Approved: February 6, 1995
Date

MINUTES OF THE HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Bill Bryant at 3:30 p.m. on January 30, 1995 in Room 527S of the Capitol.

All members were present except: Representative Gilbert, Excused
Representative Sawyer, Excused

Committee staff present: Bill Wolff, Legislative Research Department
Bruce Kinzie, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Representative Henry Helgerson
Larry Magill, Kansas Association of Insurance Agents
Terry Larson, Kansas Alliance for the Mentally Ill
Jeff Sonnich, KS, NE, OK League of Savings & Loans
David Hanson, GE Corp. Mortgage Guaranty Insurance
Chuck Stones, Kansas Bankers Association
Kathy Taylor, Kansas Bankers Association
Bill Mitchell, Kansas Land Title Association
Susie Parmer, Register of Deeds, Leavenworth County

Others attending: See attached list

Representative Henry Helgerson appeared before the Committee to request the introduction of legislation which would strike the "controlled business" prohibition provision that is currently law regarding business involvement of real estate companies and title insurance companies (Attachment 1).

Representative Smith moved for the introduction of the bill as a Committee bill. The motion was seconded by Representative Dawson. Motion carried.

Larry Magill, representing the Kansas Association of Insurance Agents, requested the introduction of legislation which would prohibit insurance rating organizations from charging a direct fee to an insured, or the insured's authorized representative for an insured's rate (Attachment 2).

Representative Les Donovan moved for the introduction of the bill as a Committee bill. The motion was seconded by Representative Samuelson. Motion carried.

Terry Larson, Kansas Alliance for the Mentally Ill, asked for bill introduction of a parity proposal for mental illness. The proposal would amend current insurance legislation to include that every insurer which provides accident and sickness insurance for medical, surgical or hospital expense cover for other than specific diseases or accidents only, provide coverage for diagnosis and treatment of mental illnesses caused by a biological disorder or environmental trauma of the brain (Attachment 3).

Representative Welshimer moved for the introduction of the proposal. The motion was seconded by Representative Landwehr. Motion carried.

Hearing on HB 2125 --Mortgage guarantee insurance companies, requiring certain examinations

Jeff Sonnich, Vice President of Kansas-Nebraska-Oklahoma League of Savings Institutions, appeared before the Committee as a proponent for the bill (Attachment 4). This bill would allow Kansas lending institutions delegated underwriting authority to place mortgage guaranty insurance. Kansas is the only state in the nation that does not allow lenders delegated underwriting authority thus putting our guaranty mortgage insurance

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

companies at a decided disadvantage. The passage of the legislation would allow in-state lenders to compete more effectively with their out-of-state counterparts.

David A. Hanson, General Electric Mortgage Insurance Corporation, appeared in support of the bill (Attachment 5). The bill would speed the guaranty insurance coverage process by allowing lenders to approve and bind mortgage guaranty insurance coverage immediately thus expediting coverage. Currently there is a duplication of effort as current legislation requires sending the credit application and property appraisal to the mortgage guaranty insurance company for a second review and approval before issuance of the policy.

Chuck Stones, Kansas Bankers Association, supported the bill because it would allow the lender to make the underwriting decision for mortgage insurance (Attachment 6). The passage of this legislation would eliminate two to three week delays in obtaining a mortgage loan.

Hearing on HB 2126--Entry of satisfaction of mortgage on real estate

Jeff Sonnich, representing Kansas-Nebraska-Oklahoma League of Savings Institutions, stated this legislation would allow Kansas lending institutions to release mortgages when a mortgagee refuses or neglects t o enter satisfaction which often occurs when dealing with out-of-state mortgage servicers (Attachment 7).

The Committee discussed the possibility of assessing fines of up to $10,000 on the mortgagee but this would be unfair if the entry of satisfaction is inadvertently omitted (especially by in-state companies). The option of filing the information electronically with the Register of Deeds was also discussed.

Kathy Taylor, Kansas Bankers Association, supported the proposed amendments because many times the completion of a loan may be held up because of the failure of the prior lender to release the mortgage (Attachment 8).

Bill Mitchell, Kansas Land Title Association, agreed this legislation would be a great step forward. He suggested that this legislation should cover attorney's opinions, liens, and title insurance as well.

Susie Parmer, Register of Deeds from Leavenworth County, reported on the Mortgage Electronic Registration System (MERS) which will effect the transfer of ownership and security interests in mortgages. The MERS registry will identify the interests of originators, servicers, mortgage investors, and warehouse lenders. This system may be used to release mortgages more efficiently and would be structured to operate within the existing legal framework. Mrs. Parmer did express concern over the number of documents which the Registers of Deeds would be required to keep.

Representative Crabb moved for the approval of the January 23 and 24 minutes. Representative Donovan seconded the motion. The motion carried.

The meeting was adjourned at 4:30 p.m. The next meeting is scheduled for January 31, 1995.

HOUSE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: January 30, 1995

NAME	REPRESENTING
Danielle Noe	KCUA
Esther M. Fitzgerald	KMIAC
Carla Byrne	Menninger
P. W. PRAWL	Small Business
Nancy Prawl	Register of Deeds
Anne Spiess	Ks. Assoc. of Counties
Terry Larson	Ks. Alliance for the M.I. / Ks. Mental Health Coalition
Judy Reinard	Ks Mental Health Coalition
Chuck Stones	KBA
Bill Sneed	State Farm
Susie Palmer	Register of Deeds Lea Co
JEFF SONNICH	KNOCSI
LARRY MAGILL	KAIA
William L. Mitchell	KLTA
Callie Denton	KS Insurance Dept
Linda J. DeCoursey	KS Insurance Dept
David A. Hanson	GE Cap. Mortg. Guar. Insur.
George Barbee	KAFS
Roger Franzke	IFC

HOUSE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: Jan 30 - continued

NAME	REPRESENTING
Kathy Olsen	Kansas Bankers Assn.

HOUSE BILL NO. ____

AN ACT relating to title insurance; requiring certain disclosures and prohibiting certain transactions; amending K.S.A. 1994 Supp. 40-2404 and repealing the existing section.

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

New Section 1. As used in this act, unless the context otherwise requires:

(a) "Associate" means any firm, association, organization, partnership, business trust, corporation or other legal entity organized for profit in which a producer of title business is a director, officer or partner thereof, or owner of a financial interest; the spouse or any relative within the second degree by blood or marriage of a producer of title business who is a natural person; any director, officer or employee of a producer of title business or associate; any legal entity that controls, is controlled by, or is under common control with a producer of title business or associate; and any natural person or legal entity with whom a producer of title business or associate has any agreement, arrangement or understanding or pursues any course of conduct, the purpose or effect of which is to evade the provisions of this section.

