Approved February 4, 1992
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

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

9:15 a.m./p.m. on Wednesday, January 29, 1992 in room 529-S of the Capitol.

All members were present except: Senators Bond, Francisco, Kerr, McClure, Moran, Parrish, Salisbury, Strick, and Yost.

Committee staff present:

Fred Carman, Revisor
Bill Wolff, Research
June Kossover, Secretary

Conferees appearing before the committee:

Richard Brock, State Insurance Department
David Hanson, National Association of Independent Insurors
George Dugger, Kansas Department on Aging
David Hanzlick, Kansas Dental Association

The meeting was called to order by Chairman Bond at 9:15 a.m.

The Chairman opened the hearing on **SB 518**, an act concerning medicare supplement policies.

Richard Brock, State Insurance Department, appeared before the committee to testify in favor of **SB 518**. Mr. Brock explained that **SB 518** is a "housekeeping" amendment necessitated by the Omnibus Reconciliation Act of 1990, which materially changed the process of federal certification of Medicare supplement policies. Therefore, the Kansas enabling act relating to minimum Medicare supplement standards needs to be amended to identify the current applicable federal law. (Attachment #1.)

Senator Salisbury made a motion, seconded by Senator Kerr, to report **SB 518** favorably and to place it on the Consent Calendar. The motion passed.

The Chairman opened the hearing on **SB 509**, an act concerning reporting requirements on product liability.

Mr. David Hanson, Kansas Insurance Association and the National Association of Independent Insurors, appeared before the committee in support of **SB 509**. This bill would change the filing date from March 15 to May 1 and allow companies that provide product liability insurance additional time to compile and file the reports, which are complicated. These reports require a substantial amount of information for each policy year from 1977 to the present. (Attachment #2.) Mr. Hanson and Mr. Brock explained the need for the reports dating back to 1977, the purpose of the reports and how the information is utilized. Since there were no further conferees, Chairman Bond declared the hearing on **SB 509** closed. Senator Salisbury made a motion to place **SB 509** on the Consent Calendar. Senator Parrish seconded the motion. The motion carried.

The Chairman opened the hearing on **SB 519**, an act concerning purchase of life insurance benefits, notice to beneficiary.

Richard Brock, Insurance Department, appeared before the committee in support of **SB 519**. Mr. Brock explained that since problems can be anticipated with the practice of policyholders selling life insurance benefits in exchange for naming the buyer as beneficiary, this bill has been developed as an interim protective measure. (Attachment #3.) Senator Salisbury expressed her concerns with attempting to address the problem before statistics are available to indicate the scope and extent of the problem. Chairman Bond

stated that the section which provides for notice to the beneficiary appears to recognize a property right of the beneficiary of an insurance policy when, in fact, there is no property right to the beneficiary, unless the beneficiary is irrevocable. The policy owner may change beneficiaries as often as he/she desires. An insurance policy cannot be considered as different from any other asset--it can be sold at any time, for any price. Senator McClure suggested that a full disclosure of implications and options should be made to the policy owner in section 2.

Mr. George Dugger, Department on Aging, appeared before the committee in support of **SB 519**. The KDOA suggests amending the bill to require that all companies subject to the bill be required to register with the Insurance Commissioner and to disclose to policyowners the possible tax consequences of the sale of their policy benefits and alternatives to such sale. (Attachment #4.)

There being no other conferees, Chairman Bond declared the hearing closed. Following discussion, Mr. Brock was requested to bring back to the committee language to replace section 2 in the bill that would more clearly define filing criteria and disclosure criteria for companies wishing to do business in Kansas.

Mr. David Hanzlick, Kansas Dental Association, appeared before the committee to request that a bill be introduced to require that any accident and sickness policy which provides coverage for any procedure involving a bone or joint of the skeletal structure also include the same coverage for any bone or joint of the face, neck or head. (Attachment #5). Chairman Bond advised that under legislation passed in 1990, K.S.A. 40-2248 and 2249, any mandate regarding health insurance policies issued in the state requires that prior to the Legislature considering any such mandates, an impact report must be prepared and that the Insurance Commissioner's office assist the party requesting additional mandates in providing information to the Legislature. Senator Yost made a motion, seconded by Senator Kerr, to introduce this legislation. The motion carried. The bill, however, will not be heard until the impact statement has been prepared and presented to the committee.

Richard Brock requested the committee to introduce proposal 14. Mr. Brock briefly explained that this proposal concerns small group insurance coverage. (Attachment #6). A motion was made by Senator Salisbury, seconded by Senator Yost, to recommend this legislation. Hearings are tentatively scheduled for the week of February 10, 1992.

Mr. Fred Carman, Revisor's Office, requested the committee to introduce a technical corrections bill defining unfair methods of competition and unfair or deceptive acts or practices in the business of insurance. A motion was made by Senator Yost and seconded by Senator Moran to introduce this bill. The motion carried.

The committee adjourned at 10:00 a.m.

