Approved: March 24, 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 March 16, 1995 in Room 527S of the Capitol.

All members were present except: Representative Tom Sawyer, Excused

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

Conferees appearing before the committee: Senator Tim Emert
Anita Larson, SBG
David Hanson, Kansas Life Insurance Association
David Ross, Kansas Life Underwriters
Tom Wilder, Kansas Insurance Department
Bill Sneed, HIAA
Brad Smoot, American Insurance Association
John P. Smith, Credit Union Administrator

Others attending: See attached list

Hearing on SB 261--Effect of marriage dissolution on designation of former spouse as beneficiary

Senator Tim Emert reviewed the bill which would change the law regarding insurance companies being obligated to pay funds to the designated beneficiary upon the death of the insured regardless of relationships or other facts (Attachment 1). Many times insurance policies and named beneficiaries are overlooked during divorce procedures. Former spouses who were named as beneficiaries of insurance policies would not be allowed to collect the insurance if the owner of the policy had remarried unless it was part of the divorce agreement. Senator Emert made the following suggestions for review of the original bill:

1. Change line 14 of page 1 to read "former spouse." Would this apply to pay-on-death accounts?

2. Change line 20 page 1 to read "shall belong to the remaining principal beneficiary, to the contingent beneficiary named in the policy" and ultimately to the estate.

3. Language to require checking Kansas death certificates to get name of spouse when someone dies. Industry needs to standardize proof-of-death requirements.

4. Would spousal election law be affected?

5. Would it be possible to set out in divorce decrees that the ex-spouse be removed as beneficiary from all insurance policies? The insurance policy is viewed as a contract between the buyer and the insurance company with no jurisdiction by the county.

Anita Larson, Security Benefit Group, appeared in opposition to the bill due to the confusion and that it may be contrary to the intent of the insured (Attachment 2). She made the following suggestions for amendments if the bill were to be favorably considered:

1. Statute should not require naming new beneficiaries. The proceeds should be distributed to the primary beneficiaries, then the contingent beneficiaries, and then to the estate.

2. Term "written notice" should be defined.

3/

3. Will this statute apply to all beneficiary designations or to designations made after the law is enacted?

4. What types of beneficiary designations will this bill impact?

David Hanson, Kansas Life Insurance Company, also appeared in opposition to the bill (Attachment 3). The provision of the bill would revoke the designation of the former spouse as a beneficiary and instead substitute the current surviving spouse and children as beneficiaries. This substitution not only ignores the owner's right to select the beneficiary, it would also ignore the owner's choice of secondary contingent beneficiaries.

David Ross, Kansas Life Underwriters, reminded the Committee that sometimes it is very intentional to leave former spouses on the policy.

Hearing on SB 52--Persons denied health insurance coverage to be notified of coverage through Kansas Health Insurance Association
Tom Wilder, Kansas Insurance Department, said even though the availability of such coverage continues to be advertised, this proposed system would guarantee notification in writing.

Bill Sneed, HIAA, said the amendment would require that all insurance companies who are members of the pool must notify individuals who have been denied health insurance coverage, for whatever reason, of the availability of coverage through the Kansas Health Insurance Association (Attachment 4).

Representative Smith recommended passage of the bill and that it be placed on the Consent Calendar. Representative Welshimer seconded the motion. Motion carried.

Hearing on SB 288--Reporting dates for product liability insurers
Tom Wilder, Kansas Insurance Department, informed the Committee that the statute which requires liability insurance carriers to report certain product liability claim information is no longer relevant (Attachment 5). The information is not needed by the Insurance Department because this data is currently collected by rating organizations and can be obtained if necessary either from the rating organizations or companies. Mr. Wilder requested that the passed legislation become effective upon publication in the Register.

Brad Smoot, American Insurance Association, stated that the current law requires carriers to cumulatively and repetitively report data on policies dating back to 1977 (Attachment 6). This information is rarely if ever used by the Insurance Department or the public.

Representative Correll moved to accept the amendment which would make the legislation effective upon publication in the Kansas Register. Motion was seconded by Representative Smith. Motion carried.

Representative Wilson moved that the bill be passed out favorably as amended. Motion was seconded by Representative Gilbert. Motion carried.

Action on SB 31--Credit unions, regulatory authority of administrator
This bill was passed out as amended by the Committee and later re-referred for further action. John Smith, Administrator of the Division of Credit Unions, asked that the Committee amend out Lines 15-19 on Page 6 which would have allowed a corporate credit union to establish a class of associate members which would have all rights, privileges and responsibilities of members except the right to vote.