(b) "Financial interest" means any direct or indirect interest, legal or beneficial, where the holder thereof is or will be entitled to 1% or more of the net profits or net worth of the entity in which such interest is held. Notwithstanding the foregoing, an interest of less than 1% or any other type of interest shall constitute a "financial interest" if the primary purpose of the acquisition or retention of that interest is the financial benefit to be obtained as a consequence of that interest from the referral of title business.

(c) "Person" means any natural person, partnership,

association, cooperative, corporation, trust or other legal entity.

(d) "Producer of title business" or "producer" means any person, including any officer, director or owner of 5% or more of the equity or capital or both of any person, engaged in this state in the trade, business, occupation or profession of:

(1) Buying or selling interests in real property;

(2) Making loans secured by interests in real property; or

(3) Acting as broker, agent, representative or attorney for a person who buys or sells any interest in real property or who lends or borrows money with such interest as security.

(e) "Refer" means to direct or cause to be directed or to exercise any power or influence over the direction of title insurance business, whether or not the consent or approval of any other person is sought or obtained with respect to the referral.

New Sec. 2. No title insurer or title agent may accept any title insurance order or issue a title insurance policy to any person if it knows or has reason to believe that such person was referred to it by any producer of title business or by any associate of such producer, where the producer, the associate, or both, have a financial interest in the title insurer or title agent to which business is referred unless the producer has disclosed to the person so referred the fact that such producer or associate has a financial interest in the title insurer or title agent.

New Sec. 3. (a) No producer of title business or associate of such producer shall require, directly or indirectly, as a condition to selling or furnishing any other person any loan or extension thereof, credit, sale, property, contract, lease or service, that such other person shall purchase title insurance of any kind through any title agent or title insurer if such producer has a financial interest in such title agent or title insurer.

(b) Any producer of title business or associate of such producer who violates the provisions of this section, or any

title insurer or title agent who accepts an order for title insurance knowing that it is in violation of this section, in addition to any other action which may be taken by any regulatory authority having jurisdiction, shall be liable to the purchaser of such title insurance in an amount equal to the premium for the title insurance.

(c) Nothing in this act shall prohibit any producer of title business or associate of such producer from referring title business to any title insurer or title agent of such producer's or associate's choice, and, if such producer or associate of such producer has any financial interest in the title insurer, from receiving income, profits or dividends produced or realized from such financial interest, so long as:

(1) Such financial interest is disclosed to the purchaser of the title insurance in accordance with section 2;

(2) the payment of income, profits or dividends is not in exchange for the referral of business; and

(3) the receipt of income, profits or dividends constitutes only a return on the investment of the producer or associate.

New Sec. 4. The commissioner of insurance may adopt rules and regulations necessary to carry out the provisions of this act.

Sec. 5. K.S.A. 1994 Supp. 40-2404 is hereby amended to read as follows: 40-2404. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) <u>Misrepresentations and false advertising of insurance policies.</u> Making, issuing, circulating or causing to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission or comparison which:

(a) Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

(b) misrepresents the dividends or share of the surplus to be received on any insurance policy;

(c) makes any false or misleading statements as to the

dividends or share of surplus previously paid on any insurance policy;

(d) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates;

(e) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;

(f) is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion or surrender of any insurance policy;

(g) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or

(h) misrepresents any insurance policy as being shares of stock.

(2) <u>False information and advertising generally.</u> Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, misrepresentation or statement with respect to the business of insurance or with respect to any person in the conduct of such person's insurance business, which is untrue, deceptive or misleading.

(3) <u>Defamation.</u> Making, publishing, disseminating or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any person, and which is calculated to injure such person.

(4) <u>Boycott, coercion and intimidation.</u> Entering into any

agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of the business of insurance, or by any act of boycott, coercion or intimidation monopolizing or attempting to monopolize any part of the business of insurance.

(5) False statements and entries. (a) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person.

(b) Knowingly making any false entry of a material fact in any book, report or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

(6) Stock operations and advisory board contracts. Issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance. Nothing herein shall prohibit the acts permitted by K.S.A. 40-232, and amendments thereto.

(7) Unfair discrimination. (a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard

in the amount of premium, policy fees or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(c) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. With respect to all other conditions, including the underlying cause of the blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons. Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured loses such person's eyesight. However, an insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness when such condition existed at the time the policy was issued.

(8) Rebates. (a) Except as otherwise expressly provided by law, knowingly permitting, offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon; paying, allowing, giving or offering to pay, allow or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, selling, purchasing or offering to give, sell or purchase as inducement to such insurance contract or annuity or in connection therewith, any stocks, bonds or other securities of any insurance company or other corporation, association or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the

contract.

(b) Nothing in subsection (7) or (8)(a) shall be construed as including within the definition of discrimination or rebates any of the following practices:

(i) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance. Any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(ii) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses; or

(iii) readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(9) Unfair claim settlement practices. It is an unfair claim settlement practice if any of the following or any rules and regulations pertaining thereto are: (A) Committed flagrantly and in conscious disregard of such provisions, or (B) committed with such frequency as to indicate a general business practice.

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(b) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(d) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(h) attempting to settle a claim for less than the amount to which a reasonable person would have believed that such person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(j) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

(k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(l) delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(n) failing to promptly provide a reasonable explanation of

the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(10) Failure to maintain complaint handling procedures. Failure of any person, who is an insurer on an insurance policy, to maintain a complete record of all the complaints which it has received since the date of its last examination under K.S.A. 40-222, and amendments thereto; but no such records shall be required for complaints received prior to the effective date of this act. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaints, the date each complaint was originally received by the insurer and the date of final disposition of each complaint. For purposes of this subsection, "complaint" means any written communication primarily expressing a grievance related to the acts and practices set out in this section.

(11) Misrepresentation in insurance applications. Making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money or other benefit from any insurer, agent, broker or individual.

(12) Statutory violations. Any violation of any of the provisions of K.S.A. 40-276a, or 40-1515, and amendments thereto, or K.S.A. 1994 Supp. 40-2,155, and amendments thereto.

(13) Disclosure of information relating to adverse underwriting decisions and refund of premiums. Failing to comply with the provisions of K.S.A. 40-2,112, and amendments thereto, within the time prescribed in such section.

(14) Rebates and other inducements in title insurance. (a) No title insurance company or title insurance agent, or any officer, employee, attorney, agent or solicitor thereof, may pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to obtaining any title insurance business, any rebate, reduction or abatement of any rate or

charge made incident to the issuance of such insurance, any special favor or advantage not generally available to others of the same classification, or any money, thing of value or other consideration or material inducement. The words "charge made incident to the issuance of such insurance" includes, without limitations, escrow, settlement and closing charges.