GUEST LIST

SENATE

COMMITTEE: FINANCIAL INSTITUTIONS AND INSURANCE DATE: 1-29-92

NAME	ADDRESS	ORGANIZATION
Dave Hanson	Topeka	NATI & Ks Ins Assns
Lee Wright	Overland Park	Farmers Ins. Group
George Dugge-	Topeka	Dept. of Ag. Ins
Dick Brock	"	Ins Dept
Bill Sneed	Topeka	State Farm
Anita Larson	Topeka	SBG, Inc
David Hanzlick	Topeka	Kansas Dental Ass'n
George Gaeckel	Topeka	AARP-SLC-NOTF
David A. Ross	Topeka	Kans. Assn. Life Underwriters
M. Hawver		Cap-Journal
Glenn Deck	Topeka	Treasurer's Office
Ken Bahn	Topeka	Ks. Hospital Assn
Lori Callahan	Topeka	Kammco

Testimony by

Dick Brock, Kansas Insurance Department

Before the Senate Financial Institutions and Insurance Committee

Senate Bill No. 518

Senate Bill No. 518 is simply a housekeeping amendment necessitated by the Omnibus Reconciliation Act of 1990 (OBRA 90). Since 1981 insurance policies designed to supplement Medicare have been subject to a federal certification program whereby if the Medicare supplement policies sold in a state do not conform to certain federal standards, the Health Care Financing Administration could, in effect, assume regulatory control over the policies issued in that state. Although a clear misnomer, this was considered to be a voluntary certification program prior to the 1990 change. However, OBRA 90 materially changed the process and, for that reason, the Kansas enabling act relating to minimum Medicare supplement standards needs to be amended to identify the current applicable federal law.

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ATTACHMENT 1

TESTIMONY ON S.B. 509

January 28, 1992

The Senate Committee on Financial Instutions
and Insurance

Re: Senate Bill 509

Chairman Bond and Members of the Committee:

On behalf of the National Association of Independent Insurers, we would request your favorable consideration of Senate Bill 509. Current law requires all insurance companies that provide product liability insurance to file annual reports with the Commissioner of Insurance by March 15. These reports require a substantial amount of information for each policy year from 1977 on. Senate Bill 509 simply changes the due date and allows these reports to be filed by May 1 of each year. This additional time will certainly help insurers as they prepare and submit the rather complicated reports. We understand that the Commissioner of Insurance is not opposed to this amendment. We would therefore request your passage of Senate Bill 509.

Thank you for your consideration.

Very truly yours,

David A. Hanson

DAVID A. HANSON

DAH:ryp 3138K

FI+I 1-29-92
ATTACHMENT #2

128-S

STATE OF KANSAS

JOAN FINNEY, GOVERNOR
GLORIA M. TIMMER, Director

DIVISION OF THE BUDGET
Room 152-E
State Capitol Building
Topeka, Kansas 66612-1578

(913) 296-2436
FAX (913) 296-0231

January 29, 1992

The Honorable Richard Bond, Chairperson
Committee on Financial Institutions and Insurance
Senate Chamber
Third Floor, Statehouse

Dear Senator Bond:

SUBJECT: Fiscal Note for SB 509 by Committee on Financial Institutions and Insurance

In accordance with KSA 75-3715a, the following fiscal note concerning SB 509 is respectfully submitted to your committee.

SB 509 proposes to amend KSA 40-1132 by changing the date that insurance companies must file product liability insurance reports with the Insurance Department. Under SB 509, the annual filing date for such reports would be changed from "January 1, or within 60 days thereafter" to "before May 1."

SB 509 would not fiscally impact state operations.

Sincerely,

Gloria M. Timmer

Gloria M. Timmer
Director of the Budget

cc: Ron Nitcher, Insurance Department

4449

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Testimony by
Dick Brock, Kansas Insurance Department
Before the Senate Financial Institutions and Insurance Committee
Senate Bill No. 519

As Commissioner Todd noted when he requested introduction of this proposal, Senate Bill 519 addresses the practice of a person, or organization paying a lump sum to a life insurance policyholder in an amount equal to some percentage of the expected benefits under a life insurance policy in exchange for that person or organization being named as the beneficiary under the policy.

Currently, this can be done by anyone from anywhere without any standards, disclosure or any other restrictions on the transaction. The practice first became visible in New Mexico 2 or 3 years ago, has since spread to California and, because the Insurance Department has received an inquiry from a firm engaged in this activity, is obviously an expanding business.

We have received no complaints from policyholders and beneficiaries and we don't want to infer that by proposing Senate Bill No. 519 we believe the activity is inherently bad. In fact, it can be advantageous in some situations as evidenced by the 1990 legislative action which permits life insurance companies to include accelerated benefit provisions in their Kansas policies. Given the relatively recent development of this activity, I suspect the vast majority, perhaps even all, the organizations currently engaged in this business are doing so with the utmost of good faith and fairness. Nevertheless, when a particular activity is directed solely toward the elderly and terminally ill people, the chances for abuse are high and become higher as more and more entrepreneurs become aware of it.

We will be the first to admit that we don't know exactly what should be done. California has enacted legislation requiring the persons and firms involved in this business to register and file a description of their operations with the Insurance Department. From that information, the

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ATTACHMENT #3

California department plans to develop what they hope will be practical and effective consumer safeguards. The National Association of Insurance Commissioners has a working group addressing the subject but no recommendations have yet been developed or adopted. Nevertheless, we don't believe we should wait until some Kansas citizen is deprived of what may be one of their most significant assets before we at least address the potential problem.

Senate Bill No. 519 is, we believe, a minimal measure that will not unduly interfere with completion of a legitimate transaction but will (1) in many, probably most cases, make another interested party aware of the transactions and (2) provide the policyholder a 3 day "cooling off" period during which they may cancel the sale. It seems to us that if we can give a person who buys a $30 can opener from a door to door salesman a 3 day cooling off period, we should be able to do at least that much for a person who, in effect, sells their life insurance protection.

To make this limited restriction even less onerous, we have included in Senate Bill No. 519 an arbitrary standard of fairness by providing that the notice and "cooling off" provisions do not apply if the policyholder is paid at least 90% of his or her expected benefits. We really don't know if 90% is in the ballpark of the going price or not -- perhaps a better way would be to exempt policies with a death benefit of less than "X" amount or perhaps we should just require the notice and "cooling off" period on all such transactions.