Representative Correll moved to reconsider action on the bill. Motion was seconded by Representative Cox. Motion carried.

Representative Merritt moved to amend the bill by striking all of Section 4. Motion was seconded by Representative Samuelson. Motion carried.

Representative Humerickhouse moved that the bill be reported favorably as amended. Motion was seconded by Representative Welshimer. Motion carried.

Action on SB 36--Accident and health insurance mandate for coverage of immunizations
Representative Welshimer moved to amended the bill by increasing the mandated immunization coverage from 36 months to 72 months. Motion was seconded by Representative Smith. Motion failed.

Representative Landwehr made a conceptual motion to make this mandate apply to all HMO's. Motion was seconded by Representative Dawson. Motion carried.

Representative Samuelson moved to report the bill favorably as amended. Motion was seconded by Representative Landwehr. Motion carried.

Action on SB 46--Clean up the health care provider insurance availability act
This bill would complete the transfer of authority for the Health Care Stabilization Fund from the Kansas Insurance Department to the Board of Governors of the Fund.

Representative Correll moved to report the bill favorably and place it on the Consent Calendar. Motion was seconded by Representative Gilbert. Motion carried.

Action on SB 126--Late enrolles for group health and accident insurance
Amendments were presented which would attempt to modify, organize, increase readability, and comply with SRS regulations (Attachment 7).

Representative Landwehr expressed displeasure with the bill due to the possible increase in premiums. She moved to table the bill and it was seconded by Representative Merritt. Motion failed.

Representative Welshimer moved to accept the proposed amendments. Motion was seconded by Representative Smith. Motion carried.

Representative Welshimer moved to report the bill favorably as amended. The motion was seconded by Representative Smith. Motion carried.

Action on SB 125--Limitations on investments in certain money market mutual funds by insurance companies
Representative Smith moved to pass the bill out favorably. Motion was seconded by Representative Merritt. Motion carried.

Action on SB 345--Life insurance company investments in financial futures
Representative Landwehr moved to pass the bill out favorably. Motion was seconded by Representative Cox. Motion carried.

Representative Correll moved for the approval of the minutes of March 13, 1995. The motion was seconded by Representative Cox. Motion carried.

The meeting adjourned at 5:15 p.m. The next meeting is scheduled for March 20, 1995.

HOUSE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: 3/16/95

NAME	REPRESENTING
Tom Wilder	Kan Dept of Insurance
Bill Sneed	KIAA
Stacey Empson	Heinemann & Weir
Danielle Noe	KCIUA
Lee Wright	Farmers Ins. Group
Jamie Corkhill	SRS/CSE
Shannon Peterson	KBA
David Ross	K. Assn. Life Underwriters
Anita Larson	Security Benefit
David Hanson	KS LIFE INSUR ASSOC
Tim Emert	Senate
John P. Smith	KS ST Dept Credit Unions
Becky Harrell	Judicial Council
Brad Smoot	AIA
Larry Magill	KAIA
Kathy Peterson	Connaught Labs, Inc

STATE OF KANSAS

TIM EMERT
SENATOR, 15TH DISTRICT
ALLEN, CHAUTAUQUA, SE COFFEY,
MONTGOMERY, WILSON, WOODSON COUNTIES
P.O. BOX 747
INDEPENDENCE, KANSAS 67301
(316) 331-1800
STATE CAPITOL BUILDING, ROOM 143-N
TOPEKA, KS 66612-1504
(913) 296-7363

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS

CHAIRMAN: JUDICIARY

MEMBER: EDUCATION
ENERGY AND NATURAL RESOURCES
TRANSPORTATION AND UTILITIES

Senate Bill No. 261

Testimony of Senator Tim Emert
March 16, 1995

Before the
House Committee on Financial Institutions and Insurance

Mr. Chairman, I appreciate the opportunity to visit with you regarding SB 261 and thank you for giving this bill a hearing.

This bill addresses numerous problems that have arisen when a spouse is named as beneficiary on a life insurance policy, the parties are divorced and the insured dies prior to formally changing that beneficiary designation.

Presently, basic contract law applies to these situations. An insurance policy is a contract between the owner and the insuring company. A part of that contract is the provision naming beneficiaries. Insurance companies are obligated to pay funds to the designated beneficiary upon the death of the insured regardless of relationships or other facts. Serious situations can and have arisen when parties are divorced and the insured dies before the owner has an opportunity to make a beneficiary change. This failure may be due to oversight or just lack of time.