(b) No insured named in a title insurance policy or contract nor any other person directly or indirectly connected with the transaction involving the issuance of the policy or contract, including, but not limited to, mortgage lender, real estate broker, builder, attorney or any officer, employee, agent representative or solicitor thereof, or any other person may knowingly receive or accept, directly or indirectly, any rebate, reduction or abatement of any charge, or any special favor or advantage or any monetary consideration or inducement referred to in (14)(a).

(c) Nothing in this section shall be construed as prohibiting:

(i) The payment of reasonable fees for services actually rendered to a title insurance agent in connection with a title insurance transaction;

(ii) the payment of an earned commission to a duly appointed title insurance agent for services actually performed in the issuance of the policy of title insurance; or

(iii) the payment of reasonable entertainment and advertising expenses.

(d) Nothing in this section prohibits the division of rates and charges between or among a title insurance company and its agent, or one or more title insurance companies and one or more title insurance agents, if such division of rates and charges does not constitute an unlawful rebate under the provisions of this section and is not in payment of a forwarding fee or a finder's fee.

~~(e)--No-title-insurer-or-title-agent--may--accept--any--order for,--issue--a-title-insurance-policy-to,-or-provide-services-to,~~

~~an-applicant-if-it-knows--or--has--reason--to--believe--that--the applicant-was-referred-to-it-by-any-producer-of-title-business-or by--any--associate--of--such--producer,--where--the-producer,-the associate,-or-both,--have--a--financial--interest--in--the--title insurer--or--title-agent-to-which-business-is-referred-unless-the producer-has-disclosed--to--the--buyer,--seller--and--lender--the financial-interest-of-the-producer-of-title-business-or-associate referring-the-title-insurance-business.~~

~~(f)--No--title-insurer-or-title-agent-may-accept-an-order-for title-insurance-business,-issue--a--title--insurance--policy,--or receive--or--retain-any-premium,-or-charge-in-connection-with-any transaction-if:-(i)-The-title-insurer-or-title-agent-knows-or-has reason-to-believe-that-the-transaction-will-constitute-controlled business-for-that-title-insurer-or-title-agent,-and-(ii)--20%--or more--of--the--gross--operating--revenue-of-that-title-insurer-or title-agent-during--the--six--full--calendar--months--immediately preceding--the--month--in--which--the--transaction-takes-place-is derived-from-controlled-business.--The-prohibitions-contained--in this--subparagraph-shall-not-apply-to-transactions-involving-real estate-located-in-a-county-that-has-a-population,-as-shown-by-the last-preceding-decennial-census,-of-10,000-or-less.~~

~~(g)~~ <u>(e)</u> The commissioner shall adopt any <u>rules and</u> regulations necessary to carry out the provisions of this act.

Sec. 6. K.S.A. 1994 Supp. 40-2404 is hereby repealed.

Sec. 7. This act shall take effect and be in force from and after its publication in the statute book.

40-1117. Same; information to be furnished insureds; hearings and appeals of insureds. Every rating organization and every insurer which makes its own rates shall, within a reasonable time after receiving written request therefor, furnish to any insured affected by a rate made by it, or to the authorized representative of such insured, all pertinent information as to such rate. Every rating organization and every insurer which makes its own rates shall provide within this state reasonable means whereby any person aggrieved by the application of its rating system may be heard, in person or by authorized representative, on written request to review the manner in which such rating system has been applied in connection with the insurance afforded such person. If the rating organization or insurer fails to grant or reject such request within 30 days after it is made, the applicant may proceed in the same manner as if such applicant's application had been rejected. Any party affected by the action of such rating organization or such insurer on such request may, within 30 days after written notice of such action, appeal to the commissioner, who after a hearing conducted in accordance with the provisions of the Kansas administrative procedure act, may affirm or reverse such action.

History: L. 1945, ch. 215, § 7; L. 1965, ch. 303, § 11; L. 1988, ch. 356, § 94; July 1, 1989.

(a)

Every rating organization and every insurer shall either include within the appropriate rate or rates the cost to provide an insured, and their authorized representative, all pertinent information as to such insured's rate or such rating organization shall recover the expense of providing such information from their member or subscriber companies. No rating organization or insurer shall charge a direct fee to an insured, or their authorized representative for an insured's rate information. As an alternate means of obtaining the information, every rating organization shall provide access to individual insureds rate information through the Information Network of Kansas. An individual insured's experience modification information shall be confidential and shall be disclosed by direct computer access only to the insured or their authorized representative. (b)

FI&I
Attachment 2
1-30-95

KANSAS MENTAL HEALTH COALITION

P. O. Box 675, Topeka, Kansas 66601-0675
Telephone: (913) 233-0755 Fax: (913) 233-4804

"Joining together in one voice on critical needs of persons with mental illness."

Stuart Frager, Ph.D., Chair
2700 W. 6th Street
Topeka, Kansas 66606

Testimony

To: Members, House Financial Institutions and Insurance Committee

From: Terry Larson, Legislative Chair, Kansas Member Health Coalition and Executive Director, Kansas Alliance for the Mentally Ill.

Date: January 30, 1995

RE: Non-Discriminatory (Parity) Private Health Insurance coverage for Medically Treatable Mental Illnesses

Thank you Chairman Bryant for giving me the opportunity to address this committee and request the introduction of a bill that would help eliminate the discrimination against diseases of the brain that are also called mental illnesses.

Attached are copies of our proposed draft bill and a paper explaining the rationale for equal private health insurance coverage of medically treatable mental illnesses which would include schizophrenia, manic-depression, major depression and certain childhood mental illnesses. Also attached is a paper addressing the issue of fiscal impact and a comprehensive impact study commissioned in Maryland.

In brief, this "parity proposal" would:

- Separate medically treatable mental illnesses out from "mental health" and place them with other disabling brain diseases (e.g. multiple sclerosis, Parkinson's Disease, Alzheimer's, epilepsy) for level of health insurance coverage.

- Preserve the existing mandates for "mental health problems" such as alcohol and drug abuse treatment. (We respectfully request that any discussion of changing the mandates not be done in conjunction with parity. They are separate issues.)

- Relieve the burden on the public mental health system which must pick up persons who have exhausted the 30-day maximum in-patient coverage benefits.

- Help reduce the stigma associated with seeking treatment for mental illnesses.

House FI&I
Attachment 3
1-30-95

DRAFT BILL

An act concerning accident and sickness insurance; relating to coverage for costs of treatment for medically treatable diseases of the brain known as mental illnesses; amending K.S.A. 40-2,105.