In any event, we are quite certain this activity is going to present a problem to some Kansas citizens if it is not subjected to some kind of requirements. For that reason, we have developed and recommend enactment of Senate Bill No. 519 at least as an interim protective measure that can, of course, be reevaluated and changed as necessary once we know more about this emerging business.

KANSAS DEPARTMENT ON AGING
TESTIMONY ON SB 519
TO THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
JANUARY 29, 1992

The Kansas Department on Aging (KDOA) supports SB 519 as a first step in providing some consumer protection to persons who may be considering selling their current life insurance policy. KDOA believes that some additional consumer safeguards would be appropriate and we will suggest some amendments later in our testimony.

While the practice of purchasing life insurance policies of typically terminally ill persons is relatively new and reports of abuse are few, we believe it is important to take a preventative approach and implement basic protections now. Persons facing both terminal illnesses and financial problems at the same time may frequently be unable to make informed choices without some regulatory safeguards.

SB 519 recognizes this and provides for a third part notification and a cancellation period. We have concerns with these provisions as currently drafted. We recommend that the notice be provided within 3 days of the date the policyowner signs the sale agreement and that the cancellation period be at least 15 days beginning with that date. As currently written, a person purchasing a policy could delay payment past three days and the cancellation period would lapse before the beneficiary is notified.

KDOA also suggests the following amendments:

-all persons subject to this bill be required to register with the Insurance Commissioner; and

-all persons subject to this bill be required to disclose to policyowners the possible tax and public benefits consequences of the sale of their policy and possible alternatives to such sale including options that might be available through their existing insurer.

These suggested amendments provide additional protection for consumers without unnecessarily burdening persons who wish to purchase life insurance policies. We urge the committee to adopt these amendments and report SB 519 as amended favorably.
Thank you for the opportunity to present comments on this bill.
I would be happy to answer any questions you may have.

FI+I 1-29-92
Attachment #4

KANSAS DENTAL ASSOCIATION

An act concerning accident and health insurance; relating to the non-discriminatory coverage of skeletal joints.

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

Section 1. Any policy of accident and sickness insurance delivered or issued for delivery to any person in this state that provides coverage for any diagnostic, therapeutic or surgical procedure involving a bone or joint of the skeletal structure shall include the same coverage for the same diagnostic, therapeutic or surgical procedure involving any other bone or joint of the face, neck or head.

Section 2. This act shall take effect and be in force from and after July 1, 1992.

5200 Huntoon
Topeka, Kansas 66604
913-272-7360

FI+I 1-29-92
Attachment #5

Explanatory Memorandum
Legislative Proposal No. 14

As a complement to 1991 House Bill 2001, the Insurance Department, in consultation with a task force created by Commissioner Todd and comprised of representatives from insurance companies, health maintenance organizations, insurance agents, benefit plan administrators and insureds, has developed Legislative Proposal No. 14 which incorporates the following components:

--- A requirement that any insurer participating in the small group health insurance business in Kansas may not decline to insure any applicant for basic coverage.

--- A reinsurance pool which permits insurers to spread the loss exposure presented by a group which would otherwise be refused coverage among all insurers participating in the small group market.

--- Underwriting restrictions comparable to those in 1991 House Bill 2001.

--- Rating restrictions which provide:

. Rates can vary by no more than 25% from the median between the highest rates charged any group and the lowest rated groups in any given class.

. The median rate for any class of business can be no more than 20% higher than the rate applicable to the lowest rated class.

. The maximum increase a small employer can receive in any year would be the difference between the current rate and the rate charged a new group in the same class plus 15%.

. A prohibition against forcing an employer group to transfer from one rating classification to another.

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Attachment #6

LEGISLATIVE PROPOSAL NO. 14

AN ACT relating to insurance; accident and sickness insurance; small employers; group coverage; rating restrictions; requirements; definitions.

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

Section 1. Purpose. The purpose and intent of this act are to promote the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of preexisting condition exclusions, to provide for development of "basic" and "standard" health benefit plans to be offered to all small employers, to provide for establishment of an allocation program, and to improve the overall fairness and efficiency of the small group health insurance market.

The act is not intended to provide a solution to the problem of affordability of health care or health insurance.

Sec. 2. Preamble. The provisions of this act shall apply to health benefit plans covering small employers as defined herein. Where the provisions of K.S.A. 1991 Supp. 40-2209 are not inconsistent with these provisions, they shall be construed as supplemental to and not in derogation or limitation of any requirements, prohibitions or restrictions contained herein.

Sec. 3. Definitions. As used in this act,

(a) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of section 7 of this act, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(b) "Approved service area" means a geographical area, as approved by the commissioner to transact insurance in this state, within which the carrier is authorized to provide coverage.

(c) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(d) "Basic small employer health care plan" means a health benefit plan developed by the board pursuant to section 9 of this act.

(e) "Board" means the board of directors of the program.

(f) "Carrier" or "small employer carrier" means any insurance company, nonprofit medical and hospital service corporation, nonprofit optometric, dental, and pharmacy service corporations, municipal group-funded pool, fraternal benefit society or health maintenance organization, as these terms are defined by state law, that offers health benefit plans covering eligible employees of one or more small employers in this state.

(g) "Case characteristics" means, with respect to a small employer, the geographic area in which the employees reside; the age and sex of the individual employees and their dependents; the appropriate industry classification as determined by the carrier, and the number of employees and dependents and such other objective criteria as may be approved family composition by the commissioner. "Case characteristics" shall not include claim experience, health status and duration of coverage since issue.