From my years of practicing law in a small town, I could give you countless examples of problems in this area.

Coincidentally, the day before this bill was heard in Senate Financial Institutions and Insurance, I received a call. A couple was

House FI&I
Attachment 1
3-16-95

married and had two young children, ages three and five. The mother abandoned the husband and children. The parties were subsequently divorced and the father obtained custody of the children and attempted to rear these children with the help of his mother and was working two jobs to support them. The actual decree of divorce was entered about a month ago. Last Thursday night the father was killed in a fire. His only asset of value was a fifty thousand dollar life insurance policy which will be paid to his former spouse.

Whether due to oversight, negligence or just forgetfulness, the father failed to change the beneficiary on his insurance policy. I was called by his mother, the grandmother of the two young children, (she will be responsible for rearing the children) trying to determine if there was any way to get some money to pay funeral expenses. I could be of no help.

The only opponent appearing in the Senate Committee was a large insurance company that stated this change could cause problems for them. However, this bill is almost identical to a Missouri law that has been in effect for a number of years and this opponent had to admit that no problems have been experience there.

The Security Benefit Group of Companies

Security Benefit Life Insurance Company
Security Benefit Group, Inc.
Security Distributors, Inc.
Security Management Company

700 Harrison St.
Topeka, Kansas 66636-0001
(913) 295-3000

March 16, 1995

Subj: Senate Bill 261
Designation of Former Spouse as Beneficiary

Dear Chairman and Committee Members:

Security Benefit Life Insurance Company is a Kansas Life insurer. Security Benefit opposes Senate Bill 261, as amended by Senate Committee.

Senate Bill 261 would automatically change the beneficiary designation upon the dissolution of a marriage. It is the general rule in most states that dissolution of marriage does not affect a beneficiary designation. We believe that enactment of this proposal may cause confusion and in some instances may be contrary to the intent of the insured.

Although it is Security Benefit's preference that the law remain unchanged and that the provisions of our contracts with our policyholders apply, if it is the Committee's will to act favorably on Senate Bill 261, we ask you to consider the following suggestions.

We believe that the intent of the owner of the policy should govern. Instead of specifically naming new beneficiaries by statute, i.e. the surviving spouse and children, we believe that the proceeds should be distributed as follows: to the remaining primary beneficiaries, if any; if none, then to the contingent beneficiaries, if any; and if none, to the estate of the insured.

We ask that the term "written notice" referenced in line 35 be specifically defined. We believe that at a minimum, insurance companies are entitled to rely on a death certificate that indicates that the insured was divorced or remarried. Written notice in another form, such as a newspaper story or reference, we believe is clearly insufficient. If, in good faith, an insurance company pays a claim in reliance on information contained in a death certificate, we believe that the insurance company should be protected from liability.

We ask that the beneficiary designations to which this statute would apply be specifically defined. Will this statute apply to all beneficiary designations or to designations made after the law is enacted?

We ask that it be clarified as to what <u>types</u> of beneficiary designations this Bill will impact. Will this designation apply to non probate "transfers on death" or "pay on death" beneficiary designations?

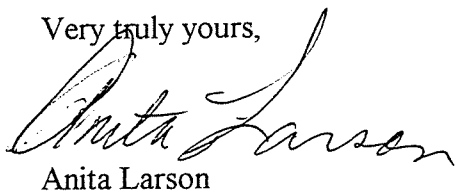
Dawn Ford

Attachment 2

3-16-95

Thank you for your time and consideration. I would be happy to address your questions and concerns.

Very truly yours,



Anita Larson
Assistant Counsel
Security Benefit Life Insurance Company

TESTIMONY ON SENATE BILL 261

TO: Chairman Bill Bryant
House Financial Institutions and Insurance Committee
Capitol Building
Topeka, Kansas

Re: Senate Bill 261

Mr. Chairman and Members of the Committee, I am David Hanson and appear on behalf of the Kansas Life Insurance Association, an association of domestic life insurance companies here in Kansas. As we have reviewed the provisions of Senate Bill 261, concerns have arisen over the public policy issue as to whether a former spouse should be recognized as a beneficiary after a divorce. Current law recognizes the property owner's right to designate and change beneficiaries. Where the owner designates his or her spouse as the beneficiary and then gets a divorce, if the owner fails to change that beneficiary for whatever reason, should we by law change that beneficiary? The provisions of Senate Bill 261 would revoke the designation of the former spouse as a beneficiary and instead substitute the current surviving spouse and children as beneficiaries. While in some cases this may produce a better result, in other cases it will create just as many problems. Such a substitution of beneficiaries not only ignores the owner's right to select the beneficiary, it would also ignore the owner's choice of secondary contingent beneficiaries.