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

(a) On or after the effective date of this act, every insurer which issues any individual or group policy of accident and sickness insurance providing medical, surgical or hospital expense coverage for other than specific diseases or accidents only and which provides for reimbursement or indemnity for services rendered to a person covered by such policy in a medical care facility, must provide for reimbursement or indemnity under such individual policy or under such group policy, except as provided in subsection ~~(d)~~ (e), which shall be limited to not less than 30 days per year when such person is confined for treatment of alcoholism, drug abuse or nervous or mental conditions in a medical care facility licensed under the provisions of K.S.A. 65-429 and amendments thereto, a treatment facility for alcoholics licensed under the provisions of K.S.A. 65-4014 and amendments thereto, a treatment facility for drug abusers licensed under the provisions of K.S.A. 65-4605 and amendments thereto, a community mental health center or clinic licensed under the provisions of K.S.A. 75-3307b and amendments thereto or a psychiatric hospital licensed under the provisions of K.S.A. 75-3307b and amendments thereto. Such individual policy or such group policy shall also provide for reimbursement or indemnity, except as provided in subsection ~~(d)~~ (e), of the costs of treatment of such person for alcoholism, drug abuse and nervous or mental conditions, limited to not less than 100% of the first $100, 80% of the next $100 and 50% of the next $1,640 in any year and limited to not less than $7,500 in such person's lifetime, in the facilities enumerated when confinement is not necessary for the treatment or by a physician licensed or psychologist licensed to practice under the laws of the state of Kansas. Notwithstanding the foregoing, every insurer which issues any individual or group policy of accident and sickness insurance providing medical, surgical or hospital expense coverage for other than specific diseases or accidents only and which provides for reimbursement or indemnity for services rendered to a person covered by such policy, shall provide coverage for diagnosis and treatment of mental illnesses under terms and conditions no less extensive than coverage provided for any other type of health care.

(b) For the purposes of this section "nervous or mental conditions" means disorders specified in the diagnostic and statistical manual of mental disorders, ~~third~~ fourth edition, (DSM ~~III, 1900~~ IV, 1994) of the American psychiatric association but shall not include conditions not attributable to a mental disorder that are a focus of attention or treatment (DSM ~~III~~ IV, V Codes).

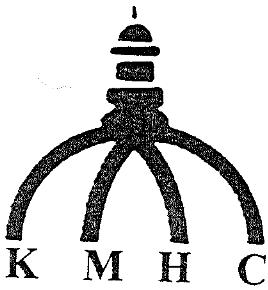
(c) For the purposes of this section "mental illnesses" means any mental disorder that current medical science affirms is caused by a biological disorder or environmental trauma of the brain and that, if untreated, may substantially limit the life activities of the person with the illness.

~~(c)~~ (d) The provisions of this section shall be applicable to health maintenance organizations organized under article 32 of chapter 40 of the Kansas Statutes Annotated.

~~(d)~~ (e) There shall be no coverage under the provisions of this section for any assessment against any person required by a diversion agreement or by order of a court to attend an alcohol and drug safety action program certified pursuant to K.S.A. 8-1008 and amendments thereto.

~~(e)~~ (f) The provisions of this section shall not apply to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation.

History: L. 1977, ch. 161, & 1; L. 1978, ch. 166, & 1; L. 1986, ch. 299, & 8; L. 1986, ch. 174, & 1; July 1.



K M H C

Stuart Frager, Ph.D., Chair
2700 W. 6th Street
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KANSAS MENTAL HEALTH COALITION

P. O. Box 675, Topeka, Kansas 66601-0675
Telephone: (913) 233-0755 Fax: (913) 233-4804

"Joining together in one voice on critical needs of persons with mental illness."

Potential Impact: Parity for Mental Illnesses in Private Health Insurance Coverage in Kansas

Prepared by Terry Larson, Kansas Mental Health Coalition and Kansas AMI, January 20, 1995

Parity will impact:

1. Premium costs for private sector individuals, employers and employees.
2. Premium costs for governmental employers and employees.
3. Public mental health system costs.
4. Public Agency costs.
5. Health insurance company costs.

1. A fiscal study specific to Kansas has not been commissioned. Utilizing data collected from studies in two other states, it is reasonable to conclude that the add-on costs to monthly premiums would be similar. Add-on means the actual additional cost of parity over current premium costs, which do include the mental health "mandates."

The Maryland study (attached) was prepared for the Alliance for the Mentally Ill of Maryland by John Krizay, January, 1992. Parity add-on costs would equal $.89 per month per person with health insurance. (Family coverage would increase by $2.23 per month.)

The 1991 California study was prepared by Coopers and Lybrand for the California Medical Association, Division of Medical Practices' Crisis Committee on Access to Health Care. Parity add-on would equal $.78 per month per person with health insurance.

2. Governmental employers' costs would be negotiated in the contract with the insurer. Whether the employer or employee pays for the add-on would also be a part of negotiation.

3. Roughly 25% of patients <u>may</u> require hospitalization beyond the 30 day cap allowed under the current mandates. Persons with mental illness are then placed in a state hospital which costs the state (and its tax payers) anywhere from $3000 to $7140 per month.

4. Public agency costs are unknown but would be limited to costs of administration. This should not result in additional personnel costs.

5. It is assumed that health insurance providers would charge all cost increases back to the policy-holders.

Strength

KANSAS MENTAL ILLNESS AWARENESS COUNCIL INC.

Lonny Lindquist
Executive Director
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MEMORANDUM

January 30, 1995

TO: MEMBERS OF FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

TO: IN RE: SUPPORT of PROPOSED INSURANCE PARITY BILL

The Kansas Mental Illness Awareness Council,(which is the State-wide organization of mental health consumers,)has worked closely with The Kansas Alliance for The Mentally Ill and other organizations on this problem of unequal and unfair treatment of having a mental illness by The Insurance Industry. It is our understanding and strong feeling for this proposed bill on Insurance Parity that it is long past due.
Mental Illnesses are illnesses of the organ in our bodies known as the brain. Just as other organs become ill they should not be segregated out to such inequality of coverage as it is.

We recognize the inter-connected nature of oppression, and that there is no Hierarchy, or worse-off social identity group. Every socially oppressed group has experienced unique challenges and social forces. Racism, sexism, classism, homophobia, anti-semi-nism, ethnic hatred, nationalism, and ableism are all forms of intolerance and prejudice. Oppression is a learned social pattern, it is not biological or instinctual. If it is learned it can also be unlearned and also never taught to new generations of children and young adults.

The Insurance Industry will not bend to giving equal and fair coverage to those who suffer with a mental illness without your help in making this a bill and passing it into law.

We Implore you to do so; it will allow many who suffer with a mental illness to obtain and keep meaningful jobs and lessen the burden of the public medicaid system.

Sincerely in your service,

Lonny Lindquist

Lonny Lindquist,
Executive Director
Kansas Mental Illness Awareness Council

Health Insurance Parity for Medically Treatable Diseases of the Brain

The questions persist:

1. Why should mental illnesses receive health insurance coverage equal to that of other physical illnesses?

2. Isn't it enough that Kansas has mandated mental health coverage? Why do advocates insist that equal coverage be mandated?