(h) Class of business" means all or a separate grouping of small employers established pursuant to section 6.

(i) "Commissioner" means the commissioner of insurance.

(j) "Department" means the insurance department.

(k) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefits plan covering such employee and the dependent eligibility standards established by the board.

(l) "Eligible employee" means an employee who works on a full-time basis, with a normal work week of 30 or more hours, and includes a sole proprietor, a partner of a partnership or an independent contractor, provided such sole proprietor, partner or independent contractor is included

as an employee under a health benefit plan of a small employer but does not include an employee who works on a part-time, temporary or substitute basis.

(m) "Financially impaired" means a member which, after the effective date of this act, is not insolvent but is:

(1) Deemed by the commissioner to be in a hazardous financial condition pursuant to K.S.A. 40-222d; or

(2) placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(n) "Health benefit plan" means any hospital or medical expense policy, health, hospital or medical service corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans. "Health benefit plan" does not include policies or certificates covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(o) "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(p) "Initial enrollment period" means the period of time specified in the health benefit plan during which an individual is first eligible to enroll in a small employer health benefit plan. Such period shall be no less favorable than a period beginning on the employee's or member's date of initial eligibility and ending 31 days thereafter.

(q) "Late enrollee" means an eligible employee or dependent who requests enrollment in a small employer's health benefit plan following the initial enrollment period provided under the terms of the first plan for which such employee or dependent was eligible through such small employer, provided an eligible employee or dependent shall not be considered a late enrollee if:

(1) The individual:

(A) Was covered under another employer-provided health benefit plan at the time the individual was eligible to enroll;

(B) states, at the time of the initial eligibility, that coverage under another employer health benefit plan was the reason for declining enrollment;

(C) has lost coverage under another employer health benefit plan as a result of the termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce; and

(D) requests enrollment within 31 days after the termination of coverage under another employer health benefit plan, or

(2) the individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period, or

(3) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made within 31 days after issuance of such court order.

(r) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(s) "Plan of operation" means the articles, bylaws and operating rules of the program adopted by the board pursuant to section 11 of this act.

(t) "Pre-existing conditions provision" means a policy provision which excludes or limits coverage for charges or expenses incurred during a specified period not to exceed one year following the insured's effective date of coverage as to a condition or related conditions for which diagnosis, treatment or advice was sought or received in the six months immediately preceding the effective date of coverage.

(u) "Premium" means monies paid by a small employer or eligible employees or both as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(v) "Program" means the Kansas small employer health reinsurance program, established under section 11 of this act.

(w) "Rating period" means any term for which a SEHC plan policy is issued but any term of less than one year shall be considered as a full year.

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(x) "SEHC plan" means the Kansas small employer health care plan which shall be a health benefit plan for small employers established by the board in accordance with section 10 of this act.

(y) "Service waiting period" means a period of time after full-time employment begins before an employee is first eligible to enroll in any applicable health benefit plan offered by the small employer.

(z) "Small employer" means any person, firm, corporation, partnership or association eligible for group sickness and accident insurance pursuant to K.S.A. 1991 Supp. 40-2209(A) actively engaged in business whose total employed work force consisted of, on at least 50 percent of its working days during the preceding year, no more than 25 eligible employees, the majority of whom were employed within the state. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer. Except as otherwise specifically provided, provisions of this act which apply to a small employer which has a health benefit plan shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this definition.

(aa) "Standard small employer health care plan" means a basic SEHC plan with specified benefit enhancements and such deductible and coinsurance provisions as may be developed by the board pursuant to section 10 of this act.

(bb) "Affiliate" or "affiliated" means an entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

Sec. 4. Applicability and scope.

(a) Any individual or group health benefit plan issued to a group authorized by K.S.A. 1991 Supp. 40-2209(A) shall be subject to the provisions of this act if it provides health care benefits covering employees of a small employer and if it meets any one of the following conditions:

(1) Any portion of the premium is paid by a small employer, or any covered individual, whether through wage adjustments, reimbursement, withholding or otherwise; or

(2) the health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purposes of section 162 or section 106 of the United States internal revenue code.

(b) For purposes of this act an aggregation of two or more small employers covered under a trust arrangement or a policy issued to an association of small employers pursuant to K.S.A. 40-2209(A)(3) or (5) shall permit employee or member units of three but no more than 25 employees or members and their dependents to participate in any health benefit plan to which this act applies. Any group which includes employee or member units of 25 or fewer employees shall be subject to the provisions of this act notwithstanding its inclusion of employee or member units with more than 25 employees or members.

(c) Except as expressly provided for in this act, no law requiring the coverage or the offer of coverage of a health care service or benefit and no law requiring the reimbursement, utilization, or consideration of a specific category of a licensed or certified health care practitioner shall apply to any SEHC plan offered or delivered to a small employer.

(d) Except as expressly provided in this act, no health benefit plan offered to a small employer shall be subject to:

(1) Any law that would inhabit any carrier from contracting with providers or groups of providers with respect to health care services or benefits;

(2) any law that would impose any restriction on the ability to negotiate with providers regarding the level or method of reimbursing care or services provided under the health benefit plan.

(e) Individual policies of accident and sickness insurance issued to individuals and their dependents totally independent of any group, association or trust arrangement permitted under K.S.A. 1991 Supp. 40-2209 shall not be subject to the provisions of this act.

