discuss the specifics. He suggested that the bill be referred to the Committee on Health Care for the 90's for further study.

Written testimony from Keith R. Landis, Christian Science Committee on Publication for Kansas, and from Myrna Stringer of the League of Women Voters of Kansas, in support of SB 205 were passed out to the members of the committee. (Attachments 2 and 3)

SB 179 - Health insurance regulation.

Senator Walker gave a brief item by item explanation of eleven of the recommendations from the Governor's Commission on Health Care. (Attachment 4)

During the brief discussion which followed, Chairman Bond opined that too many commissions were doing the same thing and accomplishing nothing and that a central focus was needed. He advised that he would request SB 179 be sent to Ways and Means Committee and rereferred to Financial Institutions and Insurance.

SB 140 - Additional charges and credits on certain real estate transactions.

Discussion resumed on this bill heard in committee on February 20. The Chairman explained to the committee that the principle issue of the bill would permit finance companies to charge an additional 1% on a note when it is prepaid and secured by a

real estate mortgage. Stan Lind, KS Association of Financial Services, agreed with the Chairman that, currently, up to 3% can be charged on a loan secured by real estate plus 18% interest and this bill would add another 1% to the transaction if the loan is prepaid. Mr. Lind informed the committee that this bill would permit finance companies to treat first and second mortgage holders the same and also that approximately 40% of their business now consists of real estate loans and it is still growing. Staff remarked that this bill really addressed second mortgages at different rates of interest. (Attachment 5)

Senator Strick made a motion to report SB 140 unfavorably. Senator Francisco seconded the motion. The motion carried.

The minutes of the Monday, March 4, meeting were approved on a motion by Senator Reilly with Senator Kerr seconding the motion. The motion carried.

The meeting adjourned at 9:59 a.m.

GUEST LIST

COMMITTEE: FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE DATE: Wed. Mar 6, '91

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Michelle Sieston	Topeka	John Peterson & Associates
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Mayer L. Goldman	Kansas City	Kansas HMO Assn.
Michael J. Herbert	Newton	Kansas Hmo Assoc.
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MARY Spinks	Topeka	Health Benefits Admin
Roger Kirkwood	Topeka	AARP-CCTF
George Gaebel	Topeka	AARP-SLC-CCTF
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TESTIMONY FAVORING PASSAGE OF SB 205

I wish I could tell you today that SB 205 is a simple little bill which will solve our health care crisis. I do, in fact, believe that SB 205 will go a long way in solving our health care problems -- but it is anything but simple.

This Plan is based on the Canadian system and provides for access to basic, primary health care services for every Kansan. Every resident of the State of Kansas will be covered by a Health Care Plan which excludes no one and, in effect, makes the state a single group for insurance purposes.

SB 205 establishes a 21-member Health Care Commission, which would manage health care in Kansas. Section 4 spells out the specific functions of the Commission. This Commission would manage the Kansas Health Care trust fund which would be the single source of payment for all covered health care services in Kansas. (p.2)

The Commission would negotiate with providers on reimbursement rates. It will establish budget and policy guidelines, establish fee schedules, and monitor the Plan and make any necessary changes in coverage.

The Commission will also appoint an 11-member Health Services Subcommittee to determine appropriate levels of coverage and services to be provided under a two-tiered coverage plan.

Attachment 1
H H I
3/6/91

This section of the Plan incorporates part of the philosophy of the Oregon Plan.

Part 1 coverage is to include basic, preventative and primary health care services. Monies spent under Part 1 coverage will cover services, prioritized to provide the best overall cost-effective health care system to the greatest number of individuals. At this time, it is impossible to be specific about what Part 1 coverage will actually cover, but it would be my intent to reallocate resources to front end services, such as prenatal care, prevention of early childhood disease, and early detection and treatment of diseases.

For every service covered under Part 1 coverage, a non-insurable copayment would be required. This copayment would be based on the individual's income and is graphed on page 5 of the bill. The reason for the copayment is to put patients back in touch with the cost of their care, and allow them to make health care decisions based on the knowledge that their care will cost them something. This, in itself, should help control over utilization and abuse. The copayments are on a sliding scale based on income and there are limits on out of pocket expenses.

Part 2 coverage would be optional, supplemental coverage and could be purchased from the Plan under a separate system, but more likely would be purchased from private insurance companies and would cover procedures and treatments not covered in Part 1. Again, Part 2 coverage would be determined by the Subcommittee but I would expect such procedures as transplants and other exotic treatments would be addressed under Part 2 coverage.

There is also a 12-month waiting period for Part 2 coverage if obtained from the Plan.

Hospitals will negotiate with the Plan an annual budget to cover anticipated services for the next year based on past performance and projected changes in price factors and service levels.

Professional organizations of other providers will negotiate for services and all providers will be reimbursed at the negotiated rate.

Funding for the Plan will require several federal waivers to allow the state to use Title 19 funds. Under this Plan, all Medicaid and Medicare clients would be indistinguishable from other participants.

Additional funding for the Plan comes from an income tax surcharge of from 1% to 5%, again based on individual income. A 10% tax on alcohol and tobacco products, a 2% tax on interest and dividend income in excess of $1,000, and an 8% payroll tax on employers will also help fund the Plan. The 8% employer payroll tax is in line with the amount employers that are currently providing health insurance benefits pay and, in many cases, it will be less. By having a payroll tax, employers such as WalMart and McDonalds who hire employees just enough hours to avoid providing benefits will be required to pay. Whether the merchant employs a person for one hour or for 60 hours, he must still pay 8% of that person's salary.

This is the first plan presented to the Legislature in which most of the problems facing health care today are addressed. It

is comprehensive and will fundamentally alter the way we provide health care in this state.

The introduction of this bill serves several useful purposes. First of all, if adopted, it would solve many of the problems we face today. Second, it puts providers on notice that we think the current system is definitely broken and must have a major overhaul to fix it. I believe this Plan is that major overhaul. It is also a message to the federal government. It is my understanding that 35 states have introduced major health care reform legislation in the past 2 years. Legislation like this tells the federal government to give us the waivers and flexibility to allow us to solve the problem or get its act together, address it and solve it on the national level.

Hearings were held last week in the Senate Public Health & Welfare committee in which there were 13 proponents including the Kansas Medical Society, the Kansas Hospital Association, AARP, Silver Haired Legislators, and others. There were 7 opponents : 3 representatives of the tobacco industry, 2 from the insurance industry and two business representatives.

On Monday the Senate Public Health & Welfare committee recommended that SB 205 be sent to the Health Care Decisions for the 90's committee for further study.

I truly believe when we eventually get around to reforming the present system, it will look very much like the system proposed in SB 205.

States must initiate national health care

By GEORGE A. SILVER
L.A. Times-Washington Post Service

If we want a national health program — and it is clear from polls over the years that most Americans do — we're going about it the wrong way. It is not only Congress to which demands should be addressed, but state legislatures as well. Those who call for a national health program have for nearly a century stubbornly concentrated on getting Congress to initiate it. In doing so, they have ignored 200 years of American history. You'd think they would have caught on by now to the futility of this approach.

Agitation for a national health program began in 1907, and bills have been introduced nearly every year since 1916. Not one of them has ever gotten out of committee. One administration after another has recommended national health insurance legislation, and Congress has received dozens of reports proposing such action over the years. The latest such episode is the report issued by the Pepper Committee, which was pronounced "dead on arrival" by members of the committee itself.

It follows the Report of the National Leadership Commission on Health Care this past year and will join it in the collection of forgotten proposals gathering dust on library shelves.

On the heels of this congressional report proposing a national health program, President Bush asked the secretary of health and human services, Louis Sullivan, to undertake another "study" and come up with a recommendation for a national health program. Dr. Sullivan will probably devote a year or so and several million dollars to producing another Congress-focused proposal to join in the archives the Wagner-Murray-Dingell bills, the Truman Report, the Eisenhower administration's "Goals for Americans," the Johnson administration's "Health Manpower Report," Walter Reuther's "Health Security bill," the Kennedy-Mills bill, and the Rockefeller Committee Report.

It has become increasingly clear that the present system is inequitable and irrational, denies access to millions of poor and minority citizens and suffers from uncontrollable costs and quality constraints. A program that will benefit all Americans — which means a national program — is unquestionably necessary. However, historically, national health and welfare legislation does not begin with congressional action; it ends there.

> Trying social policy at a lesser level before making it national policy was considered a stroke of genius.

Welfare and health services were intended to be initiated in the states, as ordered in the 10th Amendment to the Constitution: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states." Health and welfare were not mentioned as federal objectives in the Constitution. When welfare and health legislation begin in the states, the effects of the laws are tested and the laws amended, refined and polished there. After their utility and value are demonstrated, the state benefits are extended, by congressional action, to the entire nation.

For example, the elements of Social Security law existed in 24 states before the national Social Security Act was passed in 1935. The U.S. Congress didn't pass child labor legislation until 1912, yet by 1897 28 states already had child labor laws. The innovative American idea of trying a social policy at a lesser level before making it national policy was considered a stroke of genius by 19th century observers. The British scholar, Lord Bryce, commented, "A comparatively small commonwealth like an American state easily makes and unmakes its laws; mistakes are not serious, for they are soon corrected; other states profit by the experience of a law or a method which has worked well or ill in the state that has tried it."

Justice Brandeis implied that state initiatives might actually be requirements for eventual national action. "It is one of the happy incidents of the federal system that a single courageous state may, if its citizens so choose, serve as a laboratory and try novel social and economic experiments without risk to the rest of the country."

Alice Rivlin, political and economic scholar, recommends strongly that social "innovation should be tried in enough places to establish its capacity to make a difference and the conditions under which it works best."

Where Congress has taken the initiative without previous state laws as guides — as in the Medicare law, which had no state model — the law is constantly being amended and is mired in controversy. The failure of states to undertake a first step in these times of enormous medical-care costs may be the result of lack of federal support. There are so many bits and pieces of health-services responsibility, all with separate funding and administration, that a new law would only be an added financial burden. If this factor were taken into consideration, an effort to fashion a national health program could be undertaken by Congress and some state legislatures, jointly.

Dr. Sullivan can, if he chooses, take account of legislative history and recommend the traditional approach by encouraging initiation of trial programs in one or more states. His report could propose substantial financial support for a state or states that wish to undertake pilot programs of state comprehensive health services, providing universal eligibility. The experience gained from the state programs in delivering a satisfactory level of medical care, in efficient and economical payment mechanisms and in quality would be used as the framework for the national health program everyone desperately wants. In this way we might indeed have a national health program in the 21st century.

George A. Silver, emeritus professor of public health at Yale, is writing a history of health policy in the United States.

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UNIVERSAL HEALTH INSURANCE: ITS TIME HAS COME

OVER a year ago I said that "we urgently need a new and more comprehensive approach to health policy . . ." and noted that the National Leadership Commission on Health Care was planning to propose such an approach by the end of 1988.*

The Commission's report has not been released as of this writing, and when it is I expect to comment further. In the meantime, the *Journal* has published two other important contributions on this subject. In this issue and the last is a two-part description by Professor Alain Enthoven of his "Consumer-Choice Health Plan for the 1990s." This week we also publish a paper entitled "A National Health Program for the United States" by a group of physicians calling themselves "Physicians for a National Health Program." Both articles offer the outlines of a universal health insurance system designed to promote adequate coverage for all Americans, regardless of income or employment.

The Enthoven proposal is based on qualified managed care health plans that would compete for contracts with employers or state-level "public sponsors." The plans would presumably pay the hospitals. (Hospitals would also be paid by Medicare and Medicaid, which would continue under this proposal.) Employers would be required to cover all full-time employees and to pay an 8 percent payroll tax on the wages of all uncovered employees. Everyone not covered through employment would have to contribute through the income tax. Eighty percent of the average cost of premiums for basic approved coverage would be subsidized by the system, with the difference paid by beneficiaries according to their means; those with incomes below the poverty level would be totally subsidized by government. All costs of any more expensive coverage chosen by beneficiaries would be their responsibility.

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hand, proposes a single public insurance system that would pay all health care costs from a common pool drawn at first from present mixed sources, with the recommendation that the federal government should ultimately assume total responsibility. State "National Health Program Payment Boards" would negotiate with all providers, paying hospitals an annual lump sum (plus separately budgeted capital expenditures), while physicians would be paid either through a "simplified binding fee schedule" or through salaries from HMOs that contracted with the payment boards for the delivery of comprehensive care on a capitation basis. Copayments or deductibles would be required, but coverage would be complete and totally funded by the national program. Private health insurance would be gradually phased out. Existing for-profit providers would be compensated by the payment boards, but no new investor-owned providers would be allowed.

There are important differences between these two approaches. Enthoven's tries to maintain the present pluralistic insurance network while providing for universal basic coverage and moving toward a case-management, prospective-payment system. The National Health Program opts for a monopsonistic universal-coverage insurance plan that would pay for all care without specifying how it should be provided. Neither one represents the socialization of health care, because the government would not own or operate health care facilities or employ physicians. However, it seems likely that under either proposal there would be major changes in the way most physicians would be paid. Salaried group practice would displace solo fee-for-service practice as the primary arrangement because the latter would not be as competitive economically.

These two proposals are not the first plans for universal health insurance to be advanced, nor will they be the last. It is hard to predict their fate, but it is safe to say that they and others like them will receive increasing attention from policy makers as they grope for ways to repair or replace our present disastrously inadequate health care financing system. In my view, nothing short of a comprehensive plan, which includes improved technology assessment and malpractice reform as well as other reforms in medical practice, is likely to achieve the goals of universal access, cost containment, and preservation of quality that everyone seems to want. The National Leadership Commission's report will address these wider issues.

Physicians will have to play an active and constructive part in shaping a new health care system, because no comprehensive arrangement is likely to succeed without their cooperation. Now is the time for our profession to make common cause with government and with the major private payers in seeking solutions to a pressing social problem that is not going to solve itself.

ARNOLD S. RELMAN, M.D.

States must initiate national health care

By GEORGE A. SILVER
L.A. Times-Washington Post Service

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hand, proposes a single public insurance system that would pay all health care costs from a common pool drawn at first from present mixed sources, with the recommendation that the federal government should ultimately assume total responsibility. State "National Health Program Payment Boards" would negotiate with all providers, paying hospitals an annual lump sum (plus separately budgeted capital expenditures), while physicians would be paid either through a "simplified binding fee schedule" or through salaries from HMOs that contracted with the payment boards for the delivery of comprehensive care on a capitation basis. Copayments or deductibles would be required, but coverage would be complete and totally funded by the national program. Private health insurance would be gradually phased out. Existing for-profit providers would be compensated by the payment boards, but no new investor-owned providers would be allowed.

There are important differences between these two approaches. Enthoven's tries to maintain the present pluralistic insurance network while providing for universal basic coverage and moving toward a case-management, prospective-payment system. The National Health Program opts for a monopsonistic universal-coverage insurance plan that would pay for all care without specifying how it should be provided. Neither one represents the socialization of health care, because the government would not own or operate health care facilities or employ physicians. However, it seems likely that under either proposal there would be major changes in the way most physicians would be paid. Salaried group practice would displace solo fee-for-service practice as the primary arrangement because the latter would not be as competitive economically.

These two proposals are not the first plans for universal health insurance to be advanced, nor will they be the last. It is hard to predict their fate, but it is safe to say that they and others like them will receive increasing attention from policy makers as they grope for ways to repair or replace our present disastrously inadequate health care financing system. In my view, nothing short of a comprehensive plan, which includes improved technology assessment and malpractice reform as well as other reforms in medical practice, is likely to achieve the goals of universal access, cost containment, and preservation of quality that everyone seems to want. The National Leadership Commission's report will address these wider issues.

Physicians will have to play an active and constructive part in shaping a new health care system, because no comprehensive arrangement is likely to succeed without their cooperation. Now is the time for our profession to make common cause with government and with the major private payers in seeking solutions to a pressing social problem that is not going to solve itself.

Arnold S. Relman, M.D.

Christian Science Committee on Publication For Kansas

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To: Senate Committee on Financial Institutions and Insurance

Re: Senate Bill No. 205

It is requested that this bill be amended by adding the following words:

> "The plan shall include benefits comparable to medical benefits for those who rely upon spiritual means through prayer alone in accordance with a recognized religious method of healing permitted under the laws of this state."

Adding this provision will allow those who rely on spiritual healing to participate in the benefits of the plan. This seems fair because they certainly will not be excused from the required payments to support the plan.

Massachusetts, the only state with a similar plan in its statutes, does provide for payment where spiritual treatment is chosen in lieu of medical care. I understand that this plan has not yet been implemented and may be delayed by state financial problems.

I'm not sure where our proposed amendment can be inserted. I have confidence that the Revisor can find an appropriate location.

Thank you for considering this request.

This information also has been given to the Senate Committee on Public Health and Welfare.

Keith R. Landis
Committee on Publication
for Kansas

Attachment 2
FIII
3/6/91

LEAGUE OF WOMEN VOTERS OF KANSAS

919½ South Kansas Avenue Topeka, KS 66612 (913) 234-5152

SENATE FINANCIAL INSTITUTIONS AND INSURANCE
Senator Bond, Chairman
March 6, 1991

I'm Myrna Stringer, speaking on behalf of League of Women Voters of Kansas.

League of Women Voters of Kansas would like to go on record in support of the concepts included in Senate Bill 205, specifically under Section 4 (a) 6:

> "study and implementation of the most cost effective methods of providing comprehensive personal health services to all persons within this state, including increased reliance on primary and preventive care, community-based alternatives to institutional long-term careand increased emphasis on alternative providers and modes of care."

If a universal health care plan can provide up front primary and preventive health care for everyone in the state, the access issue is resolved; if the cost is based on ability to pay the affordability issue is answered.

We believe the state could spend no more than it is now spending on health care through the various programs it is trying to fund and in the long term would be able to cut back because basic, early access and preventive care simply is not as expensive as emergency room and crisis care.

The report--now a year old-- on Access To Services for the Medically Indigent and Homeless states "whether one views health care as a right or as a good investment, all Kansans should have access to a clearly defined set of basic health care services."

League of Women Voters of Kansas adopted a Medical Indigence position statement in February of 1989 which states that basic health care should be available to all citizens of Kansas; individuals should provide for their own care when feasible and affordable, though we recognize that some people are medically indigent, that is, uninsured, underinsured or for some reason unable to pay for health care. Our position also states: In the absence of federal action, the state should take the responsibility for devising a plan to care for the medically indigent in Kansas and that the state has the primary responsibility for providing funding and program guidelines for health care and health education.

Thank you.

Attachment 3
FIFI
3/6/91

DOUG WALKER
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STATE OF KANSAS

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS

MEMBER: CONFIRMATIONS
EDUCATION
ENERGY AND NATURAL RESOURCES
FEDERAL AND STATE AFFAIRS
PUBLIC HEALTH AND WELFARE

BILL EXPLANATION

SENATE BILL = 179

This bill includes 11 recommendations from the Governor's Commission on Health Care. They are:

=4: Require every insurance company to develope a community rate for all businesses they enroll with 50 or less employees.

=5: Prohibit exclusion of employees from a group due to pre-existing medical conditions (beyond eight months) at the formation of a newly enrolled group or business.

=6: Require provisions that assure portability of coverage should employees change employment and move from one small group to another.

=7: Prohibit insurers from excluding any employer group wishing to enroll.

=8: Grant insurers the ability to subrogate and coordinate benefits.

=9: Subject all insurers to the same insurance provisions.

=10: Regulate all insurers equally.

=11: Implement rate regulation for all insurers.

=12: Support and promote the implementation of H.B. 2610 and expand the program to cover employers with 50 or less employees.

=14: Provide a Medicaid "buy-in" option for individuals not eligible for Medicaid with annual incomes not exceeding 150% of the federal poverty level.

=15: Provide a Medicaid "buy-in" option for individuals unable to purchase health insurance due to health conditions.

Attachment 4
7 I + I
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Session of 1991

SENATE BILL No. 140

By Committee on Financial Institutions and Insurance

2-6

AN ACT concerning the uniform consumer credit code; additional charges and penalties on certain real estate transactions; amending K.S.A. 16a-2-509, 16a-2-510 and 16a-3-202 and K.S.A. 1990 Supp. 16a-2-501 and repealing the existing sections.

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

Section 1. K.S.A. 1990 Supp. 16a-2-501 is hereby amended to read as follows: 16a-2-501. (1) In addition to the finance charge permitted by the parts of this article on maximum finance charges for consumer credit sales and consumer loans (parts 2 and 4), a creditor may contract for and receive the following additional charges in connection with a consumer credit transaction:

(a) Official fees and taxes;

(b) charges for insurance as described in subsection (2);

(c) annual fees payable in advance or monthly fees, delinquency charges, insufficient check charges as provided in paragraph (e) of this subsection, over-limit fees and cash advance fees, for the privilege of using a lender credit card which entitles the user to purchase goods or services from at least 100 persons not related to the issuer of the lender credit card, under an arrangement pursuant to which the debts resulting from the purchases are payable to the issuer;

(d) charges for other benefits, including insurance, conferred on the consumer, if the benefits are of value to the consumer and if the charges are reasonable in relation to the benefits, are of a type which is not for credit, and are excluded as permissible additional charges from the finance charge by rules and regulations adopted by the administrator;

(e) a service charge for an insufficient check as defined and authorized by this subsection:

(i) For the purposes of this subsection, "insufficient check" means any check, order or draft drawn on any bank, credit union, savings and loan association, or other financial institution for the payment of money and delivered in payment, in whole or in part, of preexisting indebtedness of the drawer or maker, which is refused payment by the drawee because the drawer or maker does not have sufficient funds in or credits with the drawee to pay the amount of the check,

Attachment 5
H F I
3/6/91

...er or draft upon presentation, provided that any check, order or draft which is postdated or delivered to a payee who has knowledge at the time of delivery that the drawer or maker did not have sufficient funds in or credits with the drawee to pay the amount of the check, draft or order upon presentation shall not be deemed an insufficient check.

(ii) "Written notice" shall be presumed to have been given a drawer or maker of an insufficient check when notice is sent by restricted mail as defined by K.S.A. 60-103, and amendments thereto, addressed to the person to be given notice of such person's address as it appears on the insufficient check or to such person's last known address.

(iii) When an insufficient check has been given to a payee, the ...ayee may charge and collect a $10 insufficient check service charge from the drawer or maker if the payee has given the drawer or maker oral or written notice of demand that the amount of the insufficient check plus the $10 insufficient check service charge be paid to the payee within 14 days from the giving of notice.

(iv) If the drawer or maker of an insufficient check does not pay the amount of the insufficient check plus the insufficient check service charge provided for in subsection (iii) to the payee within 14 days from the giving of notice as provided in subsection (iii), the payee may add the $10 insufficient check service charge to the outstanding balance of the preexisting indebtedness of the drawer or maker to draw interest at the contract rate applicable to the preexisting indebtedness.

(2) An additional charge may be made for insurance written in connection with the transaction, including vendor's single interest insurance with respect to which the insurer has no right of subro...ation against the consumer but excluding other insurance protecting the creditor against the consumer's default or other credit loss:

(a) With respect to insurance against loss of or damage to property, or against liability, if the creditor furnishes a clear and specific statement in writing to the consumer setting forth the cost of the insurance if obtained from or through the creditor and stating that the consumer may choose the person through whom the insurance is to be obtained; and

(b) with respect to consumer credit insurance providing life, accident and health, or loss of employment coverage, if the insurance coverage is not a factor in the approval by the creditor of the ex...nsion of credit, and this fact is clearly disclosed in writing to the ...sumer, and if, in order to obtain the insurance in connection ...ith the extension of credit, the consumer gives specific affirmative

written indication of the consumer's desire to do so after written disclosure to the consumer of the cost thereof.

(3) An additional charge ~~of~~ 1% of the unpaid balance may be made for the prepayment of any loan evidenced by a note secured by a real estate mortgage where such prepayment is made within six months of the date of the execution of the loan contract.

Sec. 2. K.S.A. 16a-2-509 is hereby amended to read as follows: 16a-2-509. Subject to the provisions on rebate upon prepayment (section 16a-2-510) *and additional charges (section 16a-2-501)*, the consumer may prepay in full the unpaid balance of a consumer credit transaction at any time ~~without penalty~~.

Sec. 3. K.S.A. 16a-2-510 is hereby amended to read as follows: 16a-2-510. (1) Except as provided in subsection (2) *and subsection (3) of section 1 of this act*, upon prepayment in full of the unpaid balance of a precomputed consumer credit transaction, an amount not less than the unearned portion of the finance charge calculated according to this section shall be rebated to the consumer. If the rebate otherwise required is less than $1, no rebate need be made.

(2) Upon prepayment in full, but not upon a refinancing (section 16a-2-504), of a consumer credit transaction, whether or not precomputed, other than one pursuant to open end credit, the creditor may collect or retain a minimum charge of $5 in a transaction which had an amount financed of $75 or less, or $7.50 in a transaction which had an amount financed of more than $75, if the minimum charge was contracted for and the finance charge earned at the time of prepayment is less than the minimum charge contracted for. In those instances where the amounts financed are under or over $75 and the finance charge is less than the minimum provided therefor, then the finance charge so contracted may be retained as the minimum finance charge.

(3) The unearned portion of the finance charge shall be calculated according to the actuarial method on all consumer credit transactions made on and after July 1, 1988.

(4) For transactions in which payments are not scheduled to be made in substantially equal installments at equal periodic intervals, the administrator shall adopt rules and regulations consistent with this section providing for the calculation of the unearned portion of the finance charge.

(5) If a deferral (section 16a-2-503) has been agreed to, the unearned portion of the finance charge shall be computed without regard to the deferral. The amount of deferral charge earned at the date of prepayment shall also be calculated. If the deferral charge earned is less than the deferral charge paid, the difference shall be

not to exceed

in full

charge has been contracted for and the prepayment

without penalty, except when a loan contract secured by a real estate mortgage provides for a prepayment charge not to exceed 1% of the unpaid balance and the contract is paid in full within six months of the date of execution of the loan contract

Restate ref. to real es. & disclosure

added to the unearned portion of the finance charge. If any part of a deferral charge has been earned but has not been paid, that part shall be subtracted from the unearned portion of the finance charge or shall be added to the unpaid balance.

(6) This section does not preclude the collection or retention of delinquency charges (section 16a-2-502).

(7) If the maturity is accelerated for any reason and judgment is obtained, the judgment shall be taken in accordance with the provisions of K.S.A. 16-205, and amendments thereto.

(8) Upon prepayment in full of a consumer credit transaction by proceeds of consumer credit insurance (section 16a-4-103), the consumer or the consumer's estate is entitled to the same rebate as though the consumer had prepaid the agreement on the date the proceeds of the insurance are paid to the creditor, but no later than 10 business days after satisfactory proof of loss is furnished to the creditor.

Sec. 4. K.S.A. 16a-3-202 is hereby amended to read as follows: 16a-3-202. A written agreement which requires or provides for the signature of the consumer and which evidences a consumer credit transaction other than one pursuant to open end credit shall contain a clear, conspicuous, and printed notice to the consumer that ~~he~~ *one* should not sign the agreement before reading it, and that ~~he~~ *one* is entitled to a copy of the agreement and to prepay the unpaid balance at any time ~~without penalty~~. The following notice if clearly and conspicuously printed complies with this section:

NOTICE TO CONSUMER: 1. Do not sign this agreement before you read it. 2. You are entitled to a copy of this agreement. 3. You may prepay the unpaid balance at any time without penalty.

Sec. 5. K.S.A. 16a-2-509, 16a-2-510 and 16a-3-202 and K.S.A. 1990 Supp. 16a-2-501 are hereby repealed.

Sec. 6. This act shall take effect and be in force from and after its publication in the statute book.

without penalty, except when a loan contract secured by a real estate mortgage provides for a prepayment charge not to exceed 1% of the unpaid balance and the contract is paid in full within six months of the date of the execution of the loan contract

, unless the loan agreement is secured by a real estate mortgage and provides for a prepayment charge