3. Just what do we mean by mental illness? Isn't it the same as mental health?

4. What about those "mental health problems" that might not be covered if we do get parity?

Mental illness continues to be grossly misunderstood by the public and its policymakers. Ignorance is the only reasonable explanation for health insurance discrimination.

Mandated mental health coverage was a miracle for many. Prior to that, nearly 80% of Kansans with health insurance had no coverage for mental illness. However, the mandates place limits on treatment for mental illness that would be unacceptable for other illnesses. (Can we imagine a cancer or heart patient being booted out of the hospital at 30 days because insurance capped payment for their care?)

Equal coverage for mental illness took quite a beating when national health care was debated. Why? Because all of "mental health" was lumped in with mental illness in the discussion. Many national leaders, including Second Lady Tipper Gore, still aren't getting it. Mental illness must be considered apart from "mental health problems," including alcohol and drug abuse.

"Mental health" is important to each of us. Families in times of crisis, for example, must take care to preserve or enhance their own "mental health."

"Mental illness," on the other hand, refers to any of several neurobiological diseases of the brain. There are other brain diseases that have never been questioned, including multiple sclerosis and Parkinson's Disease, for inclusion with all other physical diseases.

M.S. is a physical brain disease which would never be lumped under "mental health," Schizophrenia is a physical brain disease, too. What's the logic?

Chemical dependency is likely to also be physical in its origins. However, ongoing medical treatment is not a part of recovery. Providing coverage for addiction disorders equal to neurobiological brain diseases makes as much sense as lumping treatment of liver disease in with treatment of alcoholism.

Mental illnesses are medically treatable. People who are appropriately treated are more productive and have to rely much less on the public system for support. Mental illnesses are no one's fault. "Mental toughness" has nothing to do with it. Thinking positive thoughts or praying a lot will not make mental illness disappear any more than they can make diabetes or epilepsy disappear.

Further, there should continue to be health insurance coverage for mental health, including alcohol and drug abuse. It goes far to reduce more serious outcomes which will cost much more down the road. If parity for mental illness is gained, there also may be some mental disorders that would not yet be included because of inconclusive evidence of their physical nature. The mandates must be retained for those conditions not covered under parity.

Finally, opponents of parity will use the "it will cost too much" argument. Studies from other states indicate that limiting parity to mental illnesses makes little difference in insurance costs. We do not want anything more than equal treatment, period.

Estimate of Added Cost
of
Covering Biologically-Based
Mental Illnesses
On the Same Basis
As All Other Illnesses

Prepared for:

The Alliance for the Mentally Ill of Maryland

John Krizay
January 5, 1992

3-8

EXECUTIVE SUMMARY

The added cost of covering the biologically-based mental illnesses on the same basis as other physical illnesses for residents of the State of Maryland is estimated, at today's prices, at approximately $1.00 per covered person per month. Using the common factor of 2.5 covered lives per employee, the per employee cost would be approximately $2.50 per employee per month. These estimates are based on actual utilization rates in Maryland for the year 1989, adjusted for provider rate increases that have taken place in the interim.

"Added" cost refers to the cost that would accrue to insurance carriers or other types of health plans above what is already required of them by Maryland law or what is normally provided by health plans that are not covered by the Maryland mandate. (The Maryland mandate requires 30 day inpatient coverage on an equal basis with other ailments covered plus unlimited outpatient coverage at an effective average co-pay of 52%.)

Added cost to HMOs, should they be required to provide the same coverage, would be approximately the same for those that do no specifically exclude "chronic mental illnesses." HMOs normally provide 30 days inpatient care plus 20 outpatient visits with nominal or no co-pay. For those HMOs that have chronicity exclusions (to the extent that they are enforceable), added costs

would likely be not more than $0.40 per person higher, i.e. $1.40 per person per month, and, perhaps even less, depending on the particular HMO's rating system.

The so-called "mental and nervous" disorders encompass a wide array of behavioral problems most of which are not believed to reflect brain disfunctioning in a physiological sense. Those that are now widely recognized as stemming from a physical or biological disorder of the brain are listed in the International Classification of Diseases under ICD-9 codes 295.0 through 299.9, making up only one-sixth of all diseases codified as mental disorders. In terms of utilization, these biologically-based diseases account for roughly one-fourth of patients presenting claims for treatment of all mental disorders, about 16% of mental health outpatient visits and about one-third of hospital days related to mental disorders in insured populations where all "mental and nervous disorders" are covered on the same basis as physical ailments.

At one time, victims of these serious mental diseases were more often than not, simply institutionalized, frequently for a lifetime. However, modern medicine has provided effective treatments so that long term hospitalization or institutionalization can be avoided. Indeed, early intervention can result in a functional patient capable of independent living with only minimal support through public funds. Equal coverage of this category of ailments in private health plans makes this kind of early intervention more likely. Families are, naturally,

reluctant to commit a family member to an institution or to rely on public facilities which, many visualize as the first step toward institutional life. They are more likely to seek help in a private setting when early symptoms appear, so that adjustments in family life and rehabilitation efforts can proceed in a timely fashion. Modern psychiatric medicine makes such a scenario feasible at minimal cost and a likely savings of public sector funds.

I. Description of Biologically-based Mental Illnesses

The accepted classification of all diseases is outlined in the International Classification of Diseases, Revision 9. (Revision 10 is expected to be released soon.) Mental disorders are also classified in more detail in the Diagnostic and Statistical Manual of Mental Disorders prepared by the American Psychiatric Association. However, most insurers categorize claims by the ICD-9 code. These appear in three digit rubrics plus two rubric sub-classifications. The mental disorders begin with ICD-9 290.0 and end with ICD-9 code 319.

The major diseases - the psychoses which encompass those mental disorders now considered to be biologically based - are those that are listed under codes 295.0 through 299.9. They are described as follows in the ICD manual:

Code	Description
295	Schizophrenic Disorders (including simple type, disorganized type, catatonic type, paranoid type, acute, latent, residual, schizo-affective, acute undifferentiated, and unspecified types.
296	Affective psychoses. (including manic disorders, single episode, manic disorders, recurrent episodes, major depressive disorders, single episodes, major depressive disorders, recurrent episodes, bipolar affective disorders (manic), bipolar effective disorders (depressed), bipolar affective disorders, mixed, bipolar affective disorders, unspecified, manic-depressive psychosis, other unspecified affective psychoses.
297	Paranoid states. (including paranoid state/simple, paranoia, paraphrenia. shared paranoid disorder, other paranoid states, unspecified paranoid

states.