Sec. 5. Underwriting requirements. Health benefit plans covering small employers that are issued or renewed within this state or outside this state covering persons residing in this state shall be subject to the following provisions, as applicable:

(a) Pre-existing conditions provisions shall not exclude or limit coverage for a period beyond 12 months following the individual's effective date of coverage and may only relate to conditions or related conditions for

which diagnosis, advice or treatment was sought, during the six months immediately preceding the effective date of coverage.

(b) Such policy may impose a waiting period, not to exceed one year for benefits for conditions, including related conditions, for which diagnosis, treatment or advice was sought or received in the six months prior to the effective date of coverage. Such policy shall waive such a waiting period to the extent the employee or member or individual dependent or family member was covered by a group sickness and accident policy prior to the effective date of coverage with no gap in coverage.

(c) Any health benefit plan issued, delivered or renewed within this state and subject to the provisions of this act, shall be renewable with respect to all eligible employees or dependents at the option of the policyholder, contractholder, or small employer, except for:

(1) Nonpayment of the required premiums by the policyholder, contractholder, or employer; or

(2) fraud or misrepresentation of the policyholder, contractholder, or employer or, with respect to coverage of individual insureds, the insureds or their representatives; or

(3) noncompliance with health benefit plan provisions; or

(4) when the total number of insured individuals covered under all of the health benefit plans of any one employer is less than the total number of individuals or percentage of individuals required by participation requirements under any specific health benefit plan of that employer;

(5) when a material and significant change in the risk characteristics of the group has occurred because the small employer is no longer actively engaged in the business in which it was engaged on the policy's effective date; or

(6) when the carrier ceases doing business in the small employer market; provided, however, that the following conditions are met:

(A) Notice of the decision to cease to do business in the small employer market is provided to the department, the board, to either the policyholder or contractholder, and the employer;

(B) health benefit plans subject to this act shall not be canceled by the carrier for one year after the date of the notice required under subparagraph 5(c)(6)(A) above unless the business has been sold to another carrier; and

(C) a carrier that ceases to do business in the small employer marketplace is prohibited from re-entering the small employer marketplace for a period of five years from the date of the notice required under subparagraph 5(c)(6)(A) above.

(d) Notwithstanding subsection 5(c) above pertaining to renewability, any such health benefit plan or any coverage provided to any individual covered by such a plan subject to the provisions of this act may be rescinded for fraud, material misrepresentation, or concealment by an applicant, employee, dependent, or small employer.

(e) A carrier shall not exclude any dependent, who would otherwise be covered under a health benefit plan on the basis of an actual or expected health condition of such person; but a carrier shall be allowed to exclude a late enrollee.

(f) Except as expressly provided by this act, every carrier doing business in the small employer market retains the authority to underwrite and rate individual accident and sickness insurance policies; and rate small employer groups using generally accepted actuarial practices.

(g) No health benefit plan issued by a carrier may limit or exclude, by use of a rider or amendment applicable to a specific individual, coverage by type of illness, treatment, medical condition, or accident, except for pre-existing conditions or diseases as permitted under subsection 5(a) of this act.

(h) In the absence of the small employer's decision to the contrary, all health benefit plans shall make coverage available to all the eligible employees of a small employer without a service waiting period. The decision of whether to impose a service waiting period for eligible employees of a small employer shall be made by the small employer, who may only choose from the service waiting periods offered by the carrier. No service waiting period shall be greater than 90 days or three calendar months and shall permit coverage to become effective no later than the first day of the month immediately following completion of the service waiting period.

(i) The benefit structure of any health benefit plan subject to the provisions of this act may be changed by the carrier to make it consistent with the benefit structure contained in health benefit plans developed by

the board for marketing to new groups but this shall not preclude the development and marketing of other health benefit plans to small employers.

(j)(1) Except as provided in subparagraph (d), requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(2) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(3)(A) Except as provided in clause (B), in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

(B) With respect to a small employer, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by such small employer in applying minimum participation requirements.

Sec. 6. Establishment of classes of business.

(a) A small employer carrier may establish a class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(1) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers;

(2) the small employer carrier has acquired a class of business from another small employer carrier; or

(3) the small employer carrier provides coverage to one or more association groups that meet the requirements of K.S.A. 1991 Supp. 40-2209(A)(5).

(b) A small employer carrier may establish up to nine separate classes of business under subsection (a).

(c) The commissioner may establish regulations to provide for a period of transition in order for a small employer carrier to come into compliance

with subsection (b) in the instance of acquisition of an additional class of business from another small employer carrier.

(d) The commissioner may approve the establishment of additional classes of business upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer marketplace.

Sec. 7. Rating requirements.

(a) Premium rates applicable to Kansas residents for health benefit plans subject to this act shall be subject to the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20 percent.

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than 25 percent of the index rate.

(3) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(B) any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

(C) any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(4) Adjustments in rates for claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(5) A small employer carrier may utilize industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification shall not exceed the lowest rate factor associated with any industry classification by more than 30 percent for the first three years immediately following the date the program becomes operational and 15 percent thereafter.

(6) In the case of health benefit plans issued prior to the effective date of this act, a premium rate for a rating period may exceed the ranges set forth in subsections (a)(1) and (2) for a period of three years following the effective date of this act. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(A) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

(B) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the carrier's rate manual for the class of business.

(7)(A) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(B) A small employer carrier shall treat all health benefit plans issued or renewed in a class of business in the same calendar month as having the same rating period.

(8) For the purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs.

(9) A small employer carrier shall not use case characteristics, other than age, gender, industry, geographic area, family composition, and group size without prior approval of the commissioner.

(10) The commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this act, including:

(A) Assuring that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans; and

(B) prescribing the manner in which case characteristics may be used by small employer carriers.

(b) A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage.