We are therefore not able to support Senate Bill 261 in its current form.

Respectfully,

DAVID A. HANSON

House FI&I
Attachment 3
3-16-95

MEMORANDUM

TO: The Honorable Bill Bryant, Chairman
House Financial Institutions and Insurance Committee

FROM: William W. Sneed, Legislative Counsel
The Health Insurance Association of America

DATE: March 16, 1995

RE: S.B. 52

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for the Health Insurance Association of America ("HIAA"). The HIAA is a health insurance trade association consisting of over 300 insurance companies that write over 80% of the health insurance in the United States today. Please accept this memorandum as our testimony in regard to S.B. 52. S.B. 52 would amend K.S.A. 40-2122. This statute defines the criteria that an individual must meet in order to procure insurance through the Kansas Health Insurance Association. The Kansas Health Insurance Association is generally referred to as the uninsurable pool. This is a statutory mechanism where individuals who cannot procure health insurance from the standard markets are able to obtain such coverage through this pool.

The amendment would require that all insurance companies who are members of the pool must notify individuals who have been denied health insurance coverage, for whatever reason, of the availability of coverage through the Kansas Health Insurance Association.

Please be advised that my client supports this measure, and in many instances, members of our Association are already providing this notification. Additionally, the Senate

GEHRT & ROBERTS, CHARTERED
5601 S.W. Barrington Court South
P.O. Box 4306
Topeka, Kansas 66604-0306
(913) 273-7722
(913) 273-8560

Attachment 4
3-16-95

Committee amendment was at our request to require such notification to be in writing in order to avoid any future disputes.

Again, on behalf of my client, we do support S.B. 52, and respectfully request your favorable consideration.

Respectfully submitted,

William W. Sneed

GEHRT & ROBERTS, CHARTERED
5601 S.W. Barrington Court South
P.O. Box 4306
Topeka, Kansas 66604-0306
(913) 273-7722
(913) 273-8560

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

From: Tom Wilder, Director of Governmental Relations
Kansas Department of Insurance

To: House Financial Institutions and Insurance Committee

Date: March 16, 1995

Re: Substitute for Senate Bill 288 (Product Liability Reports)

Senate Bill 288 as originally introduced amended K.S.A. 40-1132 which is a statute that requires insurers to report certain product liability claim information on a yearly basis to the Kansas Insurance Department. Companies must report claim information to the Department no later than May 1 of each year and the statute requires an administrative penalty of $1,000.00 if the report is not filed on time. The Kansas Department of Insurance requested the Senate Committee prepare a substitute bill which repeals the statute. The product liability claim data required under K.S.A. 40-1132 is already submitted by insurers in a somewhat different format to the rating organizations such as Insurance Services Office and it is no longer necessary for the same information to be submitted to the Department.

It is important to understand the history of K.S.A. 40-1132 and a companion statute K.S.A. 40-1133 which were first enacted in 1983 during a time when product liability insurance was expensive and difficult to obtain in Kansas. The Kansas Legislature decided to require property and casualty companies to report data on an annual basis to the Department on the dollar amount and number of product liability claims submitted to the company for the current policy year and for each policy year starting with 1977. Companies are also required to provide

House Fin. Inst.
Attachment 5

420 SW 9th Street
Topeka, Kansas 66612-1678

913 296-3071
Fax 913 296-2283

Consumer Assistance Hotline
1 800 432-2484 (Toll Free)

3-16-95

data on the amount of reserves and loss expenses for each claim. This information has been collected by the Department since the effective date of the statute in 1983 and since that time only one person has requested a copy of the report from the Insurance Department.

The Department of Insurance believes K.S.A. 40-1132 and K.S.A. 40-1133 should be repealed. This Committee should eliminate unnecessary reporting of claims data which is not needed by the Insurance Department. This data is currently collected by rating organizations and can be obtained if necessary either from the rating organizations or companies. The Kansas Department of Insurance recommends that Substitute for Senate Bill 288 be passed favorably by this Committee with one amendment. The original Substitute Bill is effective upon publication in the statute book. Since the next reports from the companies are due by May 1, 1995 it would be helpful if this legislation is made effective upon publication in the Kansas Register.