298	Other non-organic psychoses (including depressive type psychosis, excitative type psychosis, reactive confusion, acute paranoid reaction, psychogenic paranoid psychosis, other and unspecified reactive psychosis, unspecified psychosis.
299	Psychosis with origin specific to childhood (including infantile autism, disintegrative psychosis, other specified early childhood psychoses, unspecified childhood psychoses.

III. Source of Data Used in Estimate.

The data used in arriving at these estimates, in large measure, reflect actual experience of CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) eligibles seeking treatment for mental disorders in the State of Maryland. CHAMPUS utilization, appropriately adjusted for differences in coverage limits, age distribution, etc. in other states and found to be an accurate reflection of utilization in other populations.

This data base is especially apt as a source of utilization projections in Maryland because the CHAMPUS population here is relatively large. Nearly 200,000 CHAMPUS eligibles under age 65 reside here, i.e., about 4% of the total under 65 Maryland age group. Moreover, most of the CHAMPUS eligibles of Maryland reside in or near the large population centers of the state: Montgomery County, Prince Georges County, and Baltimore County. These are also the highest utilizer populations in Maryland so that estimates derived from this group are likely to overestimate state-wide utilization.

The CHAMPUS population is not an exact reflection of the general population, particularly in terms of age distribution. However, these differences are readily accounted for because CHAMPUS data is available in such complete detail, including utilization by age group and by ICD-9 group, as well as by ICD-9 categories within age groups. It is also one of the few data basis in the entire nation that reports utilization by inpatient care, residential treatment care, outpatient treatment (all by age group), by procedure code (CPT), including number of admissions, average length-of-stay, and type of provider. Additionally, both inpatient and outpatient

utilization are reported in a manner that permits accurate calculations of utilization by utilization group (i.e., the number of claimants using one visit only, the number using 2 visits only, etc. up to 61 visits by single visit increments and by larger increments beyond 61.

For this analysis, Maryland CHAMPUS data were first arrayed by the five diagnostic codes (ICD-9 codes) that represent the biologically-based mental ailments. These results were then further arrayed by age groups within each ICD-9 code and, then, the number of outpatient visits, inpatient visits, and inpatient days were calculated for each age group/ICD-9 code in terms of days or visits per 1,000 eligibles. These were then recalculated in terms of the age group distribution in the under 65 Maryland population; that is the utilization rates per 1,000 persons were applied to non-CHAMPUS Maryland population, thereby producing a projection of non-CHAMPUS utilization rates had this population been blessed with the same coverage as CHAMPUS.

CHAMPUS coverage closely approximates coverage equal to coverage of medical services for illnesses other than mental disorders (60 days inpatient care in acute facilities at nominal co-pay subject to extension upon review, unlimited outpatient coverage at an average co-pay of 22.5%). The utilization data, thus serve as an excellent base to project the limits of utilization under circumstances where the biologically-based mental diseases are treated as other physical ailments. With utilization by visit category and day category included in the data the <u>added</u> cost to typical coverage or coverage already required by law can be calculated. By calculating the current cost to insurers, estimating the additional utilization that would be likely due to the lower cost to the consumer and probable increases in cost over the ensuing two years is feasible.

IV. <u>Calculations</u>

A. Outpatient utilization:

As mentioned in Section III, the major adjustment required in applying CHAMPUS utilization rates is correction for age distribution differences. Use of outpatient care for these ICD-9 categories is highest in the 25-34 age group. At the same, it is this age cohort in the CHAMPUS age distribution that contains the smallest number of eligibles. *But since we can determine the utilization rate per 1,000 covered lives in each age cohort, we can calculate the total utilization per 1,000 for any age distribution.*

The age distribution differences between the Maryland CHAMPUS population (under 65) and the entire Maryland population is as follows:

Age Group	Maryland CHAMPUS	All Maryland
<15	28.2%	23.9%
15 - 24	16.9%	15.2%
25 - 34	9.8%	22.5%
35 - 44	12.6%	16.9%
45 - 64	32.3%	21.6%

The outpatient utilization rates per 1,000 for each age group and each ICD-9 category drawn from CHAMPUS data are as follows:

Age Grp.	295	296	297	298	299	ALL
>15	1.13	14.46	0.02	0.75	1.14	17.21
15 - 24	9.04	61.30	0.39	1.95	0.45	71.70
25 - 34	18.98	112.42	1.70	2.83	0.06	133.29
35 - 44	17.46	124.24	1.93	1.68	0.01	142.32
45 - 64	9.08	50.27	1.18	1.02	0.00	60.34
ALL [Wtd]	8.87	56.13	0.83	1.37	0.42	67.62

When applied to the entire Maryland under 65 population and adjusted for a different age distribution the total rates per thousand increase largely because of the State's larger 25 - 34 population, the highest users of outpatient care in these disease categories. The all Maryland rates are as follows:

ICD Code	Outpatient Visits/1,000
295	10.81
296	69.82
297	30.46
298	1.62
299	0.36
ALL	113.06

In calculating costs (see below), the total visit rate per thousand has been increased by 15% to account to a slow but steady growth in outpatient usage in these disease categories as revealed by a trend analysis covering the past then years.

The inpatient utilization rates per 1,000 for <u>each</u> age group and <u>each</u> ICD-9 category drawn from CHAMPUS data are as follows:

Age Grp.	295	296	297	298	299	ALL
>15	1.23	25.39	0.01	0.76	0.16	29.50
15 - 24	7.65	70.35	0.04	0.99	0.14	82.76
25 - 34	5.73	28.74	0.08	0.71	0.00	36.94
35 - 44	3.90	22.23	0.05	0.32	0.00	27.79
45 - 64	1.91	9.56	0.08	0.24	0.00	12.61
ALL [Wtd]	3.27	29.11	0.30	0.58	0.35	33.00

When applied to the entire Maryland under 65 population and adjusted for a different age distribution the <u>total</u> rates per thousand increase only slightly in the case of inpatient care because the age group with the highest user rates are found in the 15 - 24 age group in these disease categories where the share of total population is practically identical between the Maryland population and the CHAMPUS eligible population. The all Maryland rates are as follows:

ICD Code	Outpatient Visits/1,000
295	3.81
296	29.02
297	0.05
298	0.60
299	0.06
ALL	34.75

Inpatient professional services parallel inpatient day utilization rates so these figures are not repeated here. This service is, in any event, a minor cost, amounting to only $0.06 per person per month. (See below.)

V. Cost Factors

Projected costs per person per month were arrived at by using the projected utilization rates per thousand, multiplying by assumed provider rates and reducing them to per person rates, divided by 12 (months). The provider rates used are as follows:

Hospital: $500 per day, plus 20% ancillary charges.
Mental Health Professionals: MDs & Clinical Psychologists, $100 per visit, Support Counselors (MSWs, etc.) $70 per visit.