(c) The commissioner may suspend for a specified period the application of subsection (a)(1) as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

(d) Upon written application of the group policyholders, the commissioner may suspend the application of section 6 and section 7 of this

act to any group whose fundamental structure or composition would otherwise be adversely affected.

Sec. 8. Disclosure. In connection with the offering for sale of any health benefit plan to a small employer, each carrier shall make a reasonable disclosure as part of its solicitation and sales materials, of:

(a) The extent to which premium rates for a specific small employer are established or adjusted in part based upon the actual or expected variation in claims costs or actual or expected variation in health condition of the employees and dependents of such small employer;

(b) the provisions concerning such carrier's right to change premium rates and the factors other than claims experience which affect changes in premium rates; and

(c) provisions relating to renewability of policies and contracts; and

(d) the provision relating to any preexisting condition provision.

Sec. 9. Actuarial certification. Compliance with the underwriting and rating requirements contained in this act shall be demonstrated through actuarial certification. Carriers offering health benefit plans to small employers shall on or before March 15 file annually with the commissioner an actuarial certification stating that the underwriting and rating methods of the carrier:

(a) Comply with accepted actuarial practices;

(b) are uniformly applied to health benefit plans covering small employers; and

(c) comply with the provisions of this act.

Sec. 10. Small employer health care (SEHC) plans.

(a) Subject to approval by the commissioner, the board shall design the basic and standard SEHC plans which shall be eligible for reinsurance under the program. The board shall establish the form and level of coverage(s) to be made available by carriers in the SEHC plans. In designing the SEHC plans the board shall also establish benefit levels, deductibles, coinsurance factors, exclusions, and limitations for the SEHC plans and shall also incorporate such modifications as may be necessary to accommodate the method of operation and benefit plans of health maintenance organizations including any restrictions or requirements imposed by federal law. Section 4(c) of this act shall only apply to the SEHC plans designed and established pursuant to this section. The forms and levels of coverage

established by the board shall specify which components of a health benefit plan offered by a small employer carrier may be reinsured.

(b) The board shall submit such plans to the commissioner for the commissioner's approval within 180 days after the appointment of the board pursuant to section 11 of this act. Such SEHC plans may include cost containment features including, but not limited to:

(1) Utilization review of health care services, including review of the medical necessity of hospital and physician services;

(2) case management benefit alternatives;

(3) selective contracting with hospitals, physicians, and other health care providers;

(4) reasonable benefit differentials applicable to participating and nonparticipating providers; and

(5) other provisions for the cost effective management of SEHC plans.

(c) The SEHC plan established for use by health maintenance organizations shall be consistent with the basic method of operation of health maintenance organizations.

(d) After the commissioner's approval of the SEHC plans submitted by the board, and in lieu of any procedure to the contrary established by law, any carrier may certify to the commissioner, in the form and manner prescribed by the commissioner, that the SEHC plans filed by the carrier are in substantial compliance with the provisions in the corresponding approved board plan. Upon receipt by the department of such certification, the carrier may use such certified plans until such time as the commissioner, after notice and hearing, disapproves their continued use.

(e) No later than May 1, 1993 and the commissioner's approval of the small employer health care plans submitted by the board, every carrier issuing or maintaining health benefit plans covering small employers shall, as a condition of transacting such business in this state, offer at least two small employer health care plans that are developed by the board and approved by the commissioner. One health benefit plan offered by each small employer carrier shall be a basic small employer health care plan and one plan shall be a standard small employer health care plan. Every small employer which elects to be covered under such plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the carrier. Provided, however, carriers

whose bylaws or charters do not permit them to issue coverage on a marketwide basis shall only by required to guarantee issue to those small employers that meet the requirements of their charter or bylaws. Charter provisions which prohibit issuance to specific populations based on health status or health risk shall not be considered as exceptions to the requirements of this subsection.

(f) Health maintenance organizations shall not be required to offer coverage or accept applications pursuant to subsection 8(e) of this section in the case of any of the following:

(1) To a group, where the group is not physically located in the health maintenance organization's approved service area;

(2) to an employee, where the employee does not reside within the health maintenance organization's approved service area;

(3) within an area where the health maintenance organization reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not, within that area, have the capacity in its network of providers to deliver services adequately to the members of such groups because of its obligations to existing group contract holders and enrollees.

(g) A health maintenance organization that does not offer coverage pursuant to section 10(f)(3) of this act shall not offer coverage in the applicable area to new cases of employer groups with more than 25 eligible employees until the later of 90 days after each such refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services to small employer groups.

(h) A carrier shall not be required to offer coverage or accept applications pursuant to section 10(e) of this act where the commissioner finds that acceptance of an application or applications would place the carrier in a financially impaired condition, provided; however, that a carrier that has not offered coverage or accepted applications pursuant to this subsection shall not offer coverage or accept applications until the later of 180 days or a determination by the commissioner that the carrier is no longer financially impaired.

Sec. 11. Reinsurance program.

(a) There is established a non-profit entity to be known as the "Kansas small employer health reinsurance program". All carriers issuing or

maintaining health benefit plans in this state on or after the effective date of this act shall be members of the program.