BRAD SMOOT
ATTORNEY AT LAW

EIGHTH & JACKSON STREET
MERCANTILE BANK BUILDING
SUITE 808
TOPEKA, KANSAS 66612
(913) 233-0016
(913) 234-3687 FAX

10200 STATE LINE ROAD
SUITE 230
LEAWOOD, KANSAS 66206
(913) 649-6836

STATEMENT OF BRAD SMOOT, LEGISLATIVE COUNSEL FOR THE AMERICAN INSURANCE ASSOCIATION, PRESENTED TO THE KANSAS HOUSE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE REGARDING 1995 SUBSTITUTE FOR SENATE BILL 288 MARCH 16, 1995

Mr. Chairman and Members of the Committee:

I am Brad Smoot, Legislative Counsel for the American Insurance Association (AIA), a trade association representing more than 200 companies providing a variety of insurance products to Kansans and across the nation.

Senate Bill 288 was introduced by the Senate Financial Institutuions and Insurance Committee at our request. As originally drafted, the bill would have reduced a liability insurance carrier's current obligation to report product liability premium, loss and reserve experience to the Kansas Insurance Department as required by K.S.A. 40-1132. Enacted in the early 1980's, this law requires carriers to cumulatively and repetitively report data on policies dating back to 1977. To the best of our knowledge this information is rarely, if ever, used by the Insurance Department or the public. Much of this information is kept elsewhere in some form by rating organizations or individual carriers and, thus, is accessible to the Insurance Department as the need requires. Like 1994 House Bill 3041, which reduced reporting requirements for professional liability insurance carriers, S 288 will help reduce administrative costs.

At the suggestion of the Kansas Insurance Department, S 288 was amended to repeal rather than merely reduce the reporting requirements. We endorse the Senate amendments but would ask the House to make the bill effective upon publication in the Kansas Register to avoid unnecessary filing of reports in May of 1995. Thank you.

Financial
Attachment 6
3-16-95

[As Amended by Senate Committee of the Whole]

As Amended by Senate Committee

Session of 1995

SENATE BILL No. 126

By Financial Institutions and Insurance

1-26

AN ACT concerning accident and sickness insurance; late enrollees; amending K.S.A. 1994 Supp. 40-2209 and repealing the existing section

K.S.A. 40-2209g, 40-2228 and 40-3209

, 40-2209d and 40-2209e

sections

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

Section 1. K.S.A. 1994 Supp. 40-2209 is hereby amended to read as follows: 40-2209. (A) Group sickness and accident insurance is declared to be that form of sickness and accident insurance covering groups of persons, with or without one or more members of their families or one or more dependents. Except at the option of the employee or member and except employees or members enrolling in a group policy after the close of an open enrollment opportunity, no individual employee or member of an insured group and no individual dependent or family member may be excluded from eligibility or coverage under a policy providing hospital, medical or surgical expense benefits both with respect to policies issued or renewed within this state and with respect to policies issued or renewed outside this state covering persons residing in this state. For purposes of this section, an open enrollment opportunity shall be deemed to be a period no less favorable than a period beginning on the employee's or member's date of initial eligibility and ending 31 days thereafter. *An eligible employee, member or dependent who requests enrollment following the open enrollment opportunity shall be considered a late enrollee. However, an eligible employee, member or dependent shall not be considered a late enrollee if:*

(1) The individual:

(a) Was covered under another group policy which provided hospital, medical or surgical expense benefits at the time the individual was eligible to enroll;

(b) states, at the time of the open enrollment period, that coverage under another group policy which provided hospital, medical or surgical expense benefits was the reason for declining enrollment;

(c) has lost coverage under another group policy providing hospital,

Senate FIS & I
Attachment 7
3-16-95

medical or surgical expense benefits as a result of the termination of employment, the termination of the other policy's coverage, death of a spouse or divorce; and

(d) requests enrollment within 31 days after the termination of coverage under the other policy; 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)~~ *(2) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's or member's policy* ~~*and request for enrollment is made within 31 days after issuance of such court order*~~