Outpatient Costs

The data base used in these calculations indicate that about 8% of outpatient visits were of the "medical management" type at a rate of $50 per visit. Also about 18% of the outpatient visits in this disease category were for support counselors. The weighted average outpatient visit rate, thus, is $90.60 per visit.

Since our CHAMPUS data base already reflects a utilization rate at approximately equal coverage (22.5% average co-pay, i.e. 77.5% paid by the health plan), our estimates already show the maximum use rates.

As indicated above, the projections based on 1989 data suggest an outpatient utilization rate of 113 visits per thousand per year. Our trend line analysis suggests a rate for 1992 of 129.5. To calculate the difference between the cost to the insurer under the existing coverage requirements and those that would accrue to him under equal coverage requirements for these disease category, we applied an elasticity co-efficient of 0.6, derived from Rand studies modified by our own observations working with various health plans around the country. The major modification in this function is the exclusion of visits 1 - 3 where, we have noted, cost to the consumer does not seem to have any measurable effect of utilization. Cumulative visits in the 1 - 3 visit categories account for approximately 30% of all visits.

The projections indicate that under the existing system, the health plan, on average, would experience a utilization rate of 97.8 visits per 1,000 per year, and the health plan would be responsible for $45.30 per each visit. For these ICD categories, the cost would be $4.43 per person per year, or $0.37 per person/month. Under equal coverage, total utilization would be 129.5 visits per 1,000, which translates to $9.39 per person/year or $0.78 per month as the health plan's cost. The added cost, then would be the difference: $0.41 per person/month or $1.02 per employee.

Inpatient day Costs

There should be no added utilization in the first thirty days used since this is the required coverage on an equal basis in Maryland. Roughly 75% of all inpatient days are accounted for in the first 30 days. Thus, the health plan's added cost would consist of any days used above 30.

Current inpatient utilization should average around 26.4 days per 1,000 for these disease categories, according to our calculations. With equal coverage (meaning, in this instance, no day limits) only 7.9 days would be added to the health plan's responsibility i.e. 8 1/3 additional days per 1,000. At our projected rate of $600 per day ($500 plus ancillaries), The added cost would be $0.42 per person/month or $1.05 per employee. [$600 x 8.3/1,000/12]

Inpatient professional services

As mentioned earlier, inpatient professional visits closely parallel inpatient day utilization. Projections suggest an additional 7.6 added visits per 1,000 which would be the health plan's responsibility. At a visit rate of $100, this adds $0.06 per month to the health plans cost.

Added cost summary

	per person/month	per employee/month
Outpatient	$0.41	$1.03
Inpatient Days	$0.42	$1.05
Inpatient Visits	$0.06	$0.15
Total	$0.89	$2.23

These cost figures are rounded off to an even $1.00 per person and $2.50 employee in the executive summary, above.

Jeffrey D. Sonnich, Vice-President

700 S. Kansas Ave., Suite 512
Topeka, Kansas 66603
(913) 232-8215

January 30, 1995

TO: House Committee on Financial Institutions and Insurance
FROM: Jeffrey Sonnich, Vice President, KNOLSI
RE: HB 2125; Mortgage Guaranty Insurance

The Kansas-Nebraska-Oklahoma League of Savings Institutions appreciates the opportunity to appear before the House Committee on Financial Institutions and Insurance in support of House Bill 2125 which would allow Kansas lending institutions delegated underwriting authority to place mortgage guaranty insurance.

Mortgage guaranty insurance is written to reduce the lender's exposure on high-loan-to-value mortgages. Since most mortgage loans are originated to meet the underwriting guidelines of the secondary market, guaranty insurance is routinely required on loans with a loan-to-value (LTV) of 85% or higher. Coverages range from 35% to 6% of the total indebtedness depending on the LTV ratio.

K.S.A. 40-3510 requires that before any policy of mortgage guaranty insurance is written the loan documentation must be sent to the guaranty insurance company for review. HB 2125 would remove this requirement by allowing the lender, in accordance with the underwriting standards of the guaranty insurance company, the ability to place the mortgage insurance. The lender would be subject to periodic audits by the guaranty insurance company to ensure compliance with underwriting standards.

The current system for placing guaranty insurance in Kansas is out of step with the rest of the nation. Our research indicates that Kansas is the only state in the nation that does not allow lenders delegated underwriting authority.

The problem we see is that Kansas lenders are being put in a competitive disadvantage to out-of-state mortgage banking companies. These companies, by virtue of having their underwriting facilities located outside of Kansas, are able to directly underwrite guaranty insurance for their borrowers. The ability to underwrite the guaranty insurance results in reduced costs, and quicker loan approval....a decided advantage when lenders are competing in a slow housing market. HB 2125 would provide for a level playing field.

We foresee few associated risks with the additional authority, since the lender will be following the same underwriting guidelines developed by the guaranty insurance company. In fact, very few loans now sent to the guaranty insurance company for approval are denied insurance. This would seem to indicate that the process of credit analysis and underwriting are similar for both lenders and guaranty insurance companies.

In conclusion, HB 2125 will put Kansas in line with the national standard, streamline the mortgage underwriting process, and allow in-state lenders to compete more effectively with their out-of-state counterparts. We respectfully request your favorable support.

Jeffrey D. Sonnich
Vice President

House FI&I
Attachment 4
1-30-95

MEMO

TO: Representative William Bryant, Chairman
House Financial Institution and Insurance Committee
State Capitol
Topeka, Kansas

RE: House Bill No. 2125

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to appear before the Committee. I am David Hanson and am appearing on behalf of General Electric Mortgage Insurance Corporation to support House Bill 2125.

The proposed amendment will help simplify and expedite the issuance of mortgage guaranty insurance in Kansas by allowing lenders to approve and bind mortgage guaranty insurance coverage immediately, rather than the current statutory requirement of having to send the credit application and property appraisal to the mortgage guaranty insurance company for its second review and approval before the policy can be issued. The proposed change will allow delegated underwriting of mortgage guaranty insurance as is allowed in all other states. We believe this amendment will be beneficial to both borrowers and lenders in Kansas and therefore encourage your favorable consideration of House Bill No. 2125.

Respectfully,

DAVID A. HANSON

House FI+I
attachment 5
1-30-95

The Kansas Bankers Association

800 SW Jackson, Suite 1500
Topeka, KS 66612
913-232-3444 FAX 913-232-3484

1-30-95

TO: House Financial Institutions and Insurance Committee

FROM: Chuck Stones, Director of Research

RE: HB 2125

Mr. Chairman and Members of the Committee:

The Kansas Bankers Association appreciates the opportunity to appear before you in support of HB 2125.