(b) Within 60 days following the effective date of this section, the commissioner shall give notice to all members of the time and place for the initial organizational meeting, which shall take place within 120 days following the effective date of this act. The members shall select the initial board subject to approval by the commissioner. The board shall consist of 11 members who shall serve staggered terms as determined by the program's plan of operation. At least two-thirds of the members of the board shall be small employer carriers. In the event there are not sufficient small employer carriers to serve on the board, the remaining seats shall be filled by any insurer, health maintenance organization, group-funded pool or nonprofit medical and hospital service plan offering health benefit plans in this state. The board shall include:

(1) The carrier writing the largest market share of group health insurance written premiums during the last 12 full calendar months immediately preceding selection;

(2) a carrier whose principal health insurance business is in the small employer market;

(3) a carrier whose principal health insurance business is in the large employer market;

(4) nonprofit medical and hospital service corporation;

(5) a health maintenance organization;

(6) a licensed resident agent actively involved in the solicitation and sale of health benefit plans for small employers;

(7) a representative of small employers; and

(8) following the first full year of operation, a majority of the board shall, to the extent possible, be reinsuring carriers.

The commissioner shall be an ex-officio member of the board. In approving the selection of the board, the commissioner shall assure that all members of the program are fairly represented. The membership of all boards subsequent to the initial board shall, to the extent possible, reflect the same distribution described above.

(c) If the initial board is not elected at the organizational meeting, the commissioner shall appoint the initial board within 30 days of the organizational meeting.

(d) Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation, and thereafter any amendments thereto necessary or suitable, to assure the fair, reasonable and equitable administration of the program. The commissioner shall, after notice and hearing, approve the plan of operation provided the commissioner determines it to be suitable to assure the fair, reasonable and equitable administration of the program and provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of subsection (k) of this section. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this section shall be made available. Any plan of operation, or amendments thereto, submitted to the commissioner by the board pursuant to this subsection shall be deemed approved by the commissioner if not expressly disapproved in writing by the commissioner within 90 days of its receipt by the commissioner.

(e) If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The commissioner shall amend or rescind any plan adopted by the commissioner under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.

(f) The plan of operation shall establish rules, conditions, and procedures for:

(1) The handling and accounting of assets and moneys of the program and for an annual fiscal reporting to the commissioner;

(2) filling vacancies on the board, subject to the approval of the commissioner;

(3) selecting an administering insurer which shall be a carrier as defined in subsection 3(f) of this act and setting forth the powers and duties of the administering insurer;

(4) reinsuring risks in accordance with the provisions of this section;

(5) collecting assessments subject to subsection (k) of this section from all members to provide for claims reinsured by the program and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made;

(6) providing protection for carriers from the financial risk associated with small employers that present poor credit risks;

(7) establishing standards for the coverage of small employers that have high turnover employees;

(8) establishing an appeals process for carriers to seek relief when a carrier has experienced an unfair share of administrative and credit risks;

(9) determining the adjusted average market premium prices for SEHC plans sold in this state;

(10) establishing participation standards at issue and renewal for reinsured cases;

(11) establishing standards for those conditions under which a carrier would not be required to write business received from a particular agent or broker;

(12) establishing reporting requirements for carriers, agents, brokers and third party administrators that will reasonably measure the distribution of individuals and groups covered by a health benefit plan developed by the board and risks reinsured by the program; and

(13) any additional matters at the discretion of the board.

(g) The program shall have the general powers and authority granted under the laws of the state to insurance companies licensed to transact health insurance except the power to issue insurance. In addition the board shall have the specific authority to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this section, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions, or with persons or other organizations for the performance of administrative functions;

(2) sue or be used, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against any program or board member;

(3) take such legal action as necessary to avoid the payment of improper claims against the program;

(4) design the basic and standard small employer health care plans for which reinsurance will be provided and issue reinsurance policies in accordance with the requirements of this act;

(5) establish rules, conditions and procedures pertaining to the reinsurance of members' risks by the program including such variations as may be necessary to be compatible with the operation of health maintenance organizations;

(6) establish adequate and appropriate rates, rate schedules, rate adjustments, rate classifications and any other actuarial functions appropriate to the operation of the program;

(7) assess members in accordance with the provisions of subsection (k) of this section, and to make such advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any such interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

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

(9) borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

(h) Any member may reinsure coverage of any small employer group with the program provided:

(1) With respect to an SEHC plan, the program shall reinsure the level of coverage provided;

(2) with respect to other plans delivered, or issued to small employers on and after the date the program becomes operational, the program shall reinsure the level of coverage provided up to, but not exceeding, the level of coverage provided in a SEHC plan;

(3) with respect to the coverage provided to small employers issued after the effective date of this act, the carrier shall be required to use high-cost case management, hospital precertification techniques, and other cost containment techniques as established by the program;

(4) with respect to eligible employees and their dependents, a carrier may reinsure the entire employer group within 60 days of the commencement of the group's coverage under the plan;

(5) if, following the first 12 calendar months of operation, the board determines that permitting carriers to reinsure individual employees or

dependents is in the best interests of small employers, carriers or covered participants as a whole, the board may, with the approval of the commissioner, authorize the offering or issuance of reinsurance on individual employees and dependents. Such authorization shall incorporate provisions necessary to implement the authorization including but not limited to the commencement of the reinsurance coverage with respect to eligible employees and dependents who: (A) are covered by a SEHC plan that is not reinsured by the program at the time the authorization becomes effective; (B) are hired subsequent to the commencement of an employer's SEHC coverage; (C) are employed by a small employer as of the date the employer's SEHC plan coverage commences; or (D) are late enrollees. The authority to reinsure individual employees or dependents shall become effective on all policies issued, renewed or continued on and after 45 calendar days following the commissioner's approval and shall remain in effect unless removed by the board with the commissioner's approval;

(6) if an employer group is covered under a plan other than an SEHC plan and the carrier chooses to reinsure the group subsequent to the effective date of this act the carrier cannot force the employer to change to a small employer health care benefit plan. The carrier must allow the employer to maintain the same benefit plan and reinsure only the portion of the plan consistent with an SEHC plan.

(i) Premium rates charged for coverage reinsured by the program shall be established by the board created pursuant to subsection (b) of this section.

(j) The reinsurance program shall not reimburse a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier has paid a deductible of or delivered services equal to $10,000 in a calendar year for benefits covered by the program. In addition, the participating carrier shall retain 10% of the next $50,000 of benefit payments or services per reinsured employee or dependent during a calendar year and the program shall reinsure the remainder. A participating carrier's liability under this paragraph shall not exceed, in any one calendar year, a maximum amount equal to 20% of the total health benefit plan premiums earned in this state from health benefit plans covering small employers during the immediately preceding calendar year. Subject to the approval of the commissioner, the board may adjust the deductible, retention

percentage, or maximum limit to achieve better operating results under the program.

(k)(1) Following the close of each fiscal year, the administering insurer shall determine the net premiums, the program expenses for administration and the incurred losses, if any, for the year, taking into account investment income and other appropriate gains and losses. Health benefit plan premiums and benefits paid by a member that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments. For purposes of this subsection, "net premiums" means health benefit plan premiums, less administrative expense allowances.

(2) Any net loss for the year shall be recouped first by assessments of members to the extent provided below:

(A) Assessments shall first be apportioned by the board among all carriers utilizing the program in proportion to their respective shares of the total health benefit plan premiums earned in this state from health benefit plans covering small employers during the calendar year coinciding with or ending during the fiscal year of the program, or on any other equitable basis reflecting coverage of small employers as may be provided in the plan of operation. An assessment shall be made pursuant to this subsection against a health maintenance organization including those approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. 300 et seq. in accordance with an assessment formula adopted by the board and approved by the commissioner for health maintenance organizations. Such assessment formula shall recognize the restrictions imposed on health maintenance organizations by federal law and shall be adopted by the board and approved by the commissioner prior to the first anniversary of the program's operation.

(B) To the extent any such net loss is not recouped from the assessments levied under section 11(k)(2)(A) an assessment shall be apportioned by the board among all insurers, health maintenance organizations, municipal group funded pools and nonprofit medical and hospital service corporations in proportion to their respective shares of total health insurance premiums received in this state for hospital or medical expense policies, certificates, subscriber agreements or other

contracts exclusive of those not included in the definition of health benefit plan pursuant to section 3(n) of this act and the premium upon which any assessment made under (A) of this subsection was based.

(C) Assessments under section 11(k)(2)(A) shall not exceed an amount equal to five percent of such premium for health benefit plans covering small employers. Assessments under section 11(k)(2)(B) shall not exceed an amount equal to 1% of the total premium upon which the assessment is based.

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

(4) Each member's proportion of participation in the program shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with the board.

(5) Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of assessments.

(6) A member may seek from the commissioner a deferment, in whole or in part, from any assessment issued by the board. The commissioner may defer, in whole or in part, the assessment of a member if, in the opinion of the commissioner, payment of the assessment would endanger the member's ability to fulfill its contractual obligations.

(7) In the event an assessment against a member is deferred in whole or in part, the amount by which such assessment is deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in this subsection. The member receiving such deferment shall remain liable to the program for the amount deferred. The commissioner may attach appropriate conditions to any such deferment.

(l) Neither the participation as members of the program or as board members, the establishment of rates, forms, or procedures for coverage issued by the program, nor any other joint or collective action required by this act, shall be the basis of any legal action, criminal or civil liability or penalty against the program, the board, or any of its members either jointly or separately.

(m) The Kansas small employer reinsurance program shall be exempt from any and all premium taxes.

Sec. 12. Standards to assure fair marketing.

(a) Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. If a small employer carrier denies coverage not subject to this act to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan.

(b)(1) Except as provided in paragraph (2), no small employer carrier, agent or broker shall, directly or indirectly, engage in the following activities:

(A) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer;

(B) encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(2) The provisions of paragraph (1) shall not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(c)(1) Except as provided in paragraph (2), no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent or broker that provides for or results in the compensation paid to such person for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(2) Paragraph (1) shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation or geographic area of the small employer.

(d) A small employer carrier shall provide reasonable compensation to licensed agents and brokers, if any, as provided under the plan of operation of the program for the sale of a basic or standard health benefit plan.

(e) No small employer carrier shall terminate, fail to renew or limit its contract or agreement of representation with an agent or broker for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the agent or broker with the small employer carrier.

(f) No small employer carrier, agent or broker shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(g) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

(h) The commissioner may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(i) If a small employer carrier enters into a contract, agreement or other arrangement with a third party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the third party administrator shall be subject to this section as if it were a small employer carrier.

(j) The board created pursuant to section 10 of this act shall make available a broadly publicized toll free telephone number for access by small employers to information concerning this act and the health benefit plans developed pursuant to section 10.

(k) Except as provided in paragraph (1), for the purposes of this act, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this act shall apply as if all health benefit plans issued to small employers in this state by such affiliated carriers were issued by one carrier.

(1) An affiliated carrier that is a health maintenance organization having a certificate of authority under K.S.A. 40-3201 et seq. as amended, may be considered to be a separate carrier for the purpose of this act.

Sec.13. The commissioner is hereby authorized to adopt such rules and regulations as may be necessary to carry out the provisions of this act.

Sec. 14. Violations of this act shall be treated as violations of the unfair trade practices act and subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411 and amendments thereto.

Sec. 15. This act shall take effect and be in force from and after its publication in the statute book except the provisions of sections 6, 7, 8 and 9 shall become effective January 1, 1993 and their publication in the statute book.