No group policy providing hospital, medical or surgical expense benefits issued or renewed within this state or issued or renewed outside this state covering residents within this state shall limit or exclude benefits for specific conditions existing at or prior to the effective date of coverage thereunder. Such policy may impose a waiting period, not to exceed 90 days for benefits for conditions, including related conditions, for which diagnosis, treatment or advice was sought or received in the 90 days prior to the effective date of coverage. Such policy shall waive such a waiting period to the extent the employee or member or individual dependent or family member was covered by a group or individual sickness and accident policy, coverage under section 607(1) of the employees retirement income act of 1974 (ERISA), a group specified in K.S.A. 40-2222 and amendments thereto or a group subject to K.S.A. 12-2616 *et seq.* and amendments thereto which provided hospital, medical and surgical expense benefits within 31 days prior to the effective date of coverage with no gap in coverage. Any group policy may impose participation requirements, define full-time employees or members and otherwise be designed for the group as a whole through negotiations between the group sponsor and the insurer to the extent such design is not contrary to or inconsistent with this act and may be issued to such group upon the following basis:

~~(1)~~ ~~(1)~~ ~~[(3)]~~ Under a policy issued to an employer or trustees of a fund established by an employer, who is the policyholder, insuring at least three employees of such employer, for the benefit of persons other than the employer. The term "employees" shall include the officers, managers, employees and retired employees of the employer, the partners, if the employer is a partnership, the proprietor, if the employer is an individual proprietorship, the officers, managers and employees and retired employees of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, employees and retired employees of individuals and firms, the business of which and of the insured employer is under common control through stock ownership contract, or otherwise. The policy may provide that the term "employees" may include

New Paragraph (B)

New Paragraph (C)

providing hospital, medical or surgical expense benefits

(1)

the trustees or their employees, or both, if their duties are principally connected with such trusteeship. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials.

~~(2) (5) [(4)]~~ Under a policy issued to a labor union which shall have a constitution and bylaws insuring at least 25 members of such union. (2)

~~(3) (6) [(5)]~~ Under a policy issued to the trustees of a fund established by two or more employers or business associations or by one or more labor unions or by one or more employers and one or more labor unions, which trustees shall be the policyholder, to insure employees of the employers or members of the union or members of the association for the benefit of persons other than the employers or the unions or the associations. The term "employees" shall include the officers, managers, employees and retired employees of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship. (3)

~~(4) (7) [(6)]~~ A policy issued to a creditor, who shall be deemed the policyholder, to insure debtors of the creditor, subject to the following requirements: (a) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor whose indebtedness is repayable in installments, or all of any class or classes determined by conditions pertaining to the indebtedness or to the purchase giving rise to the indebtedness. (b) The premium for the policy shall be paid by the policyholder, either from the creditor's funds or from charges collected from the insured debtors, or from both. (4)

~~(5) (8) [(7)]~~ A policy issued to an association which has been organized and is maintained for the purposes other than that of obtaining insurance, insuring at least 25 members, employees, or employees of members of the association for the benefit of persons other than the association or its officers. The term "employees" shall include retired employees. The premiums for the policies shall be paid by the policyholder, either wholly from association funds, or funds contributed by the members of such association or by employees of such members or any combination thereof. (5)

~~(6) (9) [(8)]~~ Under a policy issued to any other type of group which the commissioner of insurance may find is properly subject to the issuance of a group sickness and accident policy or contract. (6)

~~(B) Each such policy shall contain in substance: (1) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warran-~~ Moved to end of section

4-3

~~ties, and that no statement made by any person insured shall be used in~~ any contest unless a copy of the instrument containing the statement is or has been furnished to such person or the insured's beneficiary.

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

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

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

Moved to end of section

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

(D) A group policy of insurance delivered or issued for delivery or renewed which provides hospital, surgical or major medical expense insurance, or any combination of these coverages, on an expense incurred basis, shall provide that an employee or member or such employee's or member's covered dependents whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy or under any group policy providing similar benefits which it replaces for at least three months immediately prior to termination, shall be entitled to have such coverage nonetheless continued under the group policy for a period of

by 29 U.S.C. 1161 et seq., or (ii) from the date the employer ceases to provide any similar group health plan to any employee. Such notices shall be provided in accordance with rules and regulations adopted by the commissioner of insurance.

~~(E)~~ (1) No policy issued by an insurer to which this section applies shall contain a provision which excludes, limits or otherwise restricts coverage because medicaid benefits as permitted by title XIX of the social security act of 1965 are or may be available for the same accident or illness.

(2) Violation of this subsection shall be subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.

Sec. 2. K.S.A. 1994 Supp. 40-2209 is hereby repealed.

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

See attached insert (E) and (F)

(G)

See attached sections

And by renumbering sections accordingly

40-2209g, 40-2228 and 40-3209 and K.S.A.

, 40-2209d and 40-2209e are

7-5

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

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

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

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

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

Sec. 2. K.S.A. 1994 Supp. 40-2209d is hereby amended to read as follows: 40-2209d. 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 K.S.A. 40-2209h and amendments thereto, 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 K.S.A. 40-2209k and amendments thereto.

(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 the Kansas Statutes Annotated, 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 K.S.A. 40-2209g and amendments thereto.

(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 and amendments thereto; 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, however 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 K.S.A. 40-22091 and amendments thereto.

(t) "Preexisting conditions provision" means a policy provision which excludes or limits coverage for charges or expenses incurred during a specified period not to exceed 90 days 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 moneys 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 K.S.A. 40-22091 and amendments thereto.

(w) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect but any period of less than one year shall be

considered as a full year.

(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 K.S.A. 40-2209k and amendments thereto.

(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 subsection (A) of K.S.A. 40-2209 and amendments thereto actively engaged in business whose total employed work force consisted of, on at least 50% of its working days during the preceding year, no more than 50 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 K.S.A. 40-2209k and amendments thereto.

(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. 3. K.S.A. 1994 Supp. 40-2209e is hereby amended to read as follows: 40-2209e. (a) Any individual or group health benefit plan issued to a group authorized by subsection (A) of K.S.A.

40-2209 and amendments thereto 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;

(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 106 or section 162 of the United States internal revenue code; or

(3) with the permission of the board, the carrier elects to renew or continue a health benefit plan covering employees of an employer who no longer meets the definition of a "small employer."

(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 subsection ~~(A)~~ (C)(3) or (5) of K.S.A. 40-2209 and amendments thereto shall permit employee or member units of more than two but less than 51 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 50 or fewer employees shall be subject to the provisions of this act notwithstanding its inclusion of employee or member units with more than 50 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 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 inhibit 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. 40-2209 and amendments thereto shall not be subject to the provisions of this act.

Sec. 4. K.S.A. 40-2209g is hereby amended to read as follows: 40-2209g. From and after January 1, 1993: (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 subsection ~~(A)~~ (C)(5) of K.S.A. 40-2209 and amendments thereto.

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

(c) The commissioner may adopt rules and 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. 5. K.S.A. 40-2228 is hereby amended to read as follows:

40-2228. (a) The commissioner may adopt reasonable rules and regulations:

(1) To establish specific standards for policy provisions of long-term care insurance policies. Such standards shall be in addition to and in accordance with applicable laws of this state, and shall address terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms; and

(2) to specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair or unfairly discriminatory to any person insured under a long-term care insurance policy.

(b) Rules and regulations adopted by the commissioner shall:

(1) Recognize the unique, developing and experimental nature of long-term care insurance; and

(2) recognize the appropriate distinctions necessary between group and individual long-term care insurance policies.

(c) The commissioner may adopt rules and regulations establishing loss-ratio standards for long-term care insurance policies if a specific reference to long-term care insurance policies is contained in the rules and regulations.

(d) No long-term care insurance policy may:

(1) Be canceled, nonrenewed, or otherwise terminated solely on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificateholder; or

(2) contain a provision establishing any new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

(e) (1) No long-term insurance policy or certificate shall

use a definition of preexisting condition which is more restrictive than the following: "Preexisting condition" means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment, or a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within:

(A) Six months preceding the effective date of coverage of an insured person who is 65 years of age or older on the effective date of coverage; or

(B) twenty-four months preceding the effective date of coverage of an insured person who is under age 65 on the effective date of coverage.

(2) No long-term care insurance policy shall exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within:

(A) Six months following the effective date of coverage of an insured person who is 65 years of age or older on the effective date of coverage; or

(B) twenty-four months following the effective date of coverage of an insured person who is under age 65 on the effective date of coverage.

(3) The commissioner may extend the limitation periods set forth in subsections (e)(1) and (e)(2) above as to specific age group categories or specific policy forms upon finding that the extension is not contrary to the best interest of the public.

(4) The definition of preexisting condition shall not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards.

(f) No long-term care insurance policy shall require prior institutionalization as a condition precedent to the payment of benefits.

(g) In order to provide for fair disclosure in the sale of long-term care insurance policies:

(1) An outline of coverage shall be delivered to an applicant for a long-term care insurance policy at the time of application. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of request, shall make such delivery no later than at the time of policy delivery. Such outline of coverage shall include:

(A) A description of the principal benefits and coverage provided in the policy;

(B) a statement of the principal exclusions, reductions and limitations contained in the policy;

(C) a statement of the renewal provisions, including any reservation in the policy of a right to change premiums; and

(D) a statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy should be consulted to determine governing contractual provisions.

(2) A certificate issued pursuant to a group long-term care insurance policy which policy is delivered or issued for delivery in this state shall include the information required by subsection ~~(B)~~ (E)(4) of K.S.A. 40-2209, and amendments thereto.

(h) No policy shall be advertised, marketed or offered as long-term care insurance unless it complies with the provisions of this act.

Sec. 6. K.S.A. 40-3209 is hereby amended to read as follows: 40-3209. (a) All forms of contracts issued by the organization to enrollees or other marketing documents purporting to describe the organization's health care services shall contain as a minimum:

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

(2) the locations of all facilities, the hours of operation and the services which are provided in each facility in the case of staff and group practices, and, in all other cases, a list of providers by specialty with a list of addresses and telephone

numbers;

(3) the financial responsibilities of the enrollee and the amount of any deductible, copayment or coinsurance required;

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

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

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

(7) a provision that an enrollee or a covered dependent of an enrollee whose coverage under a health maintenance organization group contract has been terminated for any reason but who remains in the service area and who has been continuously covered by the health maintenance organization for at least three months shall be entitled to obtain a converted contract or have such coverage continued under the group contract for a period of six months following which such enrollee or dependent shall be entitled to obtain a converted contract in accordance with the provisions of this section. The converted contract shall provide coverage at least equal to the conversion coverage options generally available from insurers or mutual nonprofit hospital and medical service corporations in the service area at the applicable premium cost. The group enrollee or enrollees shall be solely responsible for paying the premiums for the alternative coverage. The frequency of premium payment shall be the frequency customarily required by the health maintenance organization, mutual nonprofit hospital and medical service corporation or insurer for the policy form and plan selected, except that the insurer, mutual nonprofit hospital and medical service corporation or health maintenance organization shall require premium payments at least quarterly. The coverage shall be available to all enrollees of any group without medical underwriting. The requirement imposed by this subsection shall not apply to a contract which provides benefits for specific

diseases or for accidental injuries only, nor shall it apply to any employee or member or such employee's or member's covered dependents when:

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

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

(C) the employee or member is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. Written application for the converted contract shall be made and the first premium paid not later than 31 days after termination of the group coverage or receipt of notice of conversion rights from the health maintenance organization, whichever is later, and shall become effective the day following the termination of coverage under the group contract. The health maintenance organization shall give the employee or member and such employee's or member's covered dependents reasonable notice of the right to convert at least once within 30 days of termination of coverage under the group contract. The group contract and certificates may include provisions necessary to identify or obtain identification of persons and notification of events that would activate the notice requirements and conversion rights created by this section but such requirements and rights shall not be invalidated by failure of persons other than the employee or member entitled to conversion to comply with any such provisions. In addition, the converted contract shall be subject to the provisions contained in paragraphs (2), (4), (5), (6), (7), (8), (9), (13), (14), (15), (16), (18), (19) and (20) of subsection (D) of K.S.A. 40-2209, and amendments thereto; and

(8) (A) group contracts shall contain a provision extending payment of such benefits until discharged or for a period not less than 31 days following the expiration date of the contract,

whichever is earlier, for covered enrollees and dependents confined in a hospital on the date of termination; and

(B) a provision that coverage under any subsequent replacement contract that is intended to afford continuous coverage will commence immediately following expiration of any prior contract with respect to covered services not provided pursuant to subparagraph (8)(A) of this subsection.

(b) No health maintenance organization authorized under this act shall contract with any provider under provisions which require enrollees to guarantee payment, other than copayments and deductibles, to such provider in the event of nonpayment by the health maintenance organization for any services which have been performed under contracts between such enrollees and the health maintenance organization. Further, any contract between a health maintenance organization and a provider shall provide that if the health maintenance organization fails to pay for covered health care services as set forth in the contract between the health maintenance organization and its enrollee, the enrollee or covered dependents shall not be liable to any provider for any amounts owed by the health maintenance organization. If there is no written contract between the health maintenance organization and the provider or if the written contract fails to include the above provision, the enrollee and dependents are not liable to any provider for any amounts owed by the health maintenance organization.

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

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

(e) The provisions of subsections (A), (B), ~~and~~ (C), (E) and

(F) of K.S.A. 40-2209 and 40-2215 and amendments thereto shall apply to all contracts issued under this section, and the provisions of such sections shall apply to health maintenance organizations.