HB 2125 would greatly shorten the time involved in obtaining a mortgage loan. HB 2125 would allow the lender to make the underwriting decisions for mortgage insurance. The lender is subject to insurance company standards and periodic audit.

Lenders are accustomed to reviewing the required documentation, they do so for a living. This bill would stop the requirement to ship the loan paperwork to the insurer, wait for them to review the documents and return them to the lender. This will save at least a week and maybe two or three in some cases in the loan decision process.

Obviously the insurers are comfortable with this arrangement since it is being done in almost all if not all the other states.

Thank you for your attention and we urge your favorable consideration.

House FI&I
Attachment 6
1-30-95

Jeffrey D. Sonnich, Vice-President

700 S. Kansas Ave., Suite 512
Topeka, Kansas 66603
(913) 232-8215

January 30, 1995

TO: House Committee on Financial Institutions and Insurance
FROM: Jeffrey Sonnich, Vice President
RE: HB 2126; Mortgage Release

The Kansas-Nebraska-Oklahoma League of Savings Institutions appreciates the opportunity to appear before the House Committee on Financial Institutions and Insurance in support of HB 2126 which would allow Kansas lending institutions the ability to effectuate the release of a mortgage when a mortgagee refuses or neglects to enter satisfaction.

As drafted, this bill would amend K.S.A. 1994 Supp. 58-2309 (a) and K.S.A. 58-2306 to allow a mortgagor (borrower) or a lender who is "paying off" an existing loan to cause entry of satisfaction by providing the following:

- Proof that the indebtedness has been paid in full, either by canceled check or by proof of electronic funds transfer.
- A pay-off statement sent by the mortgagee dated within 45 days of the date the indebtedness had been paid.
- A certificate or affidavit sent by certified or registered mail showing written demand for the mortgage release.

This bill would provide lenders with a way to deal with the intolerable delays we are seeing in mortgage releases by some out-of-state mortgage servicers. We have seen cases where obtaining a mortgage release can take up to a year and delays from four to nine months are not uncommon. Current law will allow for damages of up to $500 dollars together with reasonable attorney's fees for failure to release the mortgage, however the cost of obtaining out-of-state counsel and other costs associated with civil actions make this provision virtually useless. In addition, the lack of a formal regulatory body to oversee these companies only compounds the problem.

From a lender standpoint, there are three major problems associated with extended delays in obtaining releases.

1. A lender seeking the release cannot obtain a final title insurance policy on the property until the previous mortgage has been released. The title insurance company will issue a commitment for title insurance that is contingent on receiving the mortgage release.
2. Salability of a loan without clear title also becomes questionable. FANNIE MAE or FREDDIE MAC may require the lender to repurchase the loan if a final title insurance policy is not received.

House FI&I
Attachment 7
1-30-95

3. Without a release, subsequent mortgages filed of record will be subordinate to those already recorded. In other words, the lender would not be "perfected" in their lien because the prior mortgage is still recorded.

While lenders are clearly effected by these delays the problem may be even worse for the borrower. Without clear title the borrower is effectively prevented from selling or refinancing their home. Imagine the following scenario: In August, a family refinances their home with an Kansas lending institution. The next month the "bread winner" of the family gets transferred to Alaska, so the family must move. One spouse stays behind to put the house up for sale, the other heads north to look for new lodgings. In November a buyer makes an offer on the Kansas house at the same time the family makes an offer, contingent on the sale their Kansas house, on an Alaskan house. In December the buyer of the Kansas house is turned down for the loan because there are two mortgages recorded on the property and no final title insurance policy is in place. Apparently, no mortgage release had been received from the original lender after the refinance in August. The sale of the house in Alaska falls through. Four months later the family is no closer to moving or being able to purchase a new home than they were in September.

While we have been as thorough as possible in drafting this bill, several concerns have been raised by industry associations and lenders. We request your consideration of the attached amendment which will hopefully clear up those concerns. The amendment would simply delete mortgagor and add escrow agents as those parties able to enter the mortgage release.

In conclusion, it has become clear over the last several years that mortgage lenders in this state need an alternative system for obtaining mortgage releases when extended delays occur. The problems associated with these delays can extend beyond the lender and effect the average homeowner in a potential harmful way. We respectfully request your favorable support of HB 2126.

Jeffrey D. Sonnich
Vice President

PROPOSED AMENDMENTS TO HB 2126

1. On Page 1, line 20, by striking "the mortgagor or" and inserting after "lender" the following:

   "or a designated escrow closing agent acting as a closing agent in a sale or refinance of the real estate subject to said mortgage,"

2. On Page 2, line 22, by striking "the mortgagor or" and inserting after "lender" the following:

   "or a designated escrow closing agent acting as a closing agent in a sale or refinance of the real estate subject to said mortgage,"

3. On Page 2, line 25, by striking "mortgagor or the" and inserting after "lender" the following:

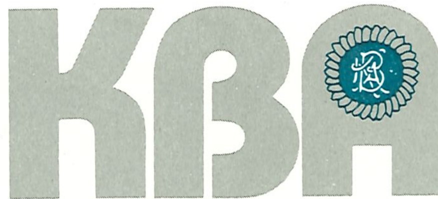
   "or a designated escrow closing agent acting as a closing agent in a sale or refinance of the real estate subject to said mortgage,"

4. On Page 2, line 27, by striking "mortgagor or the" and inserting after "lender" the following:

   "or a designated escrow closing agent acting as a closing agent in a sale or refinance of the real estate subject to said mortgage,"

5. On Page 2, line 36, by striking "the mortgagor or" and inserting after "lender" the following:

   "or a designated escrow closing agent acting as a closing agent in a sale or refinance of the real estate subject to said mortgage,"



The KANSAS BANKERS ASSOCIATION
A Full Service Banking Association

TO: House Committee on Financial Institutions and Insurance

FROM: Kathleen A. Taylor, Kansas Bankers Association

DATE: January 30, 1995

RE: **HB 2126:** Mortgage Release

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to appear today in support of **HB 2126**. This bill amends KSA 58-2309a, the provisions for release of a mortgage upon satisfaction of the underlying debt.

The proposed amendments would resolve a problem that appears to be occurring with more frequency as the shape of the banking industry changes. We believe that these amendments will be beneficial both to the customer and to the bank. Many times, the completion of a loan may be held up because of the failure of the prior lender to release the mortgage. Typically, it is not because the mortgage has not been properly retired, but because the prior lender is not aware of Kansas law on the matter or does not prioritize the release of the mortgage.

Allowing the mortgagee or the lender to cause release of the mortgage upon the production of the documentation listed, will subsequently allow the loan transaction to be completed in a timely manner. We hope that this will facilitate loan production to all institutions in our state.

Thank you for your consideration and I respectfully urge your favorable action.

House FI&I
Attachment 8
1-30-